Patient Safety Incident Response Framework (PSIRF) Policy

NHS Devon

Version	2.0
Policy Sponsor	Chief Nursing Officer
Policy Lead	Head of Patient Safety and Patient Safety Specialist
Approved by	Chief Nursing Officer and Chief Medical Officer
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Date	**Change**	**Version number of policy**	**Comments**
13/12/2024	New Policy	1.0	
24/11/2025	Policy Amendment	1.1	Updated Equality, diversity and inclusion statement 3.1 Population updated 4.4 Timescale to recruit a PSP 4.7 Committee name updated 9.3 DPT updated priorities 14.1 Updated paragraph 16.2 Committee name updated
15/12/2025	Policy Amendment	2.0	New template

Equality, diversity and inclusion statement

NHS Devon is committed to the promotion of equal opportunities, addressing health inequalities and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation. We are equally committed to the elimination of unlawful discrimination, harassment and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on, equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due

regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy read or other languages; please contact our Patient Advice and Complaints Team (PACT):

Tel: 0300 123 1672 Email: d-icb.patientexperience@nhs.net

Contents

1. Introduction

This policy describes and defines the responsibility of NHS Devon Integrated Care Board, known thereafter as NHS Devon, when providing oversight to organisations who have transitioned to the new Patient Safety Incident Response Framework (PSIRF). It will also outline how NHS Devon will support cross learning responses and provides methods and opportunities for learning and best practice to be shared across the system and beyond.

1.2 The PSIRF replaces the serious incident framework (2015) and makes no distinction between patient safety incidents and serious incidents. The previous associated thresholds to determine a serious incident no longer exists, instead it will remain flexible and consider the specific circumstances in which patient safety issues, incidents and events occurred and the needs of those affected and has four main aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement.

1.3 All organisations with an NHS standard contract have a requirement to adopt the new PSIRF, completing a patient safety incident response plan (PSIRP) and policy which is to be published on their website that is easily accessible.

1.4 The policy recognises that NHS Devon and the organisations it commissions, will be transitioning from the previous serious incident framework to the new PSIRF at various times and therefore requires dual processes to continue until all Trusts have transitioned to PSIRF and therefore read in conjunction with the following guidance:

- Serious Incident Framework – NHS England (March 2015)
- Revised Never Events policy and framework and Never Events list (2018)
- The Patient Safety Incident Response Framework 2020 NHS England (2020)
- The patient safety strategy NHS England (2019).

2. Purpose and scope

2.1 NHS Devon is required to respond to Patient Safety as outlined within the PSIRF with processes in place that demonstrates improvement and learning across the system
rather than compliance on quality and structured measures in place. This policy is specific to roles and responsibilities in relation to patient safety incident

responses conducted solely for the purpose of learning and improvement across NHS Devon and the Devon system. The following principles underpin the oversight of patient safety incident response:

- Improvement is the focus.
- Blame restricts insight.
- Learning from patient safety incidents is a proactive step towards improvement.
- Collaboration is key.
- Psychological safety allows learning to occur.
- Curiosity is powerful.

2.2 Patient safety incidents are unintended or unexpected events within a healthcare setting that could have or did cause harm to one or more patients. Any other response that seeks to find liability, accountability or causality is beyond this policy and must be handled separately from this policy. Examples of different responses, includes the complaints process, criminal proceedings, and human resource policies.

2.3 The PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety, however unlike the previous serious incident framework, it does not prescribe what incidents needs to be investigated and how organisations should investigate but does suggest different proportionate methodologies to responding and learning to incidents. Appendix 1.

2.4 PSIRF sets out national priorities but then advocates organisations to use a coordinated and data-driven approach to prioritise their local priorities, which should be detailed within each organisations Patient Safety Incident Response Plan.

3. Our Services

3.1 NHS Devon is registered with the Care Quality Commission (CQC) and is a collaboration of NHS organisations, (3 acute trusts, 2 mental health providers and 1 ambulance trust) three local councils, as well as a wide range of other independent organisations and the voluntary sector. Working together collaboratively to improve the lives of people in Devon, which has a population of 1.2 million that call Devon home.

3.2 Further information about our organisation, the services it commissions and the organisations it collaborates with can be found on the website: https://onedevon.org.uk/about-us/.

4. Roles and responsibilities

4.1 The roles and responsibilities when responding to PSIRF are clearly defined within the national guidance (appendix 2) and describes the responsibilities of National and Regional NHS England Teams in supporting Integrated Care Board (ICB) PSIRF leads, specifically regarding sharing the learning.

4.2 NHS Devon is required to collaborate, develop, and agree PSIRF plans and policies for all those Providers we commission (section 8) that have an NHS funded care contract, while overseeing effectiveness of systems response to patient safety incidents, offering co-ordination support in system-wide patient safety incident investigation (section 11) and sharing outcomes system-wide (section 12) to continuously improve safety.

