Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Patient Safety Incident Response Policy

This procedural document supersedes: CORP/RISK 36 v.1 – Patient Safety Response Incident Policy

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Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 2	June 2026	• Minor Changes to terminology	Marie Hardacre
Version 1	December 2024	• Patient Safety Flow Chart added to Version 1 as agreed and approved by TEPSOG.	Nicola Severein-Kirk
Version 1	October 2023	• This is a new procedural document, please read in full. Approved by Patient Safety Review Group.	Simon Brown/ Marie Hardacre

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1 INTRODUCTION

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (the Trust) will approach the development and maintenance of effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety events. It embeds the patient safety event response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.
This policy supports development and maintenance of an effective patient safety event response system that integrates the four key aims of the PSIRF and which also aligns to our existing Trust values:

- Compassionate engagement and involvement of those affected by patient safety events (Accountability, Respect and Support).
- Application of a range of system-based approaches to learning from patient safety events (Continuous Improvement and Accountability).
- Considered and proportionate responses to patient safety events and safety issues (Continuous Improvement and Accountability).
- Supportive oversight focused on strengthening response system functioning and improvement. (Continuous Improvement, Support, Respect and Enthusiasm).

This policy should be read in conjunction with our current Patient Safety Incident Response Plan, which is a separate document setting out how this policy will be implemented.

2 PURPOSE

This policy is specific to patient safety event responses conducted solely for the purpose of learning and improvement across the Trust.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an event.
Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes as those listed below and are therefore outside the scope of this policy.

- Claims handling.
- Human resources investigations into employment concerns.
- Professional standards investigations.
- Information governance concerns.

- Estates and facilities concern.
- Financial investigations and audits.
- Safeguarding concerns.
- Coronial inquests and criminal investigations.
- Complaints (except where a significant patient safety concern is highlighted).

For clarity, the Trust considers these processes as separate from any patient safety learning responses. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety event response.

3 ROLES AND RESPONSIBILITIES

This organisation describes clear roles and responsibilities in relation to its response to patient safety events, including investigator responsibilities and upholding national standards relating to patient safety events.

Full details of the Roles and Responsibilities are outlined in our PSIRF Plan. A copy of our current plan can be found https://extranet.dbth.nhs.uk/patient-safety-incident-response-framework-2/our-plan/.

4 OVERSIGHT ROLES AND RESPONSIBILITIES

4.1 Principles of Oversight

Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.
The Trust followed the PSIRF Implementation Standards to underpin the processes we have put in place to allow us to implement PSIRF as set out in the supporting document (NHS England (2022), p 3)[1].

4.2 Responsibilities

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission, we have specific organisational responsibilities within the Framework.
To meet these responsibilities, the Trust has designated the Chief Nurse to oversee PSIRF as the executive lead. The Chief Nurse will undertake this role in close collaboration with the Executive Medical Director.

[1] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf

4.2.1 Ensuring that the organisation meets the national patient safety standards

The Chief Nurse will oversee the development, review and approval of the Trust's policy and plan ensuring that they meet the expectations set out in the patient safety event response standards. The policy and plan will promote the restorative just culture working that the Trust aspires to.

4.2.2 Ensuring that PSIRF is central to overarching safety governance arrangements

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Quality Committee.

The PSIRF Implementation Group will provide assurance to the Quality Committee that PSIRF and related work streams have been implemented to the highest standards. Divisions will be expected to report on their patient safety event learning responses and outcomes to Patient Safety Assurance Group.

This will include reporting on ongoing monitoring and review of the Patient Safety Incident Response Plan and delivery of safety actions and improvement.

Divisions will have arrangements in place to manage the local response to patient safety events and ensure that escalation procedures as described in the patient safety event response section in this policy are effective.
The Trust has sourced necessary training as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to events.
Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years to comply with Trust guidance on policy development, alongside a review of all safety actions.

4.2.3 Quality assuring learning response outputs

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

5 OUR PATIENT SAFETY CULTURE

As a Trust, DBTH have worked over a number of years to transition to a restorative just culture within the organisation.

The Trust senior leadership have strongly embraced this work and with support from staff side colleagues have been instrumental in establishing the organisational transition to a restorative just culture. We have been fortunate to have input from internationally recognised leaders in this field

who have helped us progress our work so far to improve our organisational health and also to share our progress on this cultural shift to the benefit of others.

The main goals of restoration when an event has happened have been outlined as follows:

- Moral engagement
- Emotional healing
- Reintegration of the practitioner
- Organisational learning
- Prevention

PSIRF will enhance these by creating much stronger links between a patient safety event and learning and improvement. We aim to work in collaboration with those affected by a patient safety event – staff, patients, families, and carers to arrive at such learning and improvement within the culture we will foster. This will continue to increase transparency and openness amongst our staff in reporting of events and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

We are clear that patient safety event responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoidability or cause of death.

Our safety culture has also progressed in a positive way with reporting of patient safety events improving over time.

We will utilise findings from our staff survey metrics based on specific patient and staff safety questions to assess if we are sustaining our ongoing progress in improving our safety culture.

