DOCUMENT TYPE: **Policy**		**UNIQUE IDENTIFIER:** RMP-C-278	
DOCUMENT TITLE: Patient safety incident response policy		**VERSION NUMBER:** 1.1 **STATUS:** Ratified	
SCOPE: Trust Wide		**CLASSIFICATION:** Organisational	
AUTHOR: Hajara Ugradar	**JOB TITLE:** Associate Director of Safety and Learning	**DIVISION:** Corporate	**DEPARTMENT:** Safety and Quality
REPLACES: New Document		**HEAD OF DEPARTMENT:** Sarah Cullen, Chief Nursing Officer	
VALIDATED BY: Version 1 Board of Directors Version 1 ICB Quality Committee Version 1.1 Addendum validated by PSIRF Oversight Panel Version 1.1 Trust Management Board		**DATE:** 05 October 2023 18 October 2023 31 October 2024 06 November 2024	
RATIFIED BY: Version 1 Procedural Documents Ratification Group Chairs Approval by Michelle Durkin Version 1.1 Procedural Documents Ratification Group		**DATE:** 03 November 2023 30 November 2024	
(NOTE: Review dates may alter if any significant changes are made).		**REVIEW DATE:** 30 November 2027	

AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
1.0	19th October 2023	New Policy	New Policy	New Policy

1.1	16th October 2024	Addendum throughout policy, audit and monitoring section and in Appendix 2	Policy updated to reflect new PSIRF meetings. Safety and Learning Group replaced with PSIRF Oversight Panel and Always Safety First Learning and Improvement Group.	30 November 2027
1.1	16th October 2024	Resources and training to support patient safety incident response	Removal of stipulation that learning responses are to be led by staff at Band 8a and above or equivalent following updated national standards. Standards suggest best practice rather than mandated requirement.	30 November 2027
1.1	16th October 2024	Section 7.2	Training section updated to reflect updated national standards and organisational approach in view of limited nationally accredited training.	30 November 2027
1.1	16th October 2024	Section 8.2.2	Definition of PSIRF MDT expanded for clarity	30 November 2027
1.1	16th October 2024	Addendum throughout	Minor changes to tense and grammar where indicated.	30 November 2027

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**
Document for Public Display: **Yes**
Evidence reviewed by Library Services

CONTENTS

1.0 Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out **Lancashire Teaching Hospitals NHS Foundation Trusts** 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.

Patient safety incidents are unintended of unexpected events (including omissions) in healthcare that could have, or did, harm one or more patients.

The PSIRF replaces the Serious Incident Framework (SIF), (2015) and makes no distinction between “patient safety incidents” and “serious incidents”. It removes the “serious incidents” classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety events by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The new framework is not a different way of describing what came before; it fundamentally changes how the NHS responds to patient safety events for learning and improvement.

The PSIRF advocates a co-ordinated and data-driven response to patient safety events. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety events,
- application of a range of system-based approaches to learning from patient safety events,
- considered and proportionate responses to patient safety events and safety issues,

- supportive oversight focused on strengthening response system functioning and improvement.

This policy should be read in conjunction with our current patient safety incident response plan (PSIRP), which is a separate document setting out how this policy will be implemented.

2.0 Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across or involving **Lancashire Teaching Hospitals NHS Foundation Trust.**

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error,' are stated as the cause of an incident.

Where other processes exist with a remit of determining liability or to apportion blame, preventability or cause of death, their principal aims differ from that of a patient safety response which is conducted for the purpose of learning and improvement. Such processes as those listed below are therefore outside of the scope of the policy.

- claims management,
- investigations into employment concerns,
- professional standards investigations,
- information governance concerns,
- estates and facilities concerns,
- financial investigations and audits,
- safeguarding concerns,
- coronial inquests and criminal investigations,
- complaints (except where a significant patient safety concern is highlighted).

For clarity, whilst the Trust considers these processes as separate from any patient safety investigation, the Trust acknowledges that during the process of conducting a patient safety investigation, the Trust may identify the need to initiate another type of response. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response. The Trust also recognises that there may be some overlap in these processes when engaging with patients, families, carers and staff and will endeavour to ensure a streamlined approach to create a positive experience and reduce unnecessary distress.

3.0 Our patient safety culture

3.1 Always Safety First

Over the last few years, Lancashire Teaching Hospitals NHS Foundation Trust has developed an 'Always Safety First' philosophy and mindset which has made patient safety everyone's priority. This commitment is owned by the Trust Board who have embedded patient safety into their board development programme and board visibility programme.

