Wirral Community Health and Care NHS Foundation Trust

Wirral University Teaching Hospital NHS Foundation Trust

Policy Reference: 387

Patient Safety Incident Response Policy

Version: 4

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Approval Date:	3rd June 2026	**Approval Group:**	Trust Board
Ratification Date:	06/11/2026	**Ratification Group:**	Chair for Policy Review Group
Published Date:	06/11/2026	**Review Date:**	06/11/2029
Target Audience:	Staff working for Wirral University Teaching Hospital and Wirral Community Health and Care Foundation Trust		
Links to other Policies, Strategies, Procedures etc.	**WUTH** POL 041a Incident Reporting and Management Policy POL 007 Duty of Candour Policy Strategies Patient Experience Strategy Quality and Safety strategy The people strategy **WCHC** GP43 Duty of Candour policy GP8 Incident Management Policy People strategy Quality Strategy Digital Strategy Inclusion and health Inequalities strategy		

Key Points to support Staff

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF). It sets out how Wirral University Teaching Hospital and Wirral Community Health and Care NHS Foundation Trust will approach the development and monitoring of effective safety systems and processes, to improve our patient safety culture. This Policy should be read in conjunction with each organisation PSIRF plan. Staff should continue to report all incidents and follow each organisations Incident reporting policy for non-clinical incidents as the purpose of this policy is to focus on patient safety incidents and supporting patients/families and staff involved.

Both Trusts have worked over the last 18 months to embed elements of Safety I and II. A Safety System II approach is aligned to a proactive, restorative and learning culture. Safety System I recognises a complex adaptive system in which humans make things work by problem solving and adapting to the pressures in their environment. The Safety System II approach has a key focus on understanding what works well, as learning requires curiosity and systems thinking. We want to create space for honest accounts of fallibility, as this builds trust and openness, and we no longer tolerate blame or superficial learning. The right culture is essential to create safe systems.

The Trusts are committed to supporting psychological safety working in collaboration with those affected by a patient safety incident such as, staff, patients, families, and carers. This facilitates opportunities for everyone to have a voice and contribute to change ideas.

Both Trusts have already implemented the initial NHS England Health Education England Patient Safety Training Syllabus. We will enhance these core principles by continuing to develop patient safety competencies and by creating stronger links across patient safety events, learning and continuous improvement. Safety learning will drive effective quality improvements and clinical audit in areas identified as key priorities and known safety system risks. NHS England are currently updating training requirements for PSIRF this is due to be published April 2026. We will review training to support compliance with national guidance.

The Trusts will work in partnership with our patient safety partners to learn from recurring incidents, complaints and feedback from patients and families. This approach fosters increased transparency and openness to support incident reporting in a safe and learning environment. Using an appreciative inquiry model to include insight from things that have gone well and where things have not gone as planned.

The Trusts will continue to learn and be responsive to feedback from the annual NHS staff survey metrics based on specific patient (and staff) safety questions. As this reflects how well the patient safety culture is making positive changes on a day-to-day basis.

The Trusts recognise that NHS services have a core role to play in reducing inequalities in health. This can be achieved by improving access to services and tailoring those services around the needs of the local population, in an inclusive way. The Trusts are committed to delivering on their statutory obligations under the Equality Act (2010). Data will be used to assess any disproportionate patient safety risks, from across the nine protected characteristics. Both Trusts have strategies which recognises the importance of tackling health inequalities which aligns to PSIRF and promotes inclusion.

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1 Introduction & Purpose

This policy sets out our governance framework to embed effective safety systems and processes to learn from patient safety events proportionately and triangulate our safety systems learning. This approach helps to balance resources between conducting learning responses when new learning is highlighted and releasing time for making the safety improvements to strengthen patient safety. These requirements are fundamental to demonstrating we are delivering on the aims of the Patient Safety Incident Response Framework (PSIRF).

The framework embeds patient safety incident responses within a wider system of safety improvement and prompts a significant cultural shift towards systematic strengthening of patient safety management. This policy integrates the four key aims of PSIRF:

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

This Policy needs to be read in conjunction with WUTH/WCHC individual Patient Safety Incident Response Plans, which are separate documents and held within each organisation setting out how this policy will be implemented and explaining the processes involved. The aim is to have a joint plan when next reviewed.