6 PATIENT SAFETY PARTNERS

The Patient Safety Partner (PSP) is an evolving role developed by NHS England / Improvement to help improve patient safety across the NHS in the UK.

At DBTH NHS Foundation Trust, we work with PSPs who offer support alongside our staff, patients, and families/carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

As the role evolves, the PSPs are assisting in the implementation of patient safety improvement initiatives and developing patient safety resources for patients. Their role supports the voice of our patients, the role promoting a collaborative approach with the patient safety team, our divisional colleagues and the public.

The PSPs will be supported in their honorary role by the Patient Safety Specialist for the Trust who will provide expectations and guidance for the role.

PSPs will have regular scheduled reviews and regular one-to-one sessions with our Patient Safety Specialist and training needs will be agreed together based on the experience and knowledge of each PSP.

The PSP placements are on an honorary basis and will be reviewed annually to ensure we keep the role aligned to the patient safety agenda as this develops.

7 ADDRESSING HEALTH INEQUALITIES

The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust as a public authority is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.

Within our patient safety response toolkit, we will consider any particular features of an event which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. Any commissioned learning response will be based on consideration of health inequalities.

Engagement of patients, families and staff following a patient safety event is critical to review of patient safety events and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety event response. We will ensure that we consider the accessible information standards. Family Liaison Officers (FLO) will be the main point of contact for families during Individual PSIIs and they will support families and carers through the PSII process that follows a patient safety event. They will ensure patients, families and carers are meaningfully engaged in learning responses and that they are treated with compassion, and professionalism in respect to their individual needs.

We will ensure the highest degree of sensitivity, communication and integrity with those affected by patient safety events and this will include the provision of support to newly bereaved individuals, some of whom may be deeply distressed. We will ensure that the family's needs are met regarding the provision of timely and accurate information during the learning response and will facilitate the level of involvement they wish to have in the learning response.

The Trust's commitment to embedding just culture at DBTH has already been outlined. Further to this, the Trust has affirmed that it endorses a zero acceptance of racism, discrimination, and

unacceptable behaviours from and toward our workforce and our patients/service users, carers and families.

8 ENGAGING AND INVOLVING PATIENTS, FAMILIES AND STAFF FOLLOWING A PATIENT SAFETY EVENT

The PSIRF recognises that learning and improvement following a patient safety event can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety event response system that prioritises compassionate engagement and involvement of those affected by patient safety events (including patients, families, and staff). This involves working with those affected by patient safety events to understand and answer any questions they have in relation to the event and signpost them to support as required.

We are firmly committed to continuously improving the care and services we provide. We want to learn from any event where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence.

The trust has a number of support mechanisms in place such as the Professional Nurse/Midwifery advocates. (See Appendix E).

We recognise and acknowledge the significant impact patient safety events can have on patients, their families, and carers.

Getting involvement right with patients and families in how we respond to events is crucial, particularly to support improving the services we provide.

Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.

As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an event.

As part of our policy, we will be outlining procedures that support patients, families, and carers – based on our existing Duty of Candour Policy. This will be underpinned by Family Liaison Officers who are able to guide patients, families and carers through any learning response or review.

8.1 Resources and training to support patient safety event response

The Trust has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022)[2] to frame the resources and training required to allow for this to happen.

The Trust has governance arrangements in place to ensure that learning responses are not led by staff who were involved in the patient safety event itself or by those who directly manage those staff.

Responsibility for the allocation of the learning response lies with the divisional leadership team for defining responses having reviewed the PSIRP. A learning response lead will be nominated by the Division and that individual should have an appropriate level of seniority and influence within the Trust – this may depend on the nature and complexity of the event and response required and can be supported by the patient safety team.

The Trust has governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. Divisional senior leadership team will manage the selection of an appropriate learning response lead to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation. The Patient Safety team will support PSIIs and other learning responses where complex situations involving 2 or more divisions or systems partners possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety events will be afforded the necessary managerial support and be given time to participate in learning responses. All Trust managers will work within our just and restorative culture principles and utilise other teams such as Health and Wellbeing and Professional Nurse Advocate/Professional Midwifery Advocates when appropriate to ensure that there is a dedicated staff resource to support such engagement and involvement. The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills where and when necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

8.2 Training

The Trust has implemented a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety events and to comply with the NHS England Health Education England Patient Safety Training Syllabus. Full details of the training expectation are provided in the table (Appendix D).

9 PATIENT SAFETY INCIDENT RESPONSE PLANNING

PSIRF supports organisations to respond to events and safety issues in a way that maximises learning and improvement moving away from the Serious Incident Framework. The Patient Safety Incident

[2] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf

Response Plan (PSIRP) will include nationally set requirements; the Patient Safety Incident Response Policy (PSIRF) sets out the Trust's approach to developing and maintaining effective systems and processes for responding to patient safety events.

The Trust will take a proportionate approach to its response to patient safety events, ensuring the focus is on maximising improvement. To support this, we will review our current patient safety resources and existing safety improvement workstreams. We will triangulate data from incidents, complaints, claims, staff feedback, and other qualitative and quantitative sources to develop a comprehensive understanding of our safety position and culture.

