Patient Safety Incident Response Plan

Author:	Special Projects Lead
Contributors:	Director of Care Head of Hospice Services Clinical Governance Facilitator
Ratified by:	QG&R
Approval date:	23/10/2024
Review Date	1 yearly to ensure effectiveness then 3 yearly unless changes in local or national guidance
Policy first ratified:	23/10/24
Please read in conjunction with the SSCH PSIRF Policy	

Patient Safety Incident Response Plan

Table of Contents

Patient Safety Incident Response Plan

Introduction

The purpose of this document

This patient safety incident response plan sets out how Shooting Star Children's Hospices (SSCH) intends to respond to patient safety incidents (PSI) and our improvement and safety goals over a period of 12- 18 months.

SSCH has strong commitment to patient safety and fostering a safety and just culture which is evidenced through our governance framework (Table 5).

We are committed to strengthen this culture further by aligning the 4 pillars of PSIRF across our organisation which will support making care safer, improve our safety culture with an emphasis on continuous learning. This collaborative approach aids in a deeper understanding of incidents, contributing factors, promotes consistency and reliability and fosters shared learning.

4 pillars of PSIRF

- *Application of a range of system-based approaches to learning from patient safety incidents*
- *Compassionate engagement and involvement of those affected by patient safety incidents*
- *Supportive oversight focused on strengthening response system functioning and Improvement*
- *Considered and proportionate responses to patient safety incidents*

The plan has been designed with flexibility in mind, allowing for a range of learning responses to be used in response to the unique incidents that impact on the care we provide. Focussed on system learning, risk reduction and preventing a recurrence it aligns with our strategic aims. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

Responses covered in this plan include:

- Patient safety incident Investigation (PSIIs)
- Patient Safety Reviews (PSRs)

Where incidents and concerns are outside of the patient safety scope, a different response will be followed as per SSCH policies. For example, safeguarding investigations, complaint management, human resources investigations, criminal investigations, coroner's inquests, claims handling and professional standards investigations.

Our services

Shooting Star Children's Hospices cares for babies, children and young people with life-limiting conditions, and their families, across south-west London, north-west London and Surrey. We're here to make every moment count, whether lives are measured in days, weeks, months or years. We support families from diagnosis to end of life and throughout bereavement with a range of nursing, practical, emotional, and medical care. Our specialist care and support is free of charge and available 24 hours a day, 365 days a year. We support around 500 babies, children, or young adults who have a life-limiting condition and their families, as well as around 200 bereaved families.

Our multi-professional team's support patients and their loved ones across three different care settings:

Hospice care

Our in-patient unit offers short stay breaks for up to 6 babies, children and young people within Christopher's, our hospice site in Guildford. Here, we offer short term respite stays for complex life limited babies, children and young people, end of life care, emergency breaks and use of our bereavement suits (suits that have cooling equipment and facilities for families to sit, reflect and spend time with their loved one). These suits are for use by our in-patient unit, community or those that have died in hospital whereby the deceased is transferred to the hospice.

During all types of admission families can stay onsite at the hospice, in our family flats, where families are offered therapeutic support.

Community Nursing Team

Many of the children we support have complex care required in the community. Our community nursing team is a specialist team of nurses that is our single point of access for referrals, they will visit families and assess their needs, provide support for symptom management, end of life care and practical support.

Specialist Paediatric Palliative Care Symptom Team

Many of the children we support have very complex symptoms or require support in discussing and planning ongoing care including in some cases end of life care. The specialist palliative care team, a team of specialist consultants, nurse consultant and nurse specialists, provide this support and guidance whether that's at home, hospice or hospital.

Psychosocial Services

We offer a wide range of therapeutic and social support at Shooting Star Children's Hospices. Most are available for the whole family, including bereaved families with the extension of our Specialist Bereavement Service where we receive referrals for families whose child has died unexpectedly and were unknown to the hospice.