4.3 To support a positive patient safety culture and to help support the agenda, NHS Devon has appointed a Patient Safety Specialist (PSS), who's main purpose is to lead on workstreams identified as priorities within the Patient Safety Strategy. Our appointed PSS works collaboratively with other PSS across Devon and Cornwall organisations.

4.4 In line with the NHS Patient Safety Strategy, NHS Devon is committed to working alongside a PSP and Patient Safety Partners (PSP). PSP is the term given to a patient, carer, family member or other lay person (including NHS employees from another organisation working in a lay capacity) recruited to work in partnership to influence and improve governance and leadership of patient safety. NHS Devon plans to recruit a PSP within the 2026/2027 fiscal year.

4.5 Our Patient Safety and the Safeguarding Teams will work collaboratively together where safeguarding themes have been identified within provider settings. This collaborative approach will ensure that identified Integrated Care System (ICS) learning is effectively embedded and improves outcomes for people at risk within the Devon system.

4.6 NHS Devon will include and involve everyone within the organisation to ensure local priorities, risks, outcomes, and learning is appropriately understood and shared. This includes, though not limited to:

- Local Maternity and Neonatal Systems (LMNS)
- Children and young people
- Learning from deaths
- Mental health
- Medicines optimisation
- Infection control
- Learning from Deaths of People with a Learning Disability and Autistic People (LeDeR)

4.7 The table below outlines the specific roles and responsibilities accountable for this policy.

5. Accountabilities and duties

Chief Executive Officer	The Chief Officer has ultimate accountability for the strategic direction and operational management of NHS Devon, including compliance with all legal, statutory and policy requirements.
Chief Nursing Officer	The Chief Nursing Officer is the Executive Lead and responsible for PSIRF: • ensuring that policy is appropriate for consideration for approval • endorsing this policy ahead of submission for approval with the Policy Lead, maintaining and updating procedures/protocols and other supporting documents for this policy.
Policy Lead / Author	It is the responsibility of the Policy Lead / author to: • ensure as far as possible that the policy is in line with the patient safety strategy and PSRIF. • to complete a QEIA and Implementation Plan where required • undertake a fair and proportionate consultation period with the relevant stakeholders as part of the document's development. • to ensure that the policy is in alignment with NHS Devon's strategy and values. • ensure that the policy is developed, approved, disseminated, and monitored as set out in the document. with Policy Sponsors, maintaining and updating procedures / protocols and other supporting documents for this policy.
Patient Safety Specialist	The Patient Safety Specialist is responsible for ensuring NHS Devon's priorities set out within the patient safety strategy are completed, providing regular reports on trends, themes and learning will be included in NHS Devon's Finance, Performance & Quality Committee.
Patient Safety Partner	The Patient Safety Partner is to work in partnership to influence and improve governance and leadership of patient safety.
Line Managers	Line managers have a responsibility to ensure their staff comply with NHS Devon policies and standards within their areas of responsibility.
All Staff	Employed or engaged staff have a duty to comply with NHS Devon policies and standards as outlined in their contracts of employment and codes of conduct.

6. Patient Safety Culture

6.1 NHS Devon understands the importance of having a positive patient safety culture will work in collaboration with all those affected by a patient safety incident including staff, patients, their families, and carers to provide an informative investigation whereby learning and improvement is completed for the sole purpose of learning, identifying improvements, and mitigate future risk. Described more in section 11.

6.2 NHS Devon recognises that treating staff fairly fosters a culture of openness, respect, and dignity, helping to maintain a diverse, flexible, and motivated workforce that performs highly and delivers excellent outcomes. NHS Devon has a Fair Treatment Policy in place, alongside Freedom to Speak Guardians and Mental Health Guardians.

6.3 To identify gaps for improvement, NHS Devon gathers feedback from staff surveys and freedom to speak up guardians, to establish improvement plans to help support the improvement across the organisation on safety culture.

7. Patient Safety training and education

7.1 NHS Devon understands the importance of the patient safety syllabus and training programme, ensuring all staff complete level one of the syllabuses (essentials for patient safety). Those in a senior role also complete level one for Board and senior leadership teams.

7.2 Level two of the syllabus (Access to practice and sector specific sessions) has been identified and is mandatory for all staff within NHS Devon that have a role that is public facing or within a Board or senior leadership team. NHS Devon's Patient Safety Specialist will complete the higher-level training.

7.3 NHS Devon has processes in place to ensure the training of all employees is completed in accordance with their role. The training also forms part of the initial training that all new staff must compete.

7.4 In addition to the patient safety syllabus training, any patient safety investigation completed will be done by staff who have completed training in patient safety incident investigations (PSIIs) and support for all those involved in an incident. Furthermore, the Patient Safety Executive Lead and those staff that are in an oversight role have completed the oversight of learning from patient safety incidents training.