The Quality Oversight Review Group (QORG) meets monthly and serves as the forum where monitoring information and early warning signs are reviewed and escalated.
Our Patient Safety Incident Response Plan will detail how this has been achieved as well as how the Trust will meet both national and local focus for patient safety event responses.

10 OUR PATIENT SAFETY INCIDENT RESPONSE PLAN

Our plan sets out how the Trust intends to respond to patient safety events over a period of 12 months initially. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety event occurred and the needs of those affected, as well as the plan.

A copy of our current plan can be found https://extranet.dbth.nhs.uk/patient-safety-incident-response-framework-2/our-plan/

11 REVIEW OUR PATIENT SAFETY EVENT RESPONSE POLICY & PLAN

Our Patient Safety Incident Response Plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety events. We will review the plan every 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety event profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 – 18 months.

Updated plans will be published on our website, replacing the previous version.
A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our Integrated Care Boards (ICBs) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, Patient Safety Incident Investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement. As a Trust, we do not work in isolation and we will continue to work in collaboration with system partners at Place, Integrated Care Board (ICB) and Integrated Care Partnership (ICP) level in the delivery of our People Strategy and our wider strategic objectives. As a multi-site Trust, we work collaboratively with partners in both the South Yorkshire and Nottinghamshire systems.

12 RESPONDING TO PATIENT SAFETY EVENTS

12.1 Safety event reporting arrangements

All staff are responsible for reporting any potential or actual patient safety events on a Trust event reporting system (currently Datix) and will record the level of harm they know has been experienced by the person affected (see Appendix A).

Divisions will have daily review mechanisms in place (see figure 1.) to ensure that patient safety events can be responded to proportionately and in a timely fashion.

The Patient Safety team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

12.2 Patient safety event response decision-making

The Trust will have arrangements in place to allow it to meet the requirements for review of patient safety events under PSIRF. Some events will require mandatory PSII, others will require review by, or referral to another Regulatory body or team depending on the event. These are set out in our PSIRP.

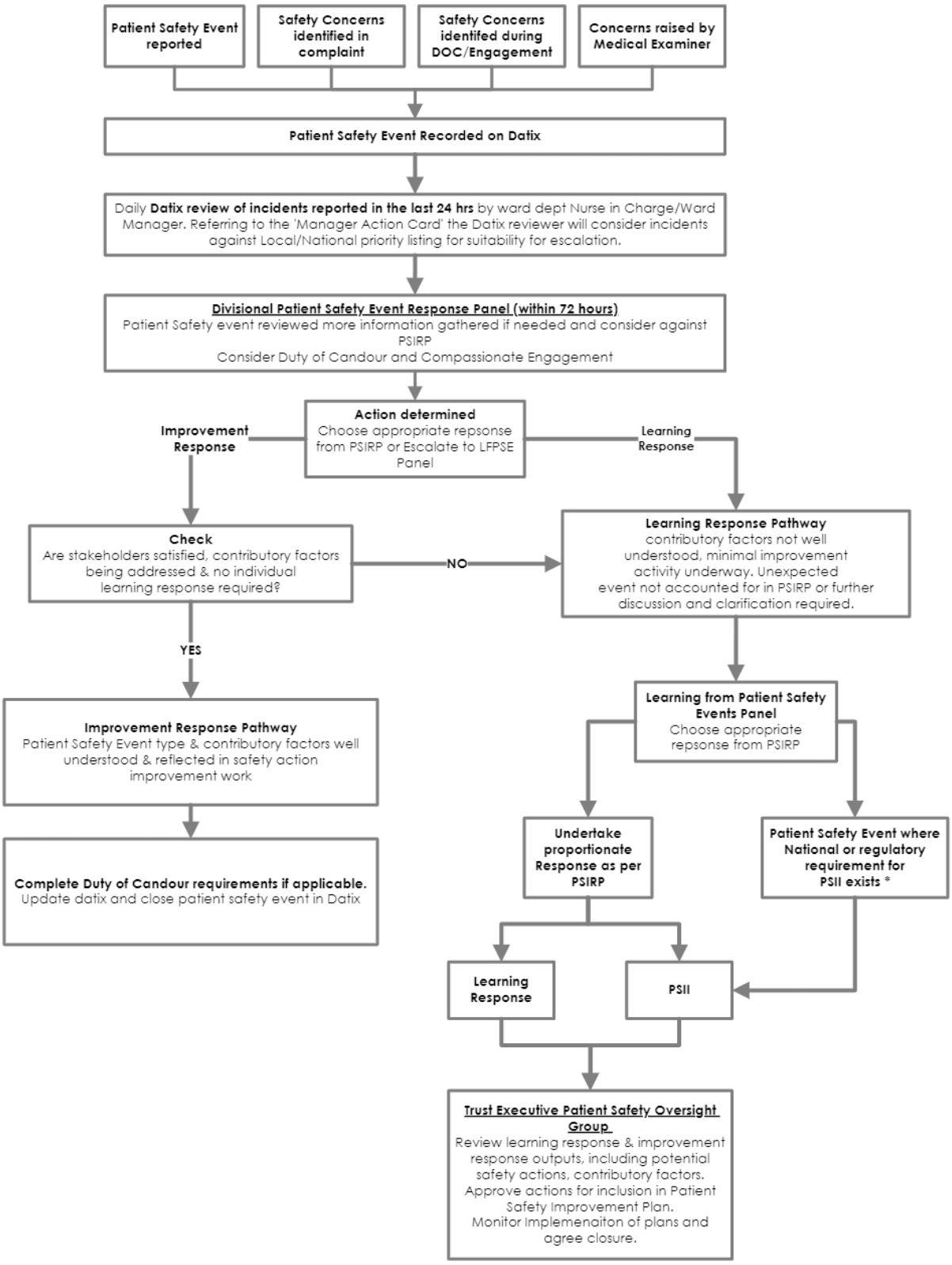
The PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. The Trust outlines within the PSIRP what learning response is indicated under the identified patient safety priorities, this ensures a balance between the benefit of learning through responding to events or exploring issues and improvement work. In the work to create our plan we have considered what our event insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety events.
We have established a process for our response to events which allows for a clear 'Ward to Board' set of mechanisms allowing for oversight of event management and our PSIRF response.