2 Definitions

This section should describe the meaning of any key points used within the policy, to highlight its meaning to the reader.

AAR	After Action Review
CAG (WCHC)	Clinical Assurance Group
CRMG (WCHC)	Clinical Risk Management Group
DOC	Duty of Candour
GMC	General Medical Council
HSSIB	Health Services Safety Investigation Body
ICS	Integrated Care System
ICB	Integrated Care Board
JUSS	Joint Union Staff Side
MDT review	Multi-disciplinary Team - Group of members review incident
NMC	Nursing and Midwifery Council
OPG	Operational Performance Group
PSIRF	Patient Safety Incident Response Framework

PSP	Patient Safety Partners
PSII	Patient Safety Incident Investigation
PSRPM (WUTH)	Patient Safety Response Planning Meeting
PSQB (WUTH)	Patient Safety Quality Board
Safety (SEIPS Model)	Systems Engineering Initiative for Patient safety
SAFE	Standards Assurance Framework for Excellence
SWARM huddles	A review by the team involved / on duty at the time of the incident including the SEIPs model for accurate learning
Thematic review	Number of similar incidents are reviewed for themes and trends
Work as done	How you work in practice
Work as prescribed	Work as directed by policies and procedures within the system
Work as imagined	The potential discrepancy between work as done and work as prescribed
Work as disclosed	Is the way people work and feel safe to disclose this aligns to psychological safety
Psychological Safety	Psychological safety is the shared belief that team members can speak up with ideas, questions, concerns, or mistakes without fear of punishment, humiliation, or retribution. It means feeling safe to take risks, be vulnerable, and challenge the status quo, which is vital for patient safety and improving team culture and a wider safety culture
Appreciative Inquiry	Appreciative Inquiry (AI) is a positive, strengths-based approach that focuses on building more of what works well, rather than focusing only on fixing problems. Instead of asking "what is wrong?", AI asks "what is right, and how can we do more of it?
Just and Learning Culture	A Just and Learning Culture in the NHS is an environment that balances fairness and accountability, focusing on what went wrong rather than who is to blame. It encourages staff to report errors, share learning, and speak up without fear of punishment, aiming for improved safety rather than finding blame

3 Duties & Responsibilities

This section describes the duties and responsibilities of anyone involved in the process being described in the policy.

WUTH employees	All staff are responsible for reporting any potential or actual patient safety incident on the Trust incident reporting system Ulysses and will record the level of harm they know has been experienced by the person affected. They are responsible for keeping up to date with patient safety training role specific and upholding the PSIRF culture. Each division have the responsibility to ensure timely investigations that flow through key governance meetings and to provide assurance on the completion of smart actions and evidence is uploaded to Ulysses and learning shared within teams involved and where appropriate organisationally
WCHC employees	All staff are responsible for reporting any potential or actual patient safety incident on the Trust incident reporting system Datix and will record the level of harm they know has been experienced by the person affected. They are responsible for keeping up to date with patient safety training role specific and upholding the PSIRF culture. The Quality and Governance team have the responsibility to ensure timely investigations

	that flow through key governance meetings and provide assurance on the completion of smart actions and evidence is uploaded to Datix and learning shared within teams involved and where appropriate organisationally

4 Policy Aims

This policy sets out how Wirral University Teaching Hospital (WUTH) and Wirral Community Health and Care Trust (WCHC) approach to developing and maintaining 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 incidents. It embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across both Trusts. Responses under this policy follow a systems-based approach which recognises that patient safety often is a result 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 and the actions or inactions of people, or 'human error', will not be stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, financial investigations and audits, coronial inquests, and criminal investigations) exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy. Information from a patient safety response process can be shared with those leading other types of investigation responses, but other processes do not influence the remit of a patient safety response.

Patient Safety Culture

Both Trusts aim to focus on a 'Just and Learning culture' that facilitates continuous learning, creates psychological safety which supports staff to raise and address concerns, and focuses upon good practice that is shared. We are both committed to promoting and improving the quality and safety of care and treatment that all patients receive in the hospital and community, as well as preserving the safety of staff, visitors, and others.