The goals and initiatives set for improvement are set through the Trust's Always Safety-First Strategy, which is the Trust's response to the NHS National Patient Safety Strategy. This ambitious strategy outlines the Trust plans and aspirations to improve quality of care and safety for our patients, service users and staff through the development of high reliable systems and processes to reduce avoidable harm using robust improvement methodology.

Always Safety First is based on a proactive regular review of our safety metrics and safety intelligence including systematic data from harms, incidents, risks, complaints, mortality and other intelligence to inform our priorities, improvement co-designed with our staff and patients, shared governance, collaborative working across divisions and clinical specialties, and learning to improve. Always Safety First is focused on achieving high reliability through standardisation, system redesign and ongoing development of pathways of care, built on a philosophy of continuous improvement led by frontline clinical

staff. Staff are supported by a real-time safety surveillance system making our data visible from Ward to Board and through collaborative learning sessions which bring teams together to learn about the improvement interventions to be embedded through shared learning and best practice, building improvement capability and actively participating, thereby forming a positive safety and continuous improvement culture.

The Trust Board and wider senior leadership team are committed to adopting a robust improvement methodology across the organisation and wider system. Improvement is organised at macro (system and organisation), meso (pathway) and micro (individual ward and department) levels as outlined in the Trust's Continuous Improvement Strategy.

3.2 Patient Experience and Involvement

Improving patient experience is also a key ambition for the Trust underpinned by the mission to provide 'Excellent Care with Compassion' and is considered a core component of safety culture. Acquiring and acting upon the feedback provided by our patients, families and carers on their experience is an important component to achieving that ambition. In 2022, the Trust co-produced a new three-year Patient Experience and Involvement Strategy. The strategy was developed and co-produced with patients, families, carers, governors, and staff. The Trust has actively sought the views of patient groups who represent those people who have protected characteristics and recognises the importance of intersectionality when considering the feedback. The strategy closely links to a number of Trust strategies, including Equality and Inclusion, Leadership and Organisational Development, Mental Health, Learning Disability and Autism, Dementia, as well as Always Safety First. The delivery of the Patient Experience and Involvement strategy is monitored through the Patient Experience and Involvement Group, which is a diverse group consisting of governors, patient representatives, carers, voluntary sector organisations and staff members and provides assurance to the Trust Safety and Quality Committee.

3.3 Alignment with the PSIRF

Both the Always Safety First and Patient Experience and Involvement Strategies focus on three areas of work. These are:

- **insight** – improving understanding of safety, patient experience and involvement by listening and drawing insights from multiple sources of information,
- **involvement** – to equip patients, colleagues and partners with the skills and opportunities to improve safety and patient experience throughout the whole system,
- i**mprovement** – to design and support improvement programmes that deliver effective and sustainable change.

Lancashire Teaching Hospitals NHS Foundation Trust believes these three work areas outlined in the Always Safety First and Patient Experience and Involvement Strategies align to the aims within the PSIRF.

Through this policy, any associated policies and the PSIRP, the Trust will:

- continue to draw on data and intelligence to identify PSIRF priorities (insight),
- further improve the involvement of our patients, staff and stakeholders in learning responses and equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system ('involvement') and
- design and support programmes that deliver effective and sustainable change in the most important areas including reducing patient harms and improving our safety culture ('improvement').

3.4 Reporting Culture

The Trust has a healthy reporting culture and staff are actively encouraged to report patient safety events that they witness. The Trust encourages staff to view the reporting of patient safety events as a learning opportunity to stop the reoccurrence of similar events.

3.5 Safety Training

In recognising the vital role staff play in speaking up, the Trust introduced 'Speak Up – Core Training' via the Trusts E-learning platform for all staff, including bank and agency staff. This mandatory training was introduced in May 2023 to raise awareness of the

support available for staff to raise concerns and to encourage a healthy speaking up culture for the benefit of patients and workers.

This new training is supported by a range of other safety training across the organisation, including the Level 1 Essentials of Patient Safety E-learning Training, which focusses on the essentials for creating patient safety. The training is mandated for all staff, including bank and agency staff and includes the following content:

- 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 do not go well,
- creating a just culture that prioritises safety and is open to learning about risk and safety.

Board and Senior Leadership Teams are also expected to complete the Level 1 Essentials of Patient Safety for Boards and Senior Leadership Teams E-learning Training. The session builds on the ‘Essentials of Patient Safety for All' session and introduces patient safety measurement, monitoring, and governance for patient safety for Boards and Senior Leaders. It also focuses on Board opportunities and responsibilities in patient safety, human and financial costs, and safety aspects.