Patient and family participation and involvement (PPI)

We are working towards developing a strategic framework whereby we have begun to embed robust child and family participation and engagement within our organisation, actively looking at ways that we can involve, and respond to the children, young people and families that we support. We are also building on sharing our achievements and the impact that we make to those that we support; along with building upon and expanding professional relationships using National guidance, collaborative working, quality and innovation. All with the aim of improving outcomes for our children and families that we support

Defining our patient safety profile

In preparation for implementation of PSIRF in Shooting Star Children's Hospices, 2 years' worth of incident data has been reviewed from the following sources:

- Incident data recorded on Vantage (our incident reporting system and includes medication safety)
- Complaints
- Safeguarding concerns
- Staff competency
- Lado referrals
- Staff Survey
- RCA investigations
- CQC inspection 2022
- Staff feedback

Scope

This review has provided an insight into patient safety incidents (PSI) across clinical areas and where children and young people are seen in a community and outpatient setting to enable us to formulate an appropriate response towards patient safety investigation. It does not include non-clinical areas such as fund raising and SSCH charity shops.

Clinical incidents from Q1 24.25 have also been reviewed with similar findings.

Analysis of the PSIs has identified areas for ongoing improvement:

- Redesign of incident reporting system & categories.
- Medication management
- Clinical safety assurance
- Managing challenging behaviour
- Adherence to Caldicott principles
- Ongoing CQC compliance
- Staff survey
- Emphasise and strengthen a culture of safety & a ‘just culture’

How do our strategic aims link to the Patient Safety Incident Response Framework (PSIRF)?

The following table shows how our strategic priorities link closely to the aims of PSIRF. We have identified how adopting PSIRF will help us towards achieving these priorities and improving care and developing a safety culture.

Table 1. PSIRF aims

PSIRF aims	How do they link with Shooting Star Hospices strategic priorities?
Application of a range of system-based approaches to learning from patient safety incidents Considered and proportionate responses to patient safety incidents	Using a range of learning responses to support patient safety incident investigation will help to deepen understanding about how and why things go wrong. This will result in being able to improve the care our children and young people receive. Proportionate responses allow for the appropriate allocation of time and resource on investigations and learning, leading to more opportunity for developing and expanding care. **Strategic Priority** **Do More** **Do Better**
Compassionate engagement and involvement of those affected by patient safety incidents Considered and proportionate responses to patient safety incidents	Having a greater focus on engaging those involved in patient safety incidents will empower those we care for. It will also ensure that learning focuses on what really matters to our children, young people and their families. **Strategic Priority** **Do More** **Do Better** **Grow People** **Co-Create**

Application of a range of system-based approaches to learning from patient safety incidents	Upskilling staff and those who investigate patient incidents to use different approaches, including SEIPS to improve effective learning post incidents. Expanding the training on the investigation methodologies to support incident investigation in other areas of the business, such as fundraising and retail. **Strategic Priority** **Do Better** **Grow People** **Co-Create**
Supportive oversight focused on strengthening response system functioning and improvement	Oversight focusing on strengthening systems as a result of an incident will improve the safety culture of the organisation and service for all. Collaborating and sharing with stakeholders may help to share improvements further than our immediate reach. These stakeholders would include other healthcare organisations locally, but also regional and national children's hospice networks and providers. **Strategic Priority** **Do Better**

Stakeholder Engagement

We engaged with key stakeholders both internally and externally to support and develop our existing knowledge around our safety incident profile. We also worked with the stakeholders to develop our plan.

Stakeholder	Involvement
Patient and public involvement	- Parent forum TBC
All Staff	• All staff in SSCH are undertaking Patient Safety training (L1)
Nursing and Care Staff	• PSIRF discussion slot on Practice & Education Away day
Heads of Service	• Team collected incident data and conducted initial analysis • Improvement plan reviewed and developed by Heads of Services.
Professional Networks	• Quality leads have collaborated to discuss incident profiles and training discussions within the children's hospice network. There has also been participation in national Hospice specific conversations, through Hospice UK. • Networking across SWL hospice providers • Children's Hospices across London Network
Senior leadership	• Senior leadership team have reviewed SSCH Patient Safety Incident Profile Review
Board of Trustees	• SSCH Patient Safety Incident Profile Review, plan and policy have been reviewed by Board at QG&R

Table 2 Stakeholder Engagement

Reviewing Incident Data

Two years' worth of patient safety incident data across the hospice services, SPACE, community teams and psychosocial teams was reviewed from the following sources:

- Incident data recorded on Vantage, our incident reporting system
- Serious Incidents
- Internal Risk Register
- SCLT & QG&R action plans
- Safeguarding Concerns – Lado referrals
- CQC engagement / inspections
- Complaints
- Staff interviews / Survey Results
- Freedom to Speak Up concerns raised
- Staff suspensions / disciplinary / competency review
- Quality Improvement Projects

This review has provided oversight of 2 years (plus Q1 24.35) of patient safety incidents reported at SSCH. Analysis has enabled us to define our patient safety improvement profile in preparation to develop our PSIRF plan

Results

Data analysis has shown the following spread of patient related incidents.