Divisions will have escalation arrangements in place for the monitoring of patient safety events and this includes daily escalation of events which appear to meet the need for further exploration as a Rapid Review/Hot Debrief to assess whether the event meets the criteria of PSII or Patient Safety Review, or due to the potential for learning and improvement or an unexpected level of risk. Divisional Patient Safety Event Response Panels will consider any such events for further escalation to the Learning from Patient Safety Events Panel.

The Learning from Patient Safety Events Panel will have delegated responsibility for the consideration of events escalated for PSII.
The Trust Executive Patient Safety Oversight Group will oversee roles, responsibilities, and outputs of the PSIRP in line with the PSIRF Policy. They have responsibility for review and sign-off of any Patient Safety Incident Investigations.

Any Patient Safety Event highlighted will follow the process outlined in Figure 1 below.

Figure 1. Patient Safety Event Decision Response Flow



12.3 Local level events

All staff (directly or through their line manager) must ensure notification of events that may require a patient safety review response as soon as practicable after the event and no later than 72 hours through Divisional escalation processes (including out of hours). A Rapid Review/Hot Debrief will be undertaken by the Division to inform decision making following this.

The Divisional Patient Safety Panel will meet at the earliest opportunity to discuss the nature of the event. Immediate learning will be shared by the most appropriate divisional representative, any mitigation that is needed to prevent recurrence and whether the Duty of Candor requirement has been met.

Where it is clear that a PSII is not required, the Divisional Patient Safety panel will consider any event as having potential for PSR. The tool to be utilised for the review will be specified and a suitable member of the divisional team to undertake the review will be allocated. This will not be any staff involved in the event or by those who directly manage the staff. The Division will also specify any subject matter expert input required. There will be clear records maintained regarding this decision-making process.

Divisional Safety Panel arrangements will include the recording of safety actions arising from any PSR or other learning response and these details will be used to inform potential safety improvement plans (see safety actions on p26 below).

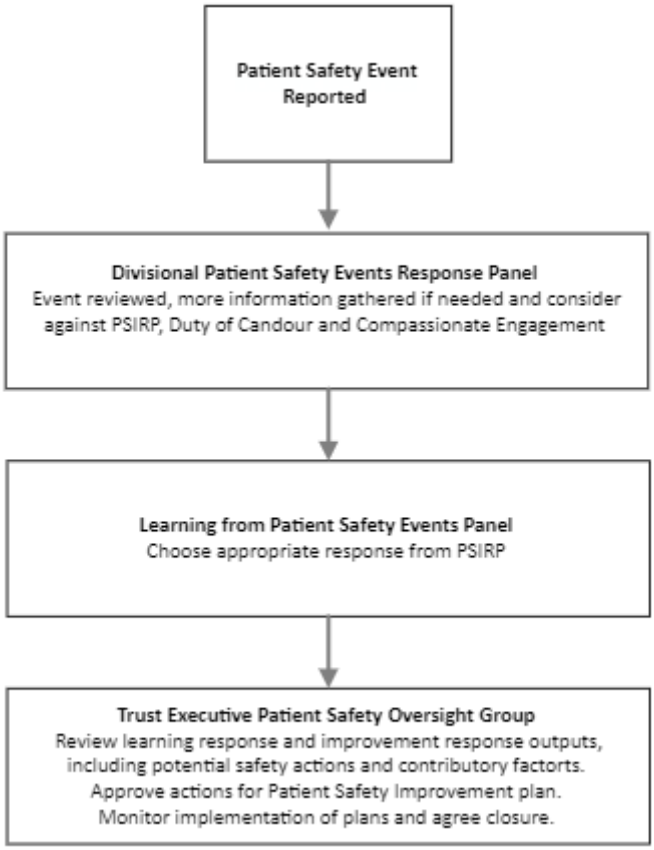
The Learning from Patient Safety Events Panel are responsible for identifying events which need communicating and escalating to NHS commissioning and regional organisations and the CQC according to accepted reporting requirements. Whilst this will include some events escalated as PSII, the Patient Safety Team will work with the Divisions to have effective processes in place to ensure that any events meeting external reporting needs are appropriately escalated.