To achieve this, it is important to support and embed a positive reporting culture throughout both organisations to enable learning when things do not go as expected. Safety conscious organisations are ones that are receptive to adverse incidents so they can learn, develop, and change practice. We have embedded these principles into our procedures for the

review of incidents.

In accordance with the Equality Act, 2010 this policy will support both Trusts to show that learning responses and investigations are reviewed with fairness and transparency. This is to reassure all staff, patients and families regardless of their protected characteristics that they are supported and listened to, when raising a concern or reporting an incident relating to the quality of care and patient safety.

We recognise the significant impact that being involved in a PSII or a learning response, such as an After-Action Review, can have on staff and patients/families. We will actively engage with staff and patients/families receive the support they need to positively contribute to the review of the incident.

There is a range of support and information available across both trusts for staff:

- Line management
- Occupational Health
- Freedom to Speak up guardian
- Information leaflet regarding the process of an investigation
- Contributing to the investigation

There is a range of support for patients/families and carers across both trusts for

- A named lead to support you through the process
- Information Leaflets
- Signposting to Wired
- Contributing to the investigation

The Patient Safety Partner (PSP)

The trusts have embedded the new role of patient safety partners over the last 3 years and uses both level 3 and level 4 Patient Safety Partners. Currently across both trusts there are five patient safety partners who are used for a range of activities level dependant, they support patient safety and strengthening systems and processes. Drawn from amongst our patients, family members or carers, partners will offer their own experiences and skills to add perspective to our quality and safety improvement work.

They will become members of committees, work with project teams, consult on policy and support learning to contribute a different and independent perspective, enriching and ensuring the best patient experience is achieved.

They will be involved in a wide range of activities and programmes of work and will contribute to improving governance and leadership within the Trust. The patient safety partners will be supported by the Head of Patient Safety and Governance; this is a dual role across both Trusts.

The partners will be provided with guidance and expectations on their role, and they will have regular scheduled reviews and any training they require will be based on their individual experience and knowledge.

Addressing Health Inequalities

Both Trusts recognise that the NHS has a primary role to play in reducing inequalities in health under the Equality Act (2010). The merging of both trusts will support with strengthening our systems and help with reducing health inequalities and enable effective working with our external partners, work has already started with working with the PCNs in reducing health inequalities.

Both Trusts are committed to delivering their statutory obligations by using data intelligently to improve access to services and tailoring services around the needs of the local population in an inclusive way. Focusing across a range of protected characteristics and apparent inequalities. To strengthen our work in addressing health inequalities, we will commit to:

- Reviewing our individual safety data, to help identify any disproportionate risk to patients with specific characteristics. This data will be used to make recommendations to our Trusts Board and partner agencies on how to work together in partnership to tackle these risks and issues.

- Respond to issues related to health inequalities as part of our patient safety incident response policy and plans.

- Engaging with patients, families and staff following a patient safety incident, with consideration of their individual needs.

- Uphold a system-based approach, ensuring that staff have received relevant training and development to support this approach. This will support the development of a Being Fair culture and help reduce areas of disparity.

Engagement and involvement following a patient safety incident Patients, families, carers and Staff.

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system, that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff).

This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. Patients and families will be supported throughout the PSII process by a named Engagement Lead. Staff involved in a PSII will receive support from their Line manager or another named lead. The Engagement Lead will facilitate how patients/families are able to contribute their experience and perspective to the investigation process to best meet their personalised needs. Engagement Leads will have undertaken specific training to perform this role; this can be accessed via the HSSIB or procured training from an agreed provider.

The Duty of Candour has been included as a professional and legal responsibility Regulation 20 under the Health and Social Care Act 2008 (Regulated Activities) 2014. Staff Involvement (including partner agencies) is of paramount importance when responding to a patient safety incident to provide a holistic and inclusive approach from the outset. This policy should also be read in conjunction with each trust's incident management policy.

Patient Safety Incident Response Planning (PSIRP) supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement. Both Trusts utilised data sets for patient safety responses and our existing safety improvement workstreams to enable an effective strategic and proportional patient safety response.

The plans has considered other sources of feedback and intelligence both qualitative and quantitative, such as complaints, risks, legal claims, safeguarding cases, mortality reviews and other forms of direct feedback from staff and patients. The plans are under continual review and will be updated as required and in accordance with emerging intelligence and improvement efforts. In line with the requirements of the Patient Safety Incident Response Framework the plan is published on our external facing website.