7.5 To ensure that NHS Devon remains aligned with the training requirements as outlined by NHS England (appendix 3), a review and evaluation is completed each year to include the staff compliance for the patient safety syllabus and a review to identify any gap in the PSIRF training.

7.6 To ensure NHS Devon remains up to date and compliant with the training requirements as outlined by NHS England (appendix 3) a yearly review is completed.

8. Health inequalities

8.1 Health inequalities are systematic, unfair, and avoidable differences in health across the population, and between different groups within society. They arise because of differences in the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can affect both our physical and mental health and wellbeing.

8.2 NHS Devon are working to deliver exceptional quality healthcare for all, ensuring equitable access, excellent experience, and optimal outcomes as this is one of the 4 key purposes of the Integrated Care System.

9. Management of NHS Devon patient safety priorities

9.1 NHS Devon provides two key services to the population of Devon: the Devon Referral Support Service (DRSS) and Continuing Healthcare (CHC). Consequently, it is crucial for NHS Devon to comprehend the priorities linked to these services and to monitor for any patient safety issues. Any identified patient safety incidents will first be reported on the Learn from Patient Safety Events (LfPSE) platform and, if necessary, undergo further review to ascertain learning outcomes.

9.2 Local priorities will be monitored and advanced by NHS Devon's steering group, alongside the oversight of actions arising from national learning responses related to never events and mental health homicides, which have been identified as key national priorities for NHS Devon.

9.3 It is recognised that NHS Devon, must have a flexible approach to allow priorities to adapt, as we learn from investigations, and embed those improved processes but also as we consider changing internal priorities like our operational plan and external and national priorities for example winter pressures to ensure we continue to respond appropriately to relevant patient safety concerns that serve the population of Devon.

9.4 What is scripted within the PSIRF is that all investigation responses regardless of the type of investigation that are being completed should prioritise compassionate engagement with those affected by patient safety incidents.

10. Provider's patient safety priorities, plan and policies

10.1 All NHS-funded care providers are required to complete a Patient Safety Incident Response Plan (PSIRP) and policy, which NHS Devon is responsible for reviewing and approving. NHS Devon holds a dedicated monthly meeting to review and sign off these organisations' PSIRF plans and policies, as outlined in Appendix 4.

10.2 All patient safety incident response plans and policies must then be published on the Providers public website, which is easily visible.

10.3 NHS England has outlined national priorities and specified the methodology for learning from these incidents, as detailed in appendix 5. Each organisation must then identify its local priorities and develop a plan to respond and learn, including the methodology that will be employed.

Identified local patient safety priorities

Torbay and South Devon NHS Foundation Trust	Royal Devon University Healthcare NHS Foundation Trust	University Hospitals Plymouth NHS Trust	Devon Partnership NHS Trust	Livewell Southwest
Delayed access to elective/ planned care. Delays across our urgent and emergency care pathway related to frailty/the elderly. Diagnostic tests and testing.	Harm occurred during transfer of patients between a care home and acute or community hospital. Harm resulting from incorrect dosage / omission of anticoagulant medication. Patients becoming critically unwell and requiring multiple (>2) emergency medical responses.	Medicines safety. Discharges. Sub-speciality working. Deteriorating patients. Capacity, flow, and re source implications.	Reducing violence and aggression against patients and staff Improving patient safety for individuals within two weeks of discharge, with a focus on preventing suicide Improving patient safety for neurodiverse individuals at risk of self-harm or suicide Improving patient safety for individuals with Dual Diagnosis with a focus on preventing harm and unexpected death.	Values and behaviours of staff impact on patient safety and experience. Reducing the rates of serious self-harming behaviours across all age groups in inpatient and community settings. Reducing the number of incidents of violence and aggression to staff. Reductions in the use of Restrictive Intervention. Incident resulting in moderate or severe harm. Incident resulting in moderate or severe harm linked to an existing Quality Improvement Programme.

11. Learn from Patient Safety Events (LfPSE)

11.1 LfPSE is a national system for all health and care organisations to report and analysis patient safety events, replacing the National Reporting and Learning System (NRLS) which was originally set up to identify hazards and risks and the Strategic Executive Information System (StEIS) which was used to record serious incidents under the Serious Incident Framework 2015.

11.2 NHS Devon reviews the data reported to LfPSE to identify overarching themes and trends. When significant patterns are observed, it provides a foundation for discussions with colleagues across the system. Enabling the sharing of insights, the development of action plans, and the implementation of best practices with the overarching aim to collaboratively improve patient safety and quality of care.

12. Engaging and involving patients, families and staff following a patient safety event

12.1 NHS Devon understands that to effectively learn from events, it is best if all those involved in the incident can participates to the narrative of what happened, allowing the opportunity for meaningful and open compassionate conversations. Those effected by an incident may include:

- The person or patient to whom the incident occurred
- Their family, friends, or carers
- The staff who were directly involved in the incident.