13 MONITORING AND COMPLIANCE

13.1 Trust Executive Patient Safety Oversight Group

The Trust will establish and maintain a Trust Executive Patient Safety Oversight Group to oversee the operation and decision-making of the Trust Learning From Patient Safety Events (LFPSE) panel and the event responses it has delegated responsibility to commission. This will support the final sign off process for all PSIIs. Through this mechanism the Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety and improvement profile within the organisation.

Any safety recommendations identified in a PSII will have actions assigned within the DATIX system. A Standard Operating Procedure has been established to provide a clear, standardised process for the collation, assurance, review, and closure of divisional actions. This outlines the process for action closure through the LFPSE Panel and TEPSOG, ensuring robust governance, compliance and auditability (Appendix F).



14 RESPONDING TO CROSS SYSTEM EVENTS/ISSUES

The Patient Safety Team will forward those events identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

The Trust will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system events. The Patient Safety team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.
The existing Clinical Quality Review Group (CQRG) will continue to support local quality and safety agendas, the learning from PSIRF and other emerging themes will feed into this as part of our patient safety reporting. The ICB Quality Leads meeting has a standing agenda item for cross-system issues which can then be escalated as required across the South Yorkshire footprint.

The Trust will defer to the ICB for consideration of support and joint agreement of co-ordination responsibilities where a cross-system event is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

15 TIMEFRAMES FOR LEARNING RESPONSES

15.1 Trust Executive Patient Safety Oversight Group

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety event is identified and should ordinarily be completed within three months of their start date, and unless there are exceptional circumstance no PSII will take more than six months to complete.

The time frame for completion of a PSII will be agreed with those affected by the event and their families, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the event, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

In exceptional circumstances (eg. when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the Learning from Patient Safety Events Panel.

In exceptional circumstances, a longer time frame may be required for completion of the PSII. In this case, any extended time frame should be agreed between the Trust, those affected and the Trust Patient Safety Oversight Committee.

16 SAFETY ACTION DEVELOPMENT AND MONITORING IMPROVMENT

The Trust acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an event or set of events to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed.

The Trust will have systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement. The Trust will generate safety actions in relation to each of these defined

areas for improvement, these will be logged and tracked using Monday.com under the Trust Safety Improvement Plan. Following this, the Trust will have measures to monitor any safety actions and set out review steps.

Learning responses should not describe areas of improvement as this can lead to premature attempts to devise a solution - safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from Divisions and the support of the Quality Improvement (Qi) Team with their improvement expertise.

16.1 Safety action development

The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022)[3] as follows:

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

16.2 Safety action monitoring

Safety actions must continue to be monitored through divisional governance arrangements to ensure that all measures implemented remain effective and sustainable. Divisions will report on progress against safety actions, including the outcomes of any relevant measures, to the Trust Executive Patient Safety Oversight Group [KJ3.1].

As outlined previously, any safety recommendations identified through a PSII will have corresponding actions recorded within the DATIX system. A Standard Operating Procedure has been established to provide a clear and consistent process for the collation, assurance, review and closure of divisional actions (Appendix F).

[3] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

16.3 Safety action monitoring

Safety improvement plans bring together findings from various responses to patient safety events and issues. The Trust has a single overarching safety improvement plan in place which are adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes or Commissioning for Quality and Innovation (CQUIN) initiatives.

The Trust Patient Safety Incident Response Plan has outlined the local priorities for focus of learning responses under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

The Trust will use the outcomes from existing patient safety event reviews (Serious Incident Root Cause Analysis reports) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work. The Divisions will work collaboratively with the Patient Safety and Quality Team to ensure there is an aligned approach to development of plans and resultant improvement efforts.

Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a local safety improvement plan will be developed. These will be identified through Divisional and Specialty governance processes and reporting to the Learning from Patient Safety Events Panel who may commission a safety improvement plan. Again, the Divisions will work collaboratively with the Patient Safety and Quality Improvement Teams and others to ensure there is an aligned approach to development of the plan and resultant improvement efforts.

Monitoring progress with regard to safety improvement plans will be overseen by the Patient Safety Review Group on a scheduled basis. The Trust Executive Patient Safety Oversight Group Review learning response & improvement response outputs, including potential safety actions and contributory factors. Approve actions for inclusion in Patient Safety Improvement Plan and monitor Implementation of plans and agree closure.

17 COMPLIANCE AND APPEALS

DBTH NHS Foundation Trust recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided by the Trust.
It is important to understand that there is a distinction made between complaints and concerns as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process.