As an extension to this and as part of the commitment to be an Always Safety First organisation, the Board has had a development session led by Professor Charles Vincent from the Health Foundation to explore how the Board can review their thinking on measurement and monitoring of patient safety. Alongside this, a wide range of multi professional senior leaders have had bespoke training on Safety II, which considers variations in everyday performance to understand how the organisation can learn from things that have gone well.

The Trust’s Safety and Learning Team have also delivered bespoke face to face Serious Incident Investigation Training for Consultants, Senior leaders and Governance Teams. The aims of the training are:

- to provide an understanding of what a serious incident is, and how the Health Service investigates them,
- to provide an understanding of the serious investigation process, methodologies and tools used,
- to provide insight into the internal and external stakeholders in a serious incident investigation and the effects on patients, families and staff involved.
- to provide information on the upcoming changes to way the NHS investigates serious incidents, adapting to a broader, proactive, risk-based approach and the compassionate engagement of those affected by patient safety events.

3.6 Just Culture

As a learning organisation, the Trust is dedicated to ongoing organisational wide cultural change through compassionate and inclusive leadership to encourage a culture of psychological safety. This is essential to underpin the ongoing development of a high-quality safe patient care system and a just, fair learning culture. The Trust has fully adopted the principles of 'Just Culture' which is detailed in the 'A Just Culture Guide' published by NHS England.

A 'Just Culture' states that actions of staff involved in a patient safety event should not automatically be examined using the Just Culture guide but that it can be a useful tool if an investigation suggests a concern about an individual. The Trust aims to do this through embracing change in how we support our staff members through an event with a compassionate and just approach, ensuring there is no focus on blame or punitive measures for individuals involved. The Trust encourages working collaboratively across services and teams to ensure a supportive, fair, and just approach in the management of safety events that is consistent across all areas and teams.

The Trust is committed to promoting a restorative culture and applies a 'Just Culture' approach to its learning response methodology and will explore the full range of factors which may have contributed to the situation to fully understand what has happened in

order to learn from patient safety events, ensure the right support is provided to staff and to prevent harm in the future.

In this context the wellbeing of our workforce is paramount and as such staff involved in safety events will be signposted to our Health and Wellbeing Service, which includes a Psychological Wellbeing Service.

Although staff should feel confident reporting patient safety events, it is recognised that reporting concerns may be difficult and a stressful process. Therefore, the Trust does have other routes where concerns can be raised and is summarised in the flow chart in Appendix 1.

3.7 Learning From Patient Safety Events

Our safety culture will further mature with the adoption of the new Learn From Patient Safety Events (LFPSE) system. The Trust migrated from the previous National Reporting and Learning System to the new LFPSE system, a new national NHS system for the recording and analysis of patient safety events that occur in healthcare in September 2023. This system enables the Trust to immediately share patient safety events with the national Patient Safety Team to inform system wide learning through an upgrade in DatixWeb technology. To emphasise the Trust's commitment to being 'open and honest,' this system also provides regulators immediate access to patient safety events reported through LFPSE.

It - introduces a number of changes that will support better understanding of the reporter and patients experience associated with a patient safety event. Notably, the reporter is now asked how concerned they are about the patient safety event they are reporting, what the perceived psychological harm is, what the perceived physical harm is and what the perceived attributable harm is. The change means patient safety events are being sent directly to the national LFPSE system enabling earlier thematic oversight of patient safety events occurring in the live system at a national level.

LFPSE will also:

- make it easier for staff across all healthcare settings to record safety events, with automated uploads from local systems to save time and effort and introducing new tools for non-hospital care where reporting levels have historically been lower.
- collect information that is better suited to learning for improvement than what is currently gathered by existing systems.
- make data on safety events easier to access, to support local and specialty-specific improvement work.
- utilise new technology to support higher quality and more timely data, machine learning, and provide better feedback for staff and organisations.

To ensure staff are aware and understand the change, a comprehensive education and communication plan was put in place during the change.

3.8 Working collaboratively.

To support the delivery of the Trust's Always Safety-First strategy, an Always Safety First Learning and Improvement Group is in place and is chaired by our Trust Patient Safety Specialists with representation from a wide group of staff across the organisation. This specialist multidisciplinary group enables a culture of continuous improvement and cross-system working to build the will to improve safety, making safety everyone's role. Going forward, we will continue to build on these relationships and together with other groups to support the successful implementation of this policy and the PSIRP. These groups may include, but is not limited to:

- Patients, families and carers, visitors and partners and advocacy services.
- Clinical Specialities and frontline teams
- Divisional Leadership teams
- Education and Training
- Organisational Development
- Human Factors
- Governance Professionals
- Digital and technology