Patient Safety Incident type (n = 661)	Percentage
Medication error	***29%***
****Other***	***13.5%***
Clinical complications	***12%***
Injury	**10%**
Data protection	***4%***
Slips, trips and falls	***3.5%***
Pressure Ulcers	**3%**
Information sharing	**3.4%**
Physical abuse	***2.4%.*** (not attributable to SSCH)
*other has not been in use since July 2023 and attributed to a range of clinical issues – with no themes noted.	

Table 3. Occurrence of patient safety incidents at SSCH (April 2022 – March 2024 + Q 1

24/25) (SSCH Patient Safety Incident Profile Review (2022-2024)

In some cases, incidents were identified and reported by staff at SSCH but were not caused by the action of SSCH staff or systems (e.g. pressure ulcers, physical abuse). In these cases, the data has still been included in the analysis so we can continue to identify PSIs which may affect our children and young people. In the case of physical abuse of young people towards SSCH staff, we have included this into our improvement plan.

Identifying PSIRF roles and responsibilities

As part of applying the principles of PSIRF at SSCH, we have identified relevant individuals for the defined roles:

PSIRF Oversight Roles:

- Director of Care / Chief Nurse (PSIRF Executive Lead)
- Medical Director
- Named individuals on the Board, including the Chair of the Quality Governance and Risk Committee
- Quality Governance and Risk Quality Committee
- Care Strategy Committee

Those in oversight roles will receive appropriate training and use an oversight mind set outlined in '*Patient Safety Incident Response Framework supporting guidance Oversight roles and responsibilities specification*' (NHS 2022).

Learning Response Leads:

- Heads of Service
- Clinical Governance Facilitator
- Lead Nurses & Practice Education Team
- Patient and Public Engagement Lead / Patient Safety Partner (PSP)

In addition to these roles, we will be introducing a new volunteer Patient Safety Partner into the organisation. They will contribute to the development of action plans following investigations and focus on actions and learning that address' the needs and preferences of children, young people and their families / carers. Following development of a role description we intend to recruit the Patient Safety Partner in two phases. Phase 1: Volunteer sought from the Parent Forum. Phase 2: Volunteer sought from the service users who have transitioned from our service.

Training

To support the effective role out of PSIRF at SSCH, the identified staff and volunteers above will undertake the following training.

Table 3. Staff and volunteer training

Those without PSIRF defined roles

	NHS Patient safety syllabus: Level 1 – Essentials for patient safety for all staff (e-learning for health)	**NHS Patient safety syllabus: Level 2 - Access to Practice** (e-learning for health)	**In house SEIPS Training** Via QEP team	**NHS Essentials of patient safety for boards and senior leadership teams** (e-learning for health)
All staff	Yes			
All Clinical Staff	Yes	Yes	Yes	
Clinical staff involved in low level incident investigations (i.e. not leading PSIRF learning responses)	Yes	Yes	Yes	
DT/OLT, Board & All Trustees				Yes

NHS training accessed through e-learning for healthcare. (https://www.e-lfh.org.uk/)

Those without PSIRF defined roles will be required to complete the Level 1 of the Patient Safety Syllabus (Essentials for Patient Safety) by March 2025. This will also be offered for all new staff as part of their induction.

In house SEIPS training is to commence for clinical staff involved in low level investigations and will incorporated within staff training with an aim of completion by the end of March 2025.

Those with PSIRF defined roles

	NHS Patient safety syllabus: Level 1 – Essentials for patient safety for all staff (e-learning for health)	NHS Patient safety syllabus: Level 2 - Access to Practice (e-learning for health)	Systems approach to learning External TBA	Involving those affected by patient safety incidents in the learning process External TBA
Those in oversight roles	Yes	Yes	Yes	Yes
Learning response leads	Yes	Yes	Yes	
Patient and public engagement leads	Yes	Yes		Yes
Patient Safety Partner	Yes	Yes		

NHS training accessed through e-learning for healthcare. (https://www.e-lfh.org.uk/)

Table 4 – training metrics

Director of Care and Special Project Lead have completed Level 2 Patient Safety Investigations provided by Health Service Safety Investigating Body (HSSIB). Special Project Lead has also completed Systems Approach to Learning (Being Human).