12.2 NHS England has provided nine principles on what compassionate engagement should include, recognising that incidents will be different and therefore the principles applied will be flexible. The nine principles include:

- Apologies are meaningful.
- Approach is individualised
- Timing is sensitive
- Those affected are treated with respect and compassion
- Guidance and clarity are provided
- Those affected are ‘heard’
- Approach is collaborative and open
- Subjectivity is accepted
- Strive for equity.

12.3 NHS Devon will ensure that Providers’ policies and plans in response to patient safety incidents will clearly describe how they plan to involve all those effected by an incident.

12.4 NHS Devon currently has a Duty of Candour policy designed to support patients and families involved in incidents.

12.5 NHS Devon offers various support mechanisms for its staff, including workplace health and wellbeing champions, mental health first aiders, freedom to speak up guardians, and staff partnerships.

13. Supporting the cross-system responses to patient safety incidents

13.1 Often, multiple organisations are involved in the care and service delivery when a patient safety incident occurs. It is the responsibility of all organisations to have an established procedure that outlines how they will identify incidents requiring a collaborative cross-system learning response. They must also detail how they will respond accordingly. It is expected, however, that the following principles are adhered to as a minimum standard:

- The organisation that identifies the incident is responsible for alerting other providers, commissioners, and partner organisations via their respective Safety teams.
- The lead organisation coordinates the investigation, and this should be agreed by all organisations involved, using the RASCI model.
- The lead organisation will be responsible for liaising with the patients and families involved and applying duty of candour principles if required.

13.2 If an organisation has insufficient capacity or capability, or unsure which organisations need to be involved in the cross-system response, they must engage with NHS Devon early to enable them to help support finding the right organisation and or individual to support the coordination of a cross-system learning response.

13.3 If an organisation requires support in coordinating all organisations identified as involved in the incident to participate in an initial scoping meeting or in establishing the terms of reference, then NHS Devon will offer the necessary support. NHS Devon understands this support is crucial to ensuring a collaborative approach is taken when responding to cross organisation learning from patient safety incidents.

13.4 On occasion NHS Devon recognises that there may be times when we need to commission or investigate an investigation (or other learning response) that is independent of the provider. This may occur when:

- An organisation is too small to provide an objective response and analysis.
- When 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.

13.5 When an occasion is identified that commissioning of an independent learning response is required, NHS Devon will request support from NHS England.

13.6 If a Lead from NHS Devon is appointed to support a cross-system learning response, they must have the necessary time and training as outlined within section 6 of this policy.

13.7 Once the lead organisation has completed the draft learning response, a follow-up meeting will be arranged, inviting all involved organisations to review and approve the draft report. The final report will then be presented at the NHS Devon Quality Assurance Meeting, and NHS Devon will monitor the implementation of actions until they are completed.

14. High profile patient safety incidents

14.1 It is expected that some patient safety incidents will have a high profile or demonstrates significant patient safety and quality challenges. These incidents may have a regulatory, legal or enforcement requirement, or they could generate media interest.

14.2 On the occasions when a high-profile incident is identified within an organisation, it is
the expectation that NHS Devon will be notified of the incident to ensure actions and learning can be shared with system partners and when required jointly provide communications.

Mental health homicide (MHH) learning responses

14.3 NHS Devon recognises that homicides committed by individuals receiving mental health care can have a deeply distressing impact on the victims' families, the patients themselves, their families, and all those affected. These tragic incidents are identified by NHS England as requiring a Patient Safety Incident Investigation (PSII) learning response. Such cases are often complex and require collaboration among multiple organisations, which may include involvement across different organisational boundaries.

14.4 NHS Devon will provide support to the lead organisation during these investigations if required. This can include assisting with the involvement of external organisations where necessary and offering investigation support.

14.5 NHS Devon understands that these learning responses take a comprehensive approach and are often bound to timings outside healthcare organisations. NHS England will play a crucial role, in the oversight and escalation of these reported incidents.

14.6 NHS Devon will ensure that all actions identified from the learning response are implemented and will therefore monitoring all actions until completion.

15. Primary Care

15.1 Primary care organisations (GP practices, pharmacies, dentists and opticians) are not yet mandated to comply with PSIRF; however, they are encouraged to begin adopting PSIRF principles. There is currently a national pilot involving GP practices underway to help shape and define how PSIRF could be applied within primary care. Primary care organisations should ensure appropriate training is in place to facilitate learning responses and have the necessary skills and tools to respond to those affected by an incident in a timely, open, and honest manner.

15.2 Additionally, the LfPSE service was developed for use by all healthcare staff, including those in general practices. Primary care organisations are required to register an account and record events that could provide learning opportunities for other organisations. Furthermore, organisations can record events involving other organisations, making it essential to have access to external learning opportunities.