The first point of contact with the Trust is the patient Advice and Liaison service (PALS) who will support the resolution of any concerns raised. It is important to address any issue raised at the earliest opportunity that may reduce the risk of escalation and increase the possibility of finding a satisfactory resolution to the problem. It may be more appropriate to deal with and resolve in a more immediate and timely manner as long as this is with the agreement of the person raising the concern.

Complaints are defined as expressions of dissatisfaction from a patient, service user, their family or carer, a person acting as their representative, or any person who is affected or likely to be affected by the action, omission or decision of the Trust and requires a formal review.

The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services
Outcomes and areas of improvement from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

18 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Our PSIRF Plan
https://extranet.dbth.nhs.uk/patient-safety-incident-response-framework-2/our-plan/

The PSIRF Workbook –
https://extranet.dbth.nhs.uk/wp-content/uploads/2024/01/PSIRF_workbook_v1.4-31-01-24.docx

19 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

20 DEFINITIONS

FLO's – Family Liaison Officers
PSII's – Patient Safety Incident Investigators
PSIRF – Patient Safety Incident Response Framework
PSIRP – Patient Safety Incident Response Plan
PSP's – Patient Safety Partners

21 REFERENCES

Doncaster & Bassetlaw Teaching Hospitals PSIRF Plan
https://nhs-doncaster-and-bassetlaw.monday.com/boards/4610276902/views/106558865

Doncaster & Bassetlaw Teaching Hospitals PSIRF Plan on a Page
https://extranet.dbth.nhs.uk/wp-content/uploads/2023/12/Plan-on-a-page.pdf

NHS England (2022) Guide to responding proportionately to patient safety incidents
b1465-3-guide-to-responding-proportionately-to-patient-safety-incidents-v1.3.pdf

22 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27), the Equality Diversity and Inclusion Policy (CORP/EMP 59) and the Civility, Respect and Resolution Policy (CORP/EMP 58).

The purpose of the EIA is to minimise and if possible, remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix G).

APPENDIX A – LEVEL OF HARM

Levels of harm were previously set out in the National Reporting and Learning Service guidance on reporting patient safety events.

In summary harm is defined as follows:

No harm (This has two sub-categories):

No harm (Impact prevented) – Any patient safety event that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. This may be locally termed a 'near miss'.

No harm (impact not prevented) - Any patient safety event that ran to completion, but no harm occurred to people receiving NHS funded care.

Low harm - Any unexpected or unintended event that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care.

Moderate harm - Any unexpected or unintended event that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Severe harm - Any unexpected or unintended event that appears to have resulted in permanent harm to one or more persons.

Death – Any unexpected or unintended event that directly resulted in the death of one or more persons.

APPENDIX B – MANAGER ACTION CARD

Manager Action Card

- Daily Datix review of incidents reported in the last 24 hrs by ward dept Nurse in Charge/Ward Manager.
- The Datix reviewer will consider incidents against Local/National priority listing for suitability for escalation for Rapid Review/Hot Debrief.
- The Datix reviewer will escalate any events of concern to the Matron for consideration of a Rapid Review/Hot Debrief as indicated by the priorities.
- The Matron will request an ad-hoc Rapid Review/Hot Debrief only where an incident appears to indicate an emergent risk and where contributory factors are not well understood and there is no ongoing improvement work.
- The Matron will remind team leaders that Rapid Review/Hot Debriefs must be completed within 72 hours of being notified that they are required.
- The Datix reviewer will assess the level of harm and confirm the correct level has been selected for incidents.
- The Datix reviewer and Matron will include the Risk and Governance team/Patient Safety team in any correspondence/tasks raised around Rapid Review/Hot Debrief.

APPENDIX C – FURTHER SUPPORT FOR THOSE AFFECTED BY PATIENT SAFETY EVENTS

We recognise that there might also be other forms of support that can help those affected by a Patient Safety events and will work with patients, families, and carers to signpost to their preferred source for this.

Child Death Support
https://www.childbereavementuk.org/grieving-for-a-child-of-any-age
https://www.lullabytrust.org.uk/bereavement-support/
Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

Citizens Advice Bureau
https://www.citizensadvice.org.uk/
Provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

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

Engaging With Bereaved Families
https://www.sad.scot.nhs.uk/bereavement/communication-with-those-who-are-bereaved/

Healthwatch
https://www.healthwatch.co.uk/ Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site. https://www.healthwatch.co.uk/your-local-healthwatch/list

Help is at Hand – for those bereaved by suicide
https://suicidebereavementuk.com/key_document/help-is-at-hand/ specifically for those bereaved by suicide this booklet offers practical support and guidance who have suffered loss in this way.