To support patient safety incident responses, PSIRF recognises that resources and capacity to investigate and learn effectively from PSII is paramount (see appendix 1 for investigation by type). It is therefore essential that both Trusts evaluates its capacity, resources and competency requirements to deliver each trusts plan. The decision to undertake an unplanned patient safety incident investigation will be made at: -

- Patient Safety Response Planning meeting (PSRP) for WUTH or by a senior manager so learning is not delayed and to promote safety
- At WCHC it will be agreed at the Clinical Risk Management Group or by the Safety Incident Review Group so learning is not delayed and to promote safety

The allocation of an Investigation Lead and an Engagement Lead will be made by

- The Division at WUTH
- Quality and Governance for WCHC

Training

Patient Safety Syllabus

When patients are harmed, it has an impact on them, their loved ones, our staff, and others who work in WUTH and WCHC. It is crucial that all staff, whatever their roles, see safety not just as our collective responsibility, but as a key priority. We all need to think differently about what patient safety means and how we can make improvements. See Appendix 1

Overall, we can make both Trusts even safer by:

- Dealing with risks before they can cause harm

- Working to create a positive patient safety culture
- Building safer systems
- Recognising everyone's role in patient safety

The Patient Safety Incident Response Framework describes three roles necessary for a patient safety incident investigation to meet the required standard.

• Learning response lead
• Oversight role
• Engagement lead
Training is provided for all three roles, as follows

Training for investigations and working with Patients and Families	WUTH	WCHC
HSSIB- A systems approach to investigating and learning from patient safety incidents	In Place, and data set available on ESR	In place
Procured training as agreed by NHSE		Medled over 3 years now concluded data set available on ESR of staff trained – WCHC will utilise HSSIB training
Engagement Lead Training	HSSIB	Incorporated in Medled Training
Oversight Roles level 3 and 4 /Level 1 senior boards and leaders	Level 1 senior leadership under review	In Place

Reviewing our PSIRF Policy and PSIRP

The PSIRP is a 'living document', that will be appropriately reviewed every 18 months as we make our way along our PSIRF journey and as both trusts become one. We will monitor the effectiveness of our plans, via the joint Patient Safety Risk and learning Review Panel and review outcomes on a quarterly basis, for both trusts. The report will flow through PSQB for WUTH and CRMG at WCHC.

The Patient Safety Risk and Learning Review Panel Meets monthly and reviews the risks identified for both organisations as per PSIRF plan. This meeting is data driven with dashboards and the triangulation of Complaints, concerns, claims, key areas of the risk register and Section 42 incidents (where there is learning). The key areas provide analysis of themes and trends and decisions are made of the next steps. The group looks at all levels of harms to support Quality Improvement, these are monitored with an Statistical Process Chart (SPC) to review the effectiveness and outcomes.

The decision-making process for the learning response.

The PSIRP provides details of the governance and oversight process, to highlight how learning and improvement is taking place across both organisations including the decision-making process, at WUTH this is the Patient Safety Response planning meeting.

At WCHC, this involves the Safety Incident Review Group who conduct an initial review of the incident, usually a case review, MDT review or a Swarm Huddle which is discussed and moderate harms and above are shared with the Clinical Risk Management Group. The group review recommendations and a peer agreement made if further learning is required, proportionally, to highlight safety systems learning. Then a learning response is conducted. This can be an After-Action Review, a Thematic Review or Case Study Review. If the incident requires a wider or joint systematic review a PSII may be agreed. At these meetings it will also be agreed if the incident meets the Duty of Candour requirements, which are outlined below: -