16. Sharing insights to improve patient safety

16.1 NHS Devon has a responsibility to ensure that the insight and learning from patient safety incidents is shared and disseminated across the system, to promote improvements in care and patient safety.

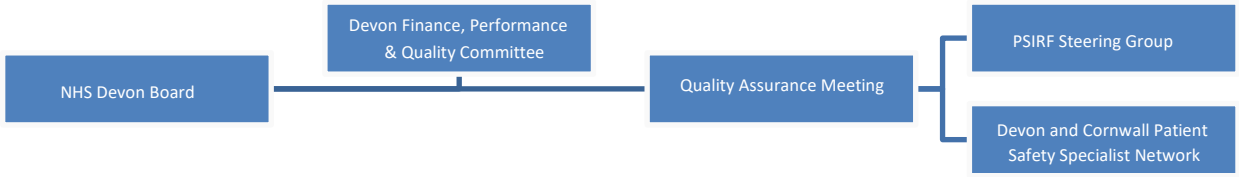
16.2 To encourage the effectiveness of system learning and achieve continuous improvement from patient safety incidents NHS Devon must adopt a comprehensive approach. This involves fostering a culture of open communication with all organisations across the system and establishing clear mechanisms to enable learning to be shared across the system.

16.3 To support the sharing of learning across the Devon system, learning will be shared within but not limited to the following the Devon and Cornwall patient safety specialists (PSS) collaborative meeting, which is held monthly and provides an opportunity to share learning. NHS Devon have developed a learning from patient safety events governance structure and learning template as detailed in appendix 6.

17. Governance

17.1 To ensure effective coordination and learning from patient safety incidents, it is crucial for NHS Devon to establish a well-defined governance structure. The diagram below illustrates this structure, which outlines the process for receiving, disseminating, and implementing lessons learned from such patient safety incidents to promote systemwide learning.

17.2 Additionally, having a clear escalation pathway is essential to ensure that NHS Devon Board is confident in its roles and responsibilities as a commissioner in response to PSIRF.



Devon and Cornwall Patient Safety Specialist Network: This network meets monthly, providing a collaborative platform for sharing insights, learning, and best practices related to patient safety. It serves as a key resource for healthcare professionals to drive improvements in patient care.

PSIRF Steering Group: Meeting monthly, this group is responsible for monitoring compliance with the PSIRF. It reviews and approves providers' PSIRF plans and policies, ensuring alignment with national guidelines. Any significant issues are escalated to the Quality Assurance Meeting (QAM).

Quality Assurance Meeting: Held monthly, this meeting provides oversight and assurance on all patient safety priorities across NHS Devon and the providers it commissions. Membership of this meeting includes safeguarding, maternity, LeDeR colleagues. It ensures that high standards of safety are upheld. Where necessary, concerns or risks are escalated to the Devon Finance, Performance & Quality Committee.

Devon Finance, Performance & Quality Committee: This committee convenes every two months and provides assurance on patient safety priorities, both for NHS Devon and its commissioned providers. It provides information within the quality report and includes data within the Integrated Performance and Quality Report. Issues requiring further attention are escalated to the Governing Body.

NHS Devon Board: Meeting every two months, the Board receives an executive summary of QPEC, providing high-level oversight and strategic direction on matters related to patient safety and quality of care.

17.3 This structure ensures a robust and systematic approach to patient safety, with clear
lines of communication and accountability across all levels of NHS Devon's governance.

18. Complaints and patient experience

18.1 NHS Devon recognise that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services which NHS Devon provides.

18.2 The patient advice and complaints team at NHS Devon are the first point of contact and will handle concerns, comments, feedback, or complaints and can be contacted by:

Phone: 0300 123 1672 (local call rate number)
Email: d-icb.patientexperience@nhs.net
Post: Patient Advice and Complaints Team
Aperture House, Pynes Hill, Rydon Lane, Exeter, EX2 5SP

18.3 If you need support in contacting NHS Devon's patient advice and complaints team, you are entitled to ask for an advocate. Advocacy services for health complaints for people living in Torbay and Plymouth is provided by The Advocacy People:

Phone: 0330 440 9000
Post: PO Box 375, Hastings, TN34 9HU
Website: www.theadvocacypeople.org.uk

18.4 Advocacy services for health complaints for people living in the rest of Devon (including Torbay & Plymouth Non-Health complaints), advocacy is provided by Devon Advocacy Consortium:

Phone: 0845 231 1900
Email: devonadvocacy@livingoptions.org

19. Implementation

19.1 All staff will be informed of the approval of the Policy via the Staff Bulletin which will provide a link to the document on the NHS Devon Intranet.

19.2 NHS Devon Senior Managers, or their designated representatives, will implement this policy by:

- Notifying all staff of its existence. New staff will be informed of this policy as part of their induction.
- Destroying all superseded paper-based versions of the policy and electronic versions retained in their area.
- Having adequate knowledge of, and / or access to, all relevant legislation in order to ensure that compliance with such legislation is maintained.
- Discussing with staff as part of their regular one-to-ones how they seek to achieve their individual objectives around policy review and maintenance.