Learning From Deaths – Information For Families
https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/
Explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Mental Health Homicide Support
https://www.england.nhs.uk/london/our-work/mental-health-support/homicide-support/

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

Parliamentary and Health Service Ombudsman

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

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

APPENDIX D – PSIRF TRAINING REQUIREMENT

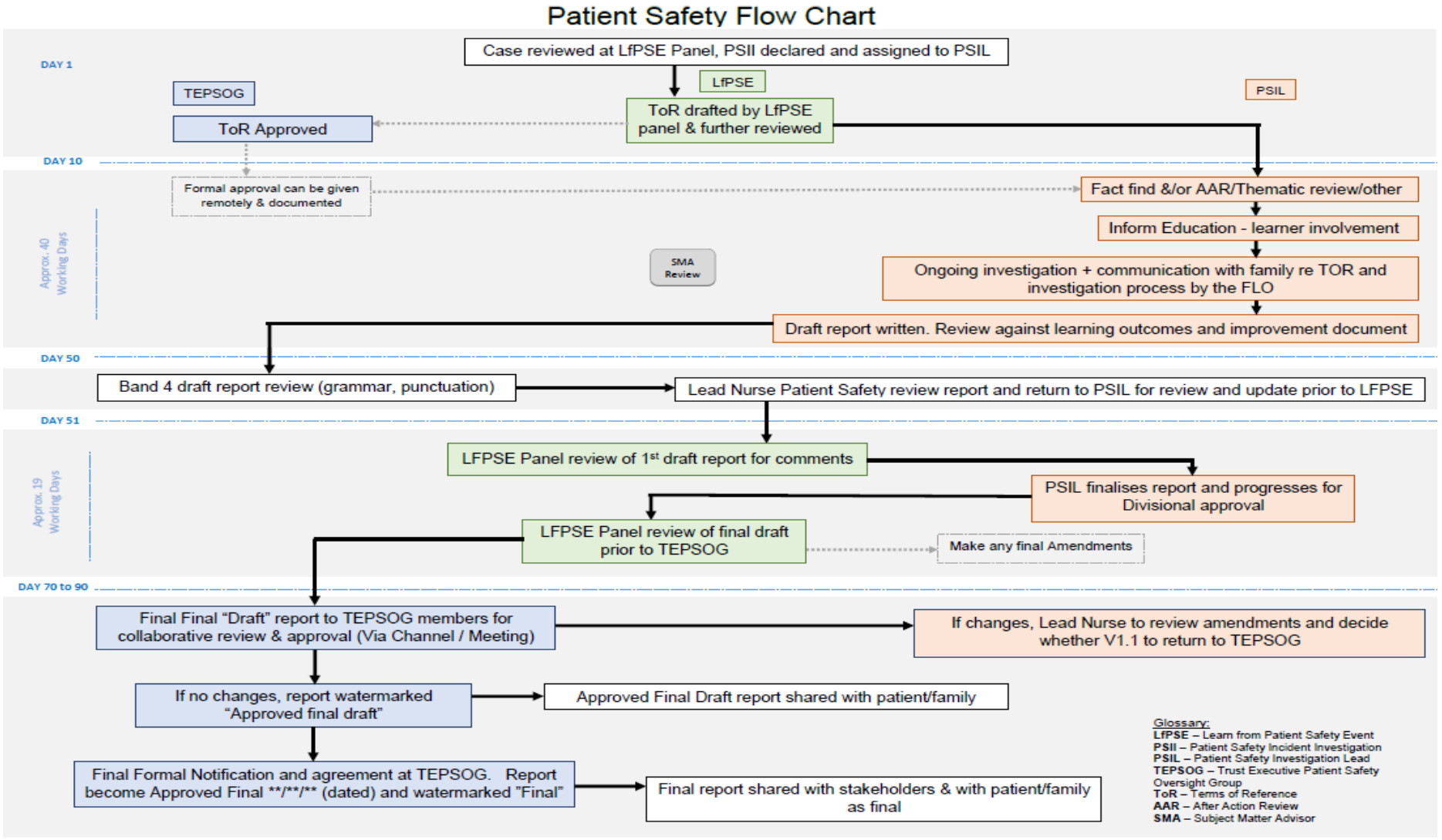
Topic	Minimum Duration/ Delivery Method	Role	Content
Patient Safety Syllabus Level 1	• This module can be accessed directly from the Health Education England eLearning for healthcare platform or ESR	• All staff, clinical and non-clinical are expected to undertake these on induction and to repeat every three years	• Internal - This comprises of a local event eLearning module setting out the Trust's expectations of staff for reporting and responding to events, including an outline of staff responsibility for Duty of Candour. This has been aligned to the national patient safety syllabus • National – Health Education England patient safety syllabus module (Essentials for patient safety) • National – Health Education England patient safety syllabus module (Essentials of patient safety for boards and senior leadership teams •
Patient Safety Syllabus Level 2	• This module is available as eLearning via ESR access	• All clinical staff at AFC Band 7 or above, with potential to support or lead patient safety event management	• National – Health Education England patient safety syllabus module (Access to Practice)

Role	Training	Competencies
Learning response leads	• Any Trust learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety events and experience of patient safety response. Records of such training will be maintained by the Learning and Development team as part of their general education governance processes. • Learning response leads must have complete Level one and two of the national patient safety syllabus.	• As a Trust we expect that those staff leading learning responses are able to • Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources. • Summarise and present complex information in a clear and logical manner and in report form. • Manage conflicting information from different internal and external sources.