Regulation 20 (Duty of Candour) definitions of harm	**NRLS definitions of harm**	**LFPSE definitions of harm**	**LFPSE level of Harm**
Source:	Regulation 20 (Duty of Candour) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.	NRLS Degree of Harm FAQs	Policy Guidance on Recording Patient Safety Events and Levels of Harm
Severe (physical)	"...any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in severe harm 'severe harm' means a permanent lessening of bodily, sensory, motor,	"Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons."	Severe harm is when at least one of the following apply: • permanent harm or permanent alteration of the physiology • needed immediate life-saving clinical intervention • is likely to have reduced the patient's life expectancy • needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment

	physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.”		• has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability of their existing health conditions • has limited or is likely to limit the patient’s independence for 6 months or more
Moderate (physical)	“...any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in moderate harm moderate harm is defined as: a. harm that requires a moderate increase in treatment, and b. significant, but not permanent, harm. ‘Moderate increase in treatment’ means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another	“Any unexpected or unintended incident 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.”	Moderate harm is when at least one of the following apply: • has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention • has limited or is likely to limit the patient’s independence, but for less than 6 months • has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm

	treatment area (such as intensive care);"		
Prolonged psychological	"...any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in prolonged psychological harm" "'prolonged psychological harm' means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days"	The FAQs state that psychological harm is not excluded and could fall under either "severe" or "moderate". It does not specify a period.	**Moderate psychological harm** Moderate psychological harm is when **at least one** of the following apply: • distress that did or is likely to need a course of treatment that extends for less than 6 months • distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than 6 months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within 6 months **Severe psychological harm** Severe psychological harm is when **at least one** of the following apply: • distress that did or is likely to need a course of treatment that continues for more than 6 months • distress that did or is likely to affect the patient's normal activities or ability to live independently for more than 6 months

			• distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within 6 months

The aim is not to investigate the same incidents in a reiterative manner, when there is no new learning, as no added value. PSIRF recognises the need to put more resources into making effective systematic safety quality improvements, enhancing data maturity, and sharing learning. This can be via through case studies, bulletins and shared learning events, for key areas or organisationally depending on the learning. Evidence of these approaches are key to enable an audit trail for monitoring how well this process is embedded across services.

Learning responses following a patient safety incident should commence as soon as possible after the patient safety incident has been identified.

The time frame for completion of an initial investigation such as an AAR is usually around 2 – 4 weeks for learning to be identified and actioned. Timing depends on the complexity of the patient safety event as a panel approach may be required, including subject experts eg to be shared with coroner or shared with families are part of Duty of Candour

In general, a PSII will be expected to be completed within a 3-month timeframe and will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. In exceptional circumstances, a longer timeframe may be required for completion eg joint PSIi's. In this case, any extended timeframe should be agreed between the Trusts and those affected. A balance must be drawn between conducting a thorough investigation with the impact of extending the timescale can have on those involved, and the risk that delayed findings may adversely have in affecting safety in the clinical environment. No local patient safety incident investigation should take longer than six months.

Actions and Plans

It is the responsibility of the service to develop SMART actions, focusing on value added areas for making the most improvements to patient safety, this may require a range of systematic safety actions. Weak actions are:

- reminding staff to follow policy
- supervising one member of the team
- Getting staff to write reflections

Ways to strengthen systematic safety systems:

- Changes in a team's workflow that they have been actively involved in developing

- Building ‘forcing functions’ into electronic health care systems
- Truly understanding work as done, prior to making changes
- The intervention is likely to eliminate the risk / or minimise the risk
- The intervention is readily available
- Inequalities are reduced by the intervention
- Follow up safety improvements with audits – to clarify if they are becoming embedded or require further review

Time needs to be spent considering how to improve the identified area, this can include multiple safety actions as a result. It is important to consider and clearly define the area for improvement, to check that safety actions are specific and effective. Safety actions need to be responsive to the improvement area, with clear action planning and clinical analysis to make the most effective safety improvements.

The acronym **SMART** stands for:

- **Specific**: Clearly define the goal, using action verbs
- **Measurable**: clarify that the goal can be measured to track progress
- **Achievable**: Set a realistic goal that can be accomplished
- **Relevant**: The goal should matter to you and align with other objectives
- **Time-bound**: Set a deadline for achieving the goal

  This framework is commonly used in goal setting to create clear and attai nable objectives.

All overarching action plans should be monitored monthly via PSQB for WUTH and CRMG for WCHC, this supports both organisations with known key areas of risk and supports timely completions or escalations.