- Ensure all staff have completed the appropriate patient safety mandatory training.

20. Approval and review

20.1 This policy will be reviewed annually, or sooner if required, to ensure that it is current, relevant and reflects the strategic aims, objectives, organisational structures and responsibilities of NHS Devon.

20.2 The approval route for this policy is via the Chief Nursing Officer and Chief Medical Officer.

21. Monitoring compliance and effectiveness

21.1 Once approved, this policy will be published on NHS Devon's intranet and website, and a copy will be shared with all NHS providers across Devon.

21.2 NHS Devon acknowledges that the principles outlined in this policy will continue to develop. As a result, the policy will be reviewed after one year and subsequently every two years, or sooner if significant national guidance changes or new learnings emerge.

22. Quality & Equality Impact Assessment (QEIA)

22.1 NHS England have completed an equality and health inequalities full analysis form for the implementation of the PSIRF which concluded that broadly all health inclusion groups should benefit from improved learning from patient safety incidents.

22.2 NHS Devon completed a local equality and quality impact assessments regarding the
transition from reporting incidents using Peer Improvement Tips for Care and Health (PITCH) to LfPSE. Whilst the transition would be a change for those reporting incidents, LfPSE is a national system which will enable themes and trends to be identified locally and nationally. It was also designed to encourage all health care professional to report incidents. Additional benefit was identified as incident can be recorded by health professionals and members of the public.

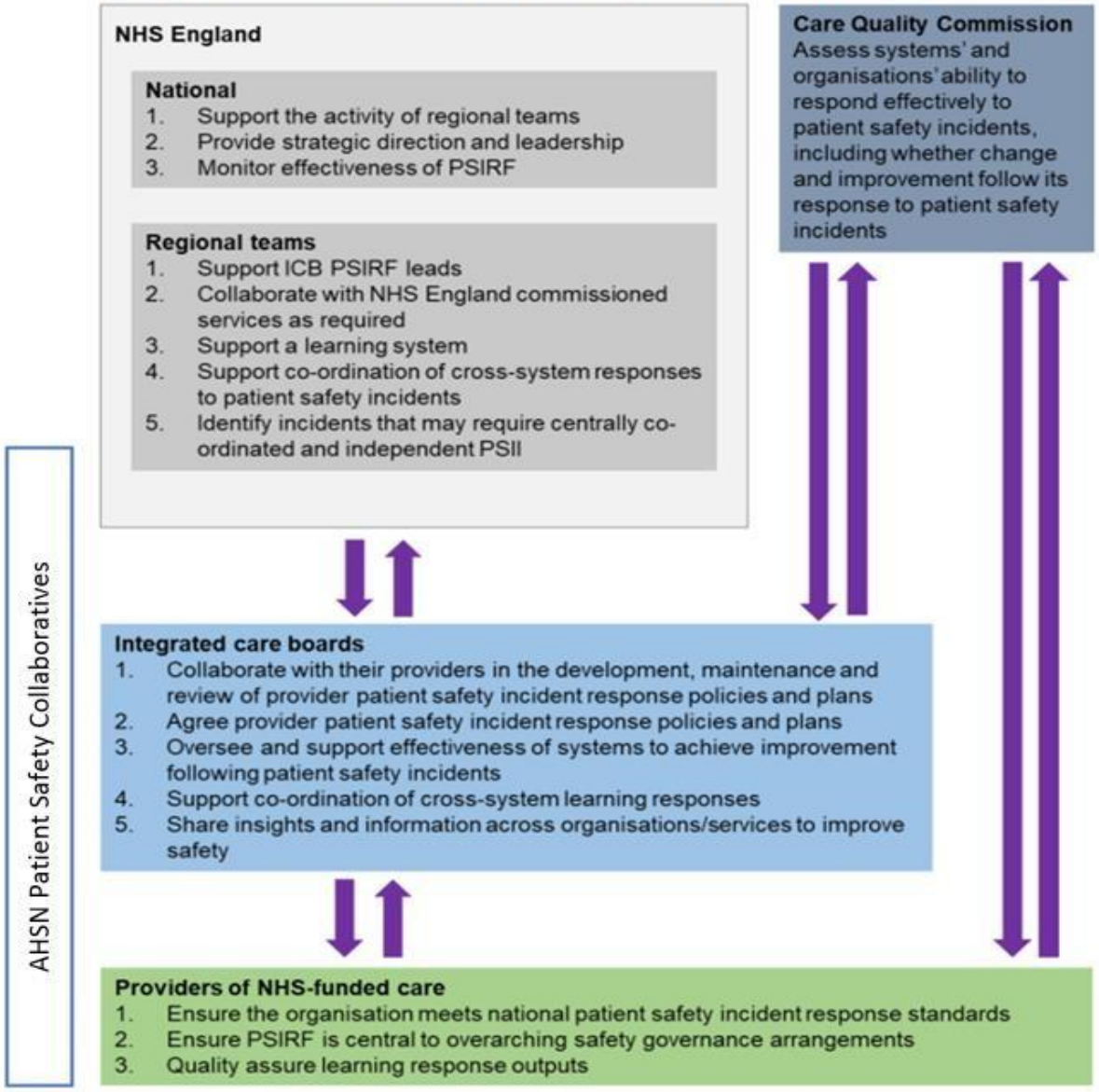
Appendix 1: National learning response methods