There is limited external training currently being provided for independent providers however this is under constant review, and we are working across Children's Hospices across London (CHaL) to source suitable training which is tailored towards hospice care.

Governance structures around patient safety

All incidents reported on our reporting system (Vantage) will be reviewed at the weekly Patient Safey Forum –PSF- (incorporated in Exec sitrep meeting) and level of response decided (monitoring, learning response or an improvement response). PSI methodology, with terms and reference and time frames will be reviewed and decided (Appendix 2 -Learning responses)

Outcomes, or grouped outcomes of lower-level incident reviews will come to a relevant committee for the learning and then reviewed for consideration of whether a higher-level learning response (e.g. PSII) is required.

Incidents that require a PSIRF style learning response will come to the SCLT Q&R committee for safety action planning and quality assurance of the investigation itself. SCLT Q&R is attended by the PSIRF executive lead, the medical director and the patient safety partner. The relevant engagement lead will also be present to represent the patient and their loved ones. It will also be attended by the relevant learning response leads. Progress with Safety Action Plans will be discussed here and escalated to QR&G. The efficacy of the safety action plans will be monitored by SCLT Q&R committee. Refer to PSIFR Policy.

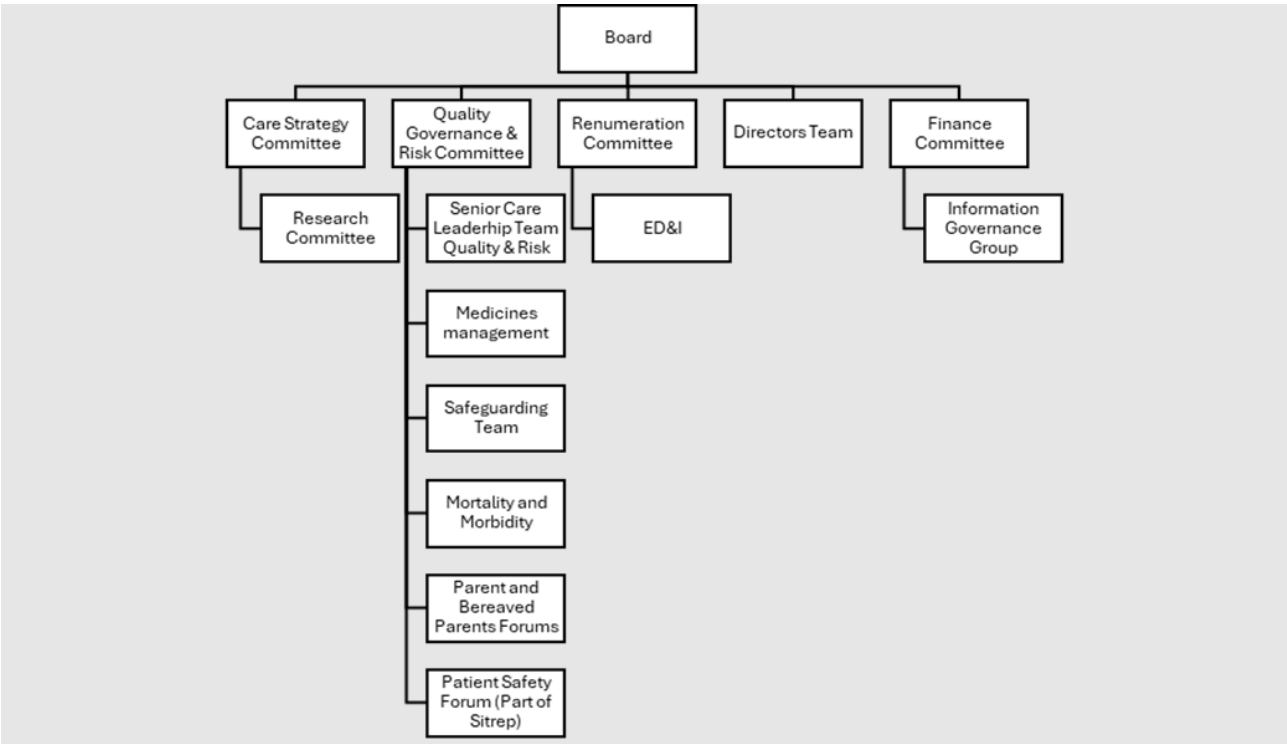

Table 5 Governance reporting structure

Patient Safety Work: Existing and Planned Improvement Work

This improvement work will be monitored at Quality, Governance & Risk (QG&R)