Individual Actions from a PSII will be monitored via the Patient Safety Response Planning meeting for WUTH and for WCHC, CRMG. This supports the imperative nature of Quality Improvements, and that evidence of completion is held at both trusts

Both Trusts, Patient Safety Incident Response Plans, have outlined the local priorities for focus of investigation 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 Divisions and services will work collaboratively with the Patient Safety Team, the Improvement team and others for a co-ordinated and aligned approach to development of action plans and resultant improvement efforts. Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed. These will be identified through the Safety Risk and Learning Review Panel who will work collaboratively with the Patient Safety Team, the Improvement team and others to provide a seamless approach to development of the safety improvement plans and resultant improvement efforts

How the organisation meets the national patient safety standards

The Executive Chief Nurse will oversee the development, review and approval of Trust's joint policy and individual PSIRF plans, ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the restorative just working culture that both Trusts has implemented over a few years.

To achieve the development of the plan and policy both Trusts will be supported by internal resources within the Governance Service Unit for WUTH and for WCHC the Quality and Governance Team. This will initially be reviewed at PSQB for WUTH and the Clinical Assurance Group which is led at Director level/Deputy Chief Nurse, prior to sign off at committee, once approved this will be reviewed by Cheshire and Mersey Regional ICB.

Promoting PSIRF as 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 Committee/Board meetings on a quarterly basis. This will enable the Board/committee to ask further questions for assurance and support a continuous understanding of organisational safety.

The Trusts will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the organisation as appropriate to the roles and responsibilities of its clinicians in supporting an effective organisational response to incidents.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plans should be undertaken at least every 18 months to comply with both PSIRF guidance on policy development alongside a review of all safety actions.

Complaints and appeals

At WUTH and WCHC we recognise that there will be occasions when patients, or carers are dissatisfied with aspects of the care and services provided by either Trust.

Both Trusts are committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the National Health Service Complaints (England) Regulations 2009. As per individual policies for managing complaints and concerns.

5 Downtime Plan

Extension for all investigation will need to be requested if the downtime is ongoing.

6 References

NHS England (2021) Core20PLUS5: An Approach to Reducing Health Inequalities
core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)

NHS England (2022) Patient safety incident response standards
B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)

NHS England (2022) Safety action development guide
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Appendix 1 - Investigations

Investigation by Type	When to use
AAR After action Review	After Action Review (AAR) is a learning response method that supports organisations to respond to a safety event or other event for the purpose of learning and improvement. Ideally an AAR needs to be finally approved within 4 weeks of the incident being recognised. Can be used across organisations or teams AARs are structured around four questions: 1. What was expected? 2. What actually happened? 3. Why was there a difference? 4. What has been learnt
MDT Multidisciplinary Team Meeting	Is a fact finding when patients have had multiple touch points with different professions needs to be completed within 2 weeks and all professionals need to be available to discuss care and understand learning
SWARM huddle	A swarm huddle approach aims to explore in a post-incident huddle what happened and how it happened in the context of how care was being delivered in the real world (i.e. work as done). It needs to be started ideally as soon as possible once the incident has occurred but within 24 hours. Can be used cross organisations or teams
PSII Patient Safety Incident Investigation	Normally after an initial AAR, MDT or swarm huddle when further learning is required or national policy is required. This needs to be completed with 3 months unless patients and families need more time for involvement.

Appendix 2 - Training

Safety Syllabus	WUTH	WCHC
Level One – Essentials for Patient Safety (estimated completion time 30mins) Is the starting point for all NHS staff, and includes sections on: • Listening to patients and raising concerns • The systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work • 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	In Place and monitored	In place and monitored
Level two – Access to Practice (estimated completion time 45mins) Access to practice is intended for all clinical and non-clinical staff who have an interest in understanding more about patient safety or who want to go on to access the higher levels of training. There are two sessions: The first introduces systems thinking (how the way we work can be used to reduce error and improve safety) and risk expertise (how we can identify and manage risk to keep patients safe). The second session looks at human factors (the science of work and of working together in safely designed systems) and safety culture (the significance of a true learning culture, free of inappropriate blame). Level two Access to Practice includes an assessment, which on completion staff will receive a certificate and will have access to the sector specific sessions covering Mental Health, Primary Care, Maternity Care, Acute Care, and Management and Administration.	In place and monitored	In place for all front-line staff