Method	Description
Patient safety incident investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.
Multidisciplinary team (MDT) review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
Swarm huddle	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
After action review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what happened? What was the difference between the expected outcome and the event? What is the learning?

Appendix 2: Roles and responsibilities

The below figure was published within the PSIRF supporting guidance, oversight roles and responsibilities specification.

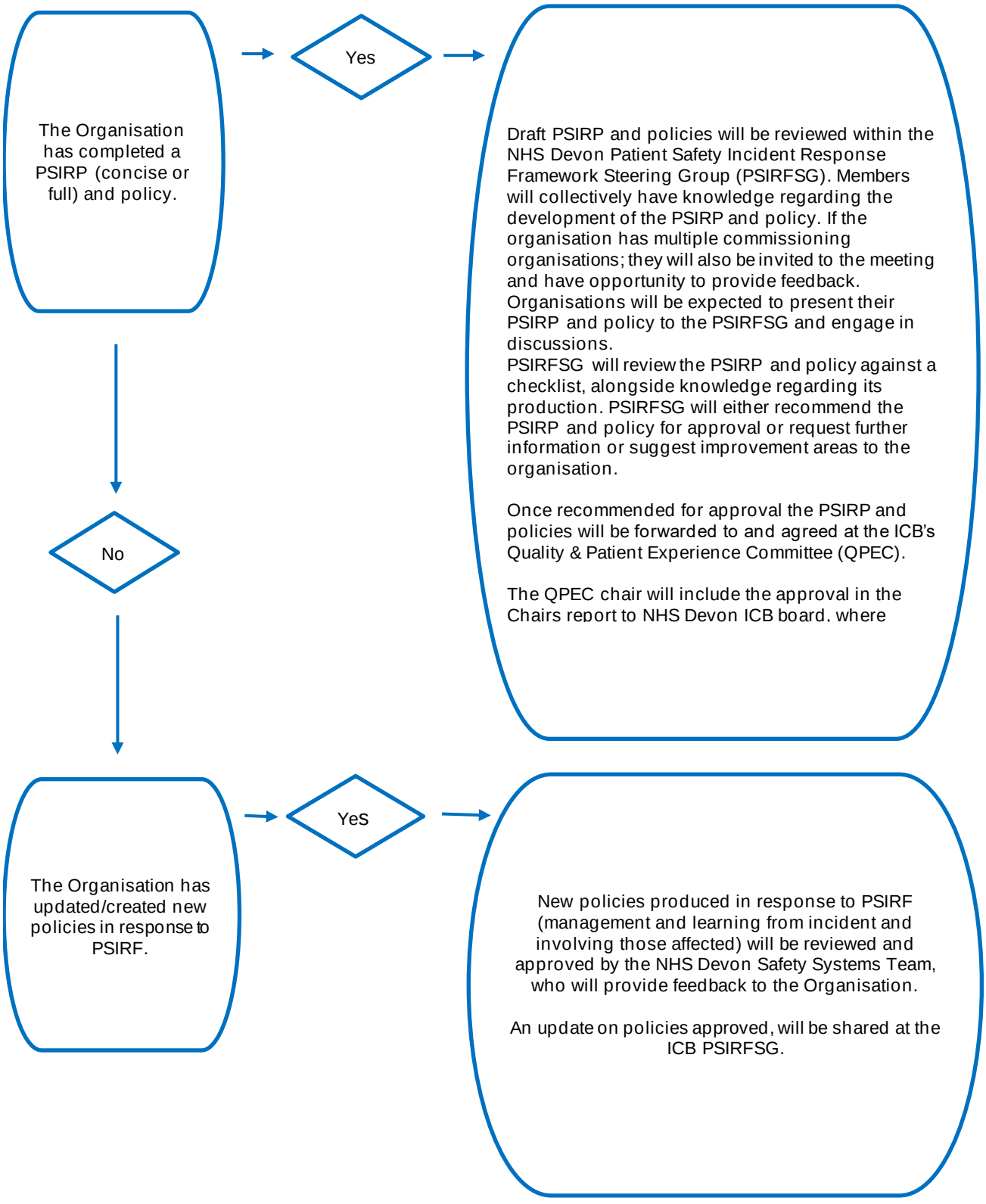
Figure 2: Organisational responsibilities for an effective governance structure