Improvement Work	Description	Lead and review date
Re-design incident reporting system (Vantage)	We will review our reporting template to improve data collection at point of reporting. This will improve the incident review process for those reviewing incidents that do not meet the criteria for a PSIRF response but still require a lower level of investigation. We aim to develop an incident trigger list for staff and support training in this area.	
Medication Management Review	We will carry out a deep dive into patient safety incidents involving medication incidents to be able to understand fully and implement QI methodology to support improvement.	
Clinical safety assurance • Pressure Ulcers • Tissue Viability • Falls prevention and reduction	We will review and implement strategies to reduce patient safety incidences in these care categories through education and training, policy and guideline development and external networking.	
Managing challenging behaviour review	We are working towards supporting training, education and communication of CYP behavioural plans to minimise incidents of physical abuse.	
Adherence to Caldicott principles	We are working towards assuring we are protecting the confidentiality of our children's and young people's health and care information, sharing appropriately and making sure data is used properly.	
Ongoing CQC compliance	We are reviewing the new CQC statements to ensure we are maintaining regulatory compliance	

Staff Survey	We have staff surveys in place, and we will ask questions relating to patient safety, understanding of processes and how to raise a concern in future surveys.	
Emphasise and strengthen a culture of safety & a 'just culture'	We are reviewing this across SSCH and will support development through training and promoting safety as a core value, promoting a fair and transparent environment, being open and honest and focussing on learning and system improvement rather than blame.	

Table 6: Existing and Planned Improvement Work

Our patient safety incident response plan: national requirements

Local patient safety risks and/or events that fall within the national priority and reporting scope.

There are other events that have a recommended response (mental health related homicide, maternity and neonatal incidents, deaths in NHS screening programmes, death in custody and domestic custody). These have not been separately stated in this PSIRP as they are unlikely to occur due to the nature of care offered by SSCH. Should such an event occur, the recommended action set out by NHS England will be followed.

Below are events that require a safety investigation response, as recommended by NHS England in their Guide to responding proportionately to patient safety incidents.

Patient safety incident type	Type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	All	Locally led PSII	Safey action plan should be agreed in SCLT Q&R. Action plan to come through QG&R for oversight and monitoring
Child/Young person death	Death of a child that is unexpected	Liaise with CDOP Locally led PSII. and/or External PSII	Liaise with CDOP and respond to recommendations from external parties. Create organisational actions and feed these into quality Improvement strategy

	Death of a child that is expected or palliative in nature	Liaise with CDOP MDT review and/or Locally led PSII.	Liaise with CDOP and Respond to recommendations from external parties. Create organisational actions and feed these into quality Improvement strategy
Safeguarding incidents	Possibly due to staff actions/inaction	Liaise with Local Authority Designated Officer (LADO) to agree response type and timelines. SSCH internal investigation and/or PSII	Liaise with LADO to agree outcomes. Create local organisational actions and feed these into the quality improvement strategy
Safeguarding incidents	Not due to staff actions/inactions	Refer to local authority safeguarding lead to agree if internal investigation appropriate.	Contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards. Respond to recommendations from external parties
Deaths of persons with learning disabilities	Young people aged over 18	Locally Led PSII (or other response) may be required alongside the LeDeR	Refer for Learning Disability Mortality Review (LeDeR) Respond to recommendations from external parties.

Table 7: SSCH response to national priorities

Our patient safety incident response plan: local focus

Local criteria for instigating a learning response

All clinical incidents should have an initial review on Vantage using the pre-set investigation template. The initial investigation should be done with the System Engineering Initiative for Patient Safety (SEIPS) framework in mind, to support effective investigation. All incidents will be reviewed weekly at our Exec SITREP meeting.