- Research and innovation
- Continuous Improvement
- Patient Safety Specialists
- Medicines Safety Officer
- Medical Examiner and Mortality
- Safeguarding, Mental Health, Learning Disability and Autism

3.9 Testing our Safety Culture

The Trust has been participating in a four year Magnet4Europe research study. The aim of the research programme is to gain insight into how hospital care may be improved by implementing the Magnet pillars of excellence from the American Nursing Credentialing Centre in European hospital settings. As a part of the research programme staff are surveyed annually focussing on staff health and wellbeing and the impact on care delivery and patient safety in their hospital. Clinical staff from nursing and medical professions are invited to participate in the survey to benchmark our organisation against the other 14 Trusts taking part from England and organisations from across Europe.

The outcomes from both the 2021 and 2022 survey showed that the Trust was the top scoring UK hospital and third of sixty seven European hospitals for nurses rating overall safety on their ward or unit. When rating the quality of care delivered nurses rated the Trust second of fourteen UK hospitals and fifth of sixty seven European hospitals. Although these findings are a good temperature check against other organisations, the Trust is committed to seek opportunities for further learning. To ensure we continue to strengthen our safety culture, we will triangulate learning from other reviews, including our staff survey metrics for specific patient and staff safety questions.

4.0 Patient safety partners

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

At Lancashire Teaching Hospitals NHS Foundation Trust, we are excited to welcome three PSPs from November 2023. The PSPs will offer support alongside our staff, patients, families and carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

This exciting new role across the NHS will evolve over time and at Lancashire Teaching Hospitals NHS Foundation Trust, the main purpose of the role is to be a voice for the patients and community who utilise our services and ensure that patient safety is at the forefront of all that we do.

PSPs will communicate rational and objective feedback focused on ensuring that patient safety is maintained, improved and remains our priority, this will include attendance at governance meetings (including the Trust's PSIRF Oversight Panel, Always Safety First Learning and Improvement Group) and Patient Experience and Involvement Group) to contribute and support the patient safety agenda, participation in investigation oversight groups, review and analysis of safety related information and being involved with contributing to documentation including policies, investigations, and reports. As the role evolves, we may ask PSPs to participate in staff and patient safety training, assist in the implementation of patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support specific to this new role.

Once in post, the PSPs will play a pivotal role in the contribution of the PSIRP including the identification of future local priorities by ensuring the voice of patients, families and carers is heard at all levels of the organisation in relation to patient safety activity.
The PSPs will be supported by the Associate Director of Quality and Experience and the Matron for Patient Safety for the Trust who will provide expectations and guidance for the role.

PSPs will have regular scheduled reviews and regular one-to-one sessions with the Associate Director of Quality and Experience and Matron for Patient Safety and training needs will be agreed together based on the experience and knowledge of each PSP. PSPs will also have access to the Trust's Health and Wellbeing and Psychological Wellbeing Services, to ensure they are afforded appropriate support, acknowledging some of the sensitivity of issues they will be involved with.

The PSP placements are on an honorary basis and will be reviewed after 18 months to ensure we keep the role aligned to the patient safety agenda as this develops.

In addition to the PSPs, the Trust will also work closely with the Maternity Voices Partnership, the Children's Youth Forum and a range of advocacy services in relation to PSIRF, providing updates on the implementation of PSIRF as well as engaging with patients, families and carers in relation to our local priorities.

5.0 Addressing health inequalities.

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. The Trust recognises that at both a national and local level the NHS has a pivotal role in reducing health inequalities through a focus on:

- providing equity of access to healthcare services,
- providing equity of experience of healthcare services,
- providing equity of outcomes from healthcare services.

The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. These are sometimes referred to as wider or social determinants of health.

Wider determinants of health are often interlinked. For example, someone who is unemployed may be more likely to live in poorer quality housing with less access to green space and less access to fresh, healthy food. This means some groups and communities

are more likely to experience poorer health than the general population. These groups are also more likely to experience challenges in accessing care.
People living in areas of high deprivation, those from Black, Asian and minority ethnic communities and those from other inclusion health group, for example the homeless, are most at risk of experiencing these inequalities.

The Trust is situated in an area where a high proportion of its population are at risk of experiencing inequalities, with 20% of the population being 10% of the most deprived nationally and up to 25% of children and 20% of over 65s living in poverty. The area where the Trust is situated also has high levels of long-term conditions including mental health, cardiovascular disease, asthma, and dementia and is an area where there is a high proportion of people from a Black, Asian and minority ethnic background.