Level One – Essentials for Patient Safety for Boards and senior leadership teams (estimated completion time 30mins) Additional session for senior leaders and executive teams, covering: • The human, organisational and financial costs of patient safety • The benefits of a framework for governance in patient safety • Understanding the need for proactive safety management and a focus on risk in addition to past harm • Key factors in leadership for patient safety • The harmful effects of safety incidents on staff at all levels	Under review	In place and monitoring
Level two – Sector Specific sessions (Accessible following completion of Level two Access to Practice) On completion of Level 2 Access to Practice all staff will have access to five patient safety sector specific sessions covering good practice, human factors, risk management, systems thinking, and safety culture. Each of these sessions can be completed by individuals or used as part of a group discussion. These sessions aim to highlight the learning from Level 2 – Access to Practice. The sessions cover: • Mental Health • Primary Care • Acute Care • Maternity Care • Management and Administration	Under review	Under review
Levels 3 and 4 Levels 3 and 4 are delivered through a blended-learning approach, with several modules delivered through online learning and followed up with an in-person event. Levels 3 and 4 explore topics such as: • Unpacking system issues • Managing patient safety risks • Understanding cultural, legal, and regulatory factors • Designing solutions	Total of 2 staff Trained working across both organisations	Total of 2 staff Trained working across both organisations Other member of staff undergoing

Equality Analysis

The Equality Analysis (EA) form should be completed in the following circumstances:

- All new policies
- All policies subject to renewal
- Business cases submitted for approval to hospital management impacting on service users or staff
- Papers submitted to hospital management detailing service redesign/reviews impacting on service users or staff
- Papers submitted to Board of Directors for approval that have any impact on service users or staff

Title	Patient safety incident response policy			
Policy Reference	387			
Lead Assessor	Lorraine Adams			
Date Completed	01/05/2026			
What groups have you consulted with? Include details of involvement in the EA process	Staff in area concerned	R	Staff side colleagues	☐
	Service users	☐	HR	☐
	Other	☐	Other	☐
	Please Give Details			
What is being assessed? Please provide a brief description and overview of the aims and objectives				
The purpose of this policy is to outline the principles that should be followed in line with the national Patient Safety Incident Response Framework, established in September 2023.				
Who will be affected (Staff, patients, wider community?)				
Staff, patients and wider community as PSIRF will involve patients, families and patient safety partners.				

Please note the results of this Equality Analysis will be published on the Trust website in accordance with the Equality Act 2010 duties for public sector organisations

Section 1 should be completed to analyse whether any aspect of your proposal/document has any impact (positive, negative or neutral) on groups from any of the protected characteristics listed overleaf.

When considering any potential impact you should use available data to inform your analysis such as PALS/Complaints data, Patient or Staff satisfaction surveys, local consultations or direct engagement activity. You should also consult available published research to support your analysis. For further support with this, please refer to the Library and Knowledge Service accessible via the Trust's intranet site or switchboard.

Section 1 – Initial analysis

What is the impact on the equality groups below?		
Positive: • Advance equality of opportunity • Foster good relations between different groups • Address explicit needs of equality target groups	**Negative:** • Unlawful discrimination, harassment and victimisation • Failure to address explicit needs of equality target groups	**Neutral:** • It is quite acceptable for the assessment to come out as Neutral impact • Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Group	**Any potential impact?** **Positive, negative or neutral**	**Comments / Evidence** (For any positive or negative impact please provide a short commentary on how you have reached this conclusion)
Disability (inc physical and mental impairments)	Positive	If the policy is implemented effectively, the approach should lead to a reduction in inequality and inequity in patient safety outcomes for people with protected characteristics. PSIRF promotes open compassionate engagement and involvement of those affected by patient safety incidents. It provides the opportunity for enhanced equality and relationships between the Trust, patients, their families and volunteers who will be able to support proportionate responses to patient safety incidents. Data and insights gathered through the PSIRF approach will be used to assess any disproportionate patient safety risks, from across the nine protected characteristics. Both Trusts have strategies which recognises the importance of tackling health inequalities which aligns to PSIRF and promotes inclusion.
Age	Positive	As above
Race (all ethnic groups)	Positive	As above

Religion or belief	Positive	As above
Sexual Orientation	Positive	As above
Pregnancy & Maternity	Positive	As above
Gender	Positive	As above
Gender Re-assignment	Positive	As above
Human Rights	Positive	As above
Other e.g. Carers	Positive	As above

If you have identified any **negative** impact you should consider whether you can make any changes immediately to minimise any risk. This should be clearly documented on your paper cover sheet/policy document detailing what the negative impact is and what has changes have been made.