	• Learning response leads will undertake appropriate continuous professional development on event response skills and knowledge. • To maintain expertise the Trust will undertake an annual networking event for all learning response leads via our Trust-wide leadership forums. • Learning response leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the relevant Divisional risk and Governance teams and the Patient Safety team will support this.	• Communicate highly complex matters and in difficult situations. • Support for those new to this role will be offered from Divisional senior managers, Divisional risk and Governance teams and the Patient Safety team.
Engagement and involvement Leads	• Engagement and involvement with those affected by a patient safety event will be undertaken by those who have undergone a minimum of six hours training. • Records of such training will be maintained by the ESR system as part of their general education governance processes. • Engagement leads must have completed Level one and two of the national patient safety syllabus. • Engagement leads will undertake appropriate continuous professional development on event response skills and knowledge. • To maintain expertise the Trust will undertake an annual networking event for all engagement leads via our Trust-wide leadership forums. • Engagement leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Patient Safety team and supported by Divisional Risk and Governance leads.	As a Trust we expect that those staff who are engagement leads are able to • Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way. • Listen and hear the distress of others in a measured and supportive way. • Maintain clear records of information gathered and contact those affected. • Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation. • Recognise when those affected by patient safety events require onward signposting or referral to support services.
Oversight roles	• All patient safety response oversight will be led/conducted by those who have had a minimum of	As a Trust we expect staff with oversight roles to be able to

	two days formal training and skills development in learning from patient safety events and one day training in oversight of learning from patient safety events. Records of such training will be maintained by the ESR System as part of their general education governance processes. • Those with an oversight role on our Trust Board and leadership team (i.e., executive leads) must have completed the appropriate modules from the national patient safety syllabus - Level one - essentials of patient safety and essentials of patient safety for boards and senior leadership teams. • All those with an oversight role in relation to PSIRF will undertake continuous professional development in event response skills and knowledge, and network with peers at least annually to build and maintain their expertise.	• Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement). • Apply human factors and systems thinking principles. • Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources. • Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues. • Recognise when safety actions following a patient safety event response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences). • Summarise and present complex information in a clear and logical manner and in report form.

APPENDIX E – PATIENT SAFETY FLOW CHART



APPENDIX F – STANDARD OPERATING PROCEDURES FOR PROCESSING FOR PSII ACTION MONITORING, ASSURANCE AND CLOSURE VIA LFPSE

PROCESSING FOR PSII ACTION MONITORING, ASSURANCE AND CLOSURE VIA LFPSE

STANDARD OPERATING PROCEDURE

1. Purpose

To establish a clear, standardised process for the collation, assurance, review, and closure of divisional actions through the LFPSE Panel and TEPSOG, ensuring robust governance, compliance, and auditability.

2. Scope

This SOP applies to Divisional Lead Nurses (DLNs), Governance Leads (GLs), LFPSE Panel members, and TEPSOG. It covers all PSII actions requiring formal assurance and sign-off prior to closure.

3. Roles & Responsibilities

Patient Safety & Quality Officer collates and distributes actions one month prior to the deadline. DLN and GL jointly produce an assurance paper with evidence of monitoring and compliance. LFPSE Panel reviews submissions and determines if sufficient assurance exists. TEPSOG provides executive review and final sign-off.

4. Procedure

Step 1: Patient Safety & Quality Officer collates actions one month prior and circulates to DLN and GL.
Step 2: DLN and GL prepare assurance paper including monitoring evidence and compliance.
Step 3: Submit to the LFPSE Panel.
Step 4: LFPSE reviews prior to TEPSOG and determines if assurance is sufficient.
Step 5: TEPSOG reviews and provides executive sign-off.
Step 6: Outcome is communicated; if closure is agreed, division may close actions.

5. Assurance and Governance

   This process ensures consistent oversight, robust evidence-based assurance, and executive scrutiny. No action will be closed without LFPSE assurance and TEPSOG sign-off.

6. Key Outputs

   Monthly action log, divisional assurance paper, LFPSE review outcome, TEPSOG decision record, closure confirmation.

7. Compliance Requirements

   All divisions must adhere to this SOP. Insufficient evidence will result in non-progression and continued monitoring.

8. Document Control

   Version 1.0 – May 2026

APPENDIX G - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
PSIRF Policy	All	Marie Hardacre	Existing	June 2026

1) Who is responsible for this policy? Name of Division/Directorate: Corporate Nursing

2) Describe the purpose of the service / function / policy / project/ strategy? This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (the Trust) will approach the development and maintenance of effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety.

3) Are there any associated objectives? Legislation, targets national expectation, standards:

4) What factors contribute or detract from achieving intended outcomes? –

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - Yes Positively**.** Broadly all groups should benefit from better learning from patient safety incidents, leading to a reduction of those incidents and improved standards of healthcare

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] – N/A

6) Is there any scope for new measures which would promote equality? [any actions to be taken]

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: January 2028 (Policy valid until June 2029)

Checked by: Simon Brown **Date:** 5 June 2026