Historically, 'in depth' investigations have been reserved for incidents leading to moderate harm, or above. In designing our local focus, we will consider the following criteria:

Criteria	Examples
Potential for learning	• There is a potential to inform improvement • Initial review suggests there may be system wide factors that have contributed to the incident • Impact on quality of care, or the capacity/delivery of service
Likelihood for reoccurrence	• There is a persistent risk • There was potential for the incident to escalate • The frequency of events has been higher than usual

If either of these criteria are met, we will complete an appropriate review using one of the learning response methods as defined below.

Patient safety incident type or issue	Planned response	Anticipated improvement route
FALLS: All falls in house	Swarm huddle as soon as possible after the event (same day). Thematic analysis of falls	Immediate huddle to mitigate risks Themes of fall to be pulled by learning response lead and collated, using a SEIPS approach. Analysis of thematic data to be supported by the SCLT Q&R. Learning to come SCLT Q&R to generate an appropriate action plan, with the support of the falls group. Then to come to QG&R for oversight.

FALLS: Falls inhouse in house that meet local criteria after initial mitigation from the swarm huddle	*Either and/or* PSII to follow the initial swarm huddle	PSII by learning response lead SEIPS approach and family engagement as part of the investigation. Outcomes of investigation to come back to SCLT development of action plan. Then to QG&R for oversight.
MEDICATION INCIDENTS: Medication incidents that meet local criteria	*Either and/or* After Action Review MDT review with thematic analysis PSII	Investigation will be led by a learning response lead. SEIPS approach and family engagement as part of the investigation. Outcomes of investigation to come back to Medicines Management Group for development of action plan and then SCLT Q&R for agreement. Then to QG&R oversight.

PRESSURE ULCERS: Pressure Ulcers that meet local criteria	MDT review PSII	Investigation will be led by a learning response lead. SEIPS approach and patient engagement as part of the investigation. Outcomes of investigation to come back to SCLT Q&R development and agreement of action plan. Then to QG&R for oversight.
BEHAVIOURAL INCIDENTS: Which resulting in harm to a child/young person or staff member or where there is potential for new learning	*Either and/or* Swarm huddle After action review MDT review PSII if indicated	Patient Safety Forum to review a decide level of response. Liaise with LADO if appropriate. SEIPS approach and patient engagement as part of the investigation. Outcomes of investigation to come back to SCLT Q&R development and agreement of action plan. Then to QG&R for oversight.
INFECTION PREVENTION AND CONTROL:	*Either and/or* Swarm huddle After action review MDT review Thematic review PSII if indicated Annual IPC audit	Patient Safety Forum to review a decide level of response. Liaise with LADO if appropriate. SEIPS approach and patient engagement as part of the investigation. Outcomes of investigation to come back to SCLT Q&R development and agreement of action plan. Then to QG&R for oversight.

COMMUNITY & SPACE: Clinical incident within the community & SPACE service that meet local criteria	After Action Review MDT review PSII	From our 2-year incident review, we know that fewer incidents occur in our community and SPACE teams. In view of this, we need to take a pragmatic approach to identifying the incident response type, which will be dependent on the incident itself. Outcomes of the investigation will come back to the SCLT Q&R for agreement of the action plan. Then to QG&R for oversight.

Table 8: SSCH response to local priorities

All incidents reported on our reporting system (Vantage) will be reviewed at the weekly Patient Safey Forum (incorporated in Exec SITREP meeting) and level of response decided (monitoring, learning response or an improvement response). PSI methodology, with terms and reference and time frames will be reviewed and decided.

Episodes of good or positive care

Reviewing episodes of good or positive care can inform safety action planning, to help achieve consistent, improved care. At SSCH, we have a number of diversity and inclusion workstreams looking at improving care, and access to care for those we currently underserve. We are particularly interested in reviewing cases that are good examples of care offered to:

- People with learning disabilities
- Ethnic minorities
- People experiencing homelessness
- LGBTQIA+ community
- People for whom English is not their preferred language and people with barriers to communication.

Cases can be identified by any clinical staff (via our routine collection of good care examples, as well as stories shared routinely at our internal clinical governance meetings). An after-action review or MDT review will be completed by a learning response lead. The case will be presented to the Safety Action Forum for action planning, monitoring and oversight.