Appendix 3: PSIRF training requirements

Topic	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
Systems approach to learning from patient safety Incidents	2 days/12 hours	• Introduction to complex systems, systems thinking and human factors • Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews • Safety action development, measurement, and monitoring	✓		✓
Oversight of learning from patient safety incidents	1 day/6 hours	• NHS PSIRF and associated documents • Effective oversight and supporting processes • Maintaining an open, transparent and improvement focused culture • PSII commissioning and planning			✓
Involving those affected by patient safety incidents in the learning process	1 day/6 hours	• Duty of Candour • Just culture • Being open and apologising • Effective communication • Effective involvement • Sharing findings • Signposting and support		✓	✓
Patient safety syllabus level 1: Essentials for patient safety	eLearning	• Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety and is open to learning about risk and safety	✓	✓	✓
Patient safety syllabus level 2: Access to practice	eLearning	• Introduction to systems thinking and risk expertise • Human factors • Safety culture	✓	✓	✓
Continuing professional development (CPD)	At least annually	• To stay up to date with best practice (eg through conferences, webinars, etc) • Contribute to a minimum of two learning responses	✓	✓	✓

Appendix 4: PSIRF and policy sign off process



Appendix 5: National priorities and learning responses

Locally-led PSII

- Deaths tought more likely than not due to problems in care
- Deaths of patients detained under the mental health act 1983
- Never events
- Consider Incidents in NHS screening programmes

Refer to NHS England Regional Independant Investigation Team (RIIT)

- Mental health-related homicides

Refer to Heath Safety Investigation Branch (HSIB)

- Maternity and neonatal incidents meeting HSIB criteria

Refer to Child Death Overview Panel and locally-led PSII

- Child deaths

Refer to Learning Disability Mortaility Review (LeDeR)

- Deaths of persons with learning disabilities

Refer to local authority safeguarding lead

- Safeguarding incidents in which babies, children or young people are on a child protection plan, looked after plan, or a victim of wilful neglect or domestic adbuse/violentceAdultsa are in receipt of care
- Radicalisation to terrorism related incident

Refer to Community Safety Partnership (CSP)

- Domestic homicide

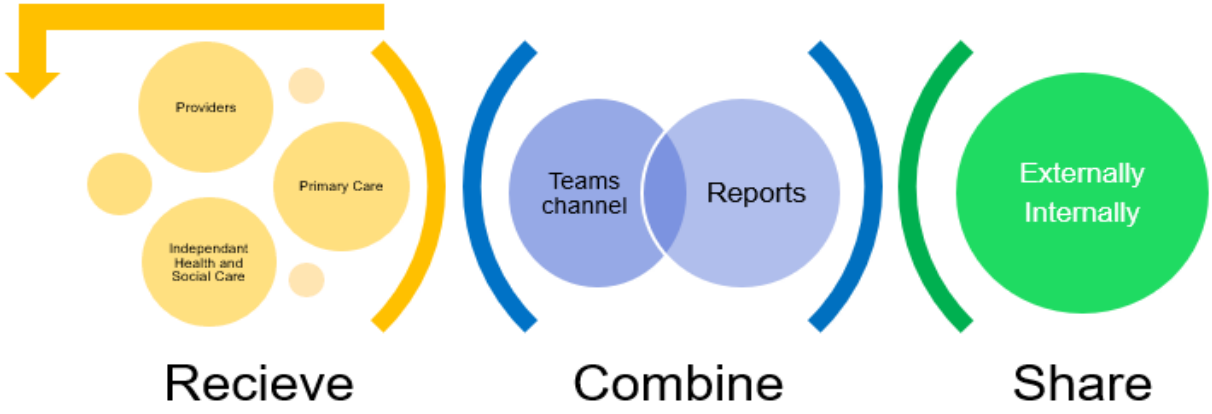
Refer to Prision and Probation Ombudsman (PPO)

- Death in custody

Appendix 6: Learning from patient safety incidents process and template

The NHS Devon Patient Safety & Quality Team participates in Provider collaborative meetings, where they will use a standard template to share identified learnings that would be beneficial to disseminate across the broader NHS Devon system or beyond.

Learning from patient safety incidents governance structure



The NHS Devon Safety Systems Team will gather all learning responses, present them on the team's channel, and generate regular reports. These reports will be shared with the Quality Assurance Meeting and the Quality & Patient Experience Committee.

The NHS Devon Patient Safety & Quality Team, along with designated colleagues (such as those in maternity and safeguarding), will have access to the team's channel where all learnings will be compiled for further dissemination.

Learning template

This template is to record learning / case examples / information from patient safety incidents to enable wider circulation of learning with the aim of preventing further similar events from occurring.