If you have identified any **negative** impact that has a high risk of adversely affecting any groups defined as having a protected characteristic then please continue to section 2.

In all cases - you should submit this document with your paper and / or policy in accordance with the governance structure with copies to wih-tr.EqualityWUTH@nhs.net for monitoring purposes.

Section 2 – Full analysis

If you have identified that there are potentially detrimental effects on certain protected groups, you need to consult with staff, representative bodies, local interest groups and customers that belong to these groups to analyse the effect of this impact and how it can be negated or minimised. There may also be published information available which will help with your analysis.

Who and how have you engaged to gather evidence to complete your full analysis? (List)	
Name & Job Title	**Name & Job Title**
What are the main outcomes of your engagement activity?	
What is your overall analysis based on your engagement activity?	

Section 3 – Action Plan

You should detail any actions arising from your full analysis in the following table; all actions should be added to the risk register for monitoring.

Action required	Lead name	Target date for completion	How will you measure outcomes

Following completion of the full analysis you should submit this document with your paper and or policy in accordance with the governance structure.

You should also send a copy of this document to wih.tr.equalityWUTH@nhs.net for monitoring purposes.

Consultation, Communication, and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Equality Analysis	Lorraine Adams	29/07/2026	This document is embedded within the Policy template
Policy Author Checklist	Lorraine Adams	29/07/2026	Checked for workforce / development, medicines, finance, or wider corporate implications.
Other Stakeholders / Groups Consulted as Part of Current Version Development	Patient Safety Quality Board (WUTH) SOG (WCHC) Integrated Care Board		
Trust Staff Consultation via Intranet	30/07/2026 – 14/08/2026		

Date notice posted in the News Bulletin.	N/A	**Date notice posted on the intranet**	06/11/2026

Describe the Implementation Plan for the Policy / Procedure (Considerations include; launch event, awareness sessions, communication / training via DMTs and other management structures, etc)	**By Whom will this be Delivered?**
Trust wide communications to raise awareness of PSIRF and this policy.	GSU (WUTH) and Quality and Governance Service (WCHC) via Trust Communications
Presentation at Chief Nurse Check in / All Staff Briefing	Safety Management Lead
Dissemination to Consultant body	Deputy Medical Director

Version History

Date	Ver	Author Name and Designation	Summary of Main Changes
Aug 2023	1	Leigh McNeill	
May 2024	2	Leigh McNeill	Amendment to REC Process to include Multi- REC cases
DEC 2024	3	Catherine Cumberlidge	Amendment to REC Process to more proportionate response to falls, pressure ulcers and IPC incidents.
Nov 26	4	Lorraine Adams	Updated to reflect WUTH & WCHC Joint approach to Patient Safety Incident Responses. Now a Joint Policy

Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Timeliness of Patient Safety Responses: • Managerial Review - 5 working days • Rapid Evaluation of Care (REC) - 5 working days. • Facilitated Reflective Session (FRS) Reports – 40 working days • PSIIs – (individual timescales) maximum 6 months	95% completed in timescale	Captured in Intelligence Report	Quality Committee	Quarterly	Head of Patient Safety and Governance
Training of Response Leads • PSII Leads having undergone 2 day HSIB training • FRS Leads having undergone in house training • REC Leads having undergone in house training	100% compliance	Captured in Intelligence Report	Quality Committee	Quarterly	Head of Patient Safety and Governance
Engagement Lead allocation for all PS Responses	100% compliance	Captured in Intelligence Report	Quality Committee	Quarterly	Head of Patient Safety and Governance

Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Governance Meeting Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Governance Support Unit / Quality and Governance Service	PSQB / SOG	Quarterly

Safety of Patients and Public

Confirm the content of this policy does **not** risk the safety of patients or the public if it is uploaded to the public facing website	X
*If the content **does** affect the safety of patients or the public* if it is uploaded to the public facing website *please contact the Policy Coordinator or Risk Management Team for advice*	