Monitoring and Review

This PSIP, alongside the PSIRF Policy, will be formerly reviewed annually following implementation in October 2025 by the Exec Lead and those in oversight roles prior to further review and ratification in the QG&R committee.
This will include:
Annual review of due governance on oversight role
Monthly then quarterly and annual review of incident investigation and analysis
Annual development of patient safety action plan with a clear process for monitoring through the senior care leadership team monthly meeting then quarterly quality, governance and risk committee that reports to the board.

RATIFIED BY: QG&R	**DATE: 23/10/24**

References

NHS (2024) The Patient Safety Incident Response Framework https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/ [accessed 6.9.24]

NHS (2022) Patient Safety Incident Response Framework supporting guidance Oversight roles and responsibilities specification Version 1, https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf [accessed 24.10.24]

Appendix 1: Glossary

After Action Review (AAR): 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.

Care Quality Commission (CQC): The regulators for health care services

Clinical & Community Quality Assurance Committee (CCQA): A clinical sub-committee of the Board, attended by trustees, board advisors and some staff in positions that provide oversight regarding PSIRF.

Health Care Acquired Infection (HCAI) : Infections that can develop as a direct result of healthcare interventions, such as medical or surgical treatments, or from being in contact with a healthcare setting. These infections cover a wide range of conditions and pose a serious risk to patients, staff, and visitors. Examples include methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.difficile).

Infection Prevention Control (IPC) : The approach which health care settings take to prevent the transmission of avoidable infections, including health care acquired infections.

Multidisciplinary team (MDT) review: A discussion with multiple professionals to understand incidents and why the outcomes differed from the expected. The MDT review can be used to look at groups of incidents rather than single episodes. Can be used to understand the “work as done” when it may be more difficult to collect staff recollections.

Patient Safety Incident Response Framework (PSIRF): The NHS’s approach to handling patient safety incidents. This approach replaces the previous Serious Incident Framework and represents a significant shift in how the NHS responds to incidents.

Patient Safety Incident Investigation (PSII): An in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.

Quality Governance and Risk (QG&R): A quarterly committee at Board level that provides oversight for clinical issues, incidents and development at SSCH. It is chaired by a Care Trustee.

SCLTQ&R: A monthly committee that provides oversight for clinical issues, incidents and development at SSCH. It is chaired by the Director of Care who is the PSIRF Executive Lead.

The committee has responsibility for developing safety action plans following a learning response, particularly PSIIs.

The meeting is attended by those in a position to provide PSIRF oversight, the learning response lead, the engagement lead (to represent the perspective of the patient / family) and the Patient Safety Partner.

Patient Safety Forum (PSF): A weekly meeting within Exec SITREP which review all incidents and provides decision to support PSI methodology. The meeting is attended by those in a position to provide PSIRF oversight, and PSIRF executive lead

Swarm Huddle: A meeting that occurs immediately after an event happens. Staff 'swarm' to the site to quickly analyse what happened and how. They decide what needs to be done to reduce risk.

System Engineering Initiative for Patient Safety (SEIPS) Framework: A framework that helps you understand how a multifactorial work system may have contributed to a process (work as done) and the eventual outcome.

Thematic Analysis: Collating themes from similar incident reviews / observations to identify common themes that may contribute to the risk of those incidents occurring again.

Appendix 2 Learning Responses

PSIRF Learning Response Reference Guide

The learning response reference guide can be used at the weekly SITREP meeting to guide decision making.

Timescales for Patient Safety Incident Investigations (PSII)

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within six months of its start date.

Timescales for other forms of learning response

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete.

Learning Response	When to use	Time required to complete	Who is involved
After Action Review	After any activity or event where there is something new to learn	Approx. 45-90 minutes	Those directly involved in the event and others connected to the event or the patient pathway.
MDT review	Following multiple similar incidents (including incidents where multiple patients were harmed or where there are similar types of incidents) When time has passed since the incidents occurred or staff not available for other learning response types	Approx. 2-3 hours	Those directly involved in these events, plus subject matter experts and senior clinicians.
PSII (patient safety incident investigation)	PSIIs are the highest level of investigation and are mandated for certain types of incidents. They will be led by trained staff and should include an engagement lead and subject matter expert. They are investigated using a systems-based approach.	Timeframes for PSIIs will be decided upon by the terms of reference. These can take up to 6 months.	Those directly involved in the event, led by someone independent to the event, plus subject matter experts and senior clinicians.
SWARM	As soon as possible after a patient safety incident occurs	No more than 30 minutes	Those directly involved in the incident.