As an anchor institution in Lancashire and South Cumbria, Lancashire Teaching Hospitals NHS Foundation Trust has a significant social, economic and environmental impact on the local community during its day-to-day activities. The Trust is committed to ensuring that it makes a positive impact, or at least reduces any negative impact that it has on the local community. As part of the Trusts Level 1 Social Value Quality Mark accreditation, the Trust has made several pledges, including a pledge to reduce the health inequalities affecting the wellbeing of our patients and local communities.

The Trust will achieve this through delivering on its statutory obligations under the Equality Act, (2010) and will use data intelligently to assess any disproportionate patient safety risk to patients from across the range of protected characteristics. Currently, the Trust captures sex, disability, religion or belief and marriage and civil partnership status through the Trust's Electronic Patient Records. This will be further supported through the introduction of the new national LFPSE system, which will allow for the details of patients age, sex and ethnicity protected characteristics to be recorded in patient safety incident records on our incident and risk management system Datix. This will enable the Trust to undertake analysis of intelligence of these protected characteristics, providing insight into apparent inequalities.

In our response toolkit, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.

We will also address health inequalities as part of our safety incident response, utilising the national NHS England 'Core20PLUS5' approach. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. As one of the 7 accelerator sites across the country, the Trust is working collaboratively with the Integrated Care System (ICS) Population Health Management Team and the Cancer Alliance co-lead the ICS Core20PLUS5 programme, working with partners to improve access to cancer screening and cancer care. An action plan in response to Core20PLUS5 has also been developed with the Chief Nursing Officer as the executive lead for Core20PLUS5 who the executive lead for PSIRF is also.

The Trust is also engaging with organisations from across the ICS including the voluntary sector to work collaboratively to reduce health inequalities. Examples include, working with primary care networks, participation in local conferences for system partners and participation in place based boards.

By establishing our local priorities, plan and policies aligned to the PSIRF we will work to triangulate intelligence, ensuring that potential inequalities are considered. Where data suggests additional areas for improvement this will be aligned to future PSIRF plans and this policy. As a Trust we are aware that data continuously provides up-to-date intelligence in association with addressing health inequalities and therefore the use of our incident management system, aligned to patient characteristics and local intelligence, is pivotal to supporting health equality and the reduction of inequalities.

Engagement of patient, families, carers and staff following a patient safety incident is critical to review of patient safety events and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other

methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

The Trust is committed to 'consistently providing excellent care' and 'being a great place to work.' This means as a Trust, we do not tolerate, under any circumstances, any form of racial abuse, discrimination or unacceptable behaviours from and towards, our patients, families, carers and our staff. This includes all protected characteristics as our focus is to deliver the best care to our patients, regardless of, their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. This commitment is led by our Trust Board supported by our Trust Equality and Inclusion Strategy and other supporting strategies, with staff encouraged to report safety events using our incident reporting system. We will use this commitment to underpin future patient safety training, communications and the rollout of our local priorities and plan. In addition, this will continue to feature as part of our wider organisational cultural change programmes. Recognising this, we will ensure that this is pivotal to upholding a system-based approach to reducing health inequalities and poor experience of our staff and ultimately patient outcomes based on individuals' specific characteristics.

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

The 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 events (including patients, families and staff).

This involves working with those affected by patient safety events to understand and answer any questions they have in relation to the incident and signpost them to support as required.

We are committed to continuous improvement throughout the services we provide. We want to learn from any event where care does not go as planned or expected by our staff, patients, their families, carers, and other organisations.

6.1 Patient and Family Liaison

Getting involvement right with patients and families in how we respond to safety events is crucial, particularly to support improving the services we provide. Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake or an omission in care has been made.

The statutory Duty of Candour was brought into law in 2014 for NHS Trusts and is now seen as a crucial, underpinning aspect of a safe, open and transparent culture. It is fundamentally linked to concepts of openness and transparency and must be applied to all notifiable patient safety events.

The Duty of Candour is a general duty to be open and transparent with people in receipt of care.

If Duty of Candour applies to a patient safety incident, the Trust must undertake the following:

1. Tell the person/people involved (including family where appropriate) that the patient safety incident has taken place.
2. Apologise. For example, “we are very sorry that this happened.”
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
6. Keep a secure written record of all meetings and communications.

The Trust encourages all staff to meet the regulatory and professional requirements of Duty of Candour, by being open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident. As part of our new policy framework, we will be outlining procedures that support patients, families, and carers – based on our existing Duty of Candour Policy. This will set out the responsibilities for overseeing, implementing and applying Duty of Candour.

It is expected that an 'Engagement Lead' is appointed following each incident. This would be a senior member of staff or a member of our multi-professional governance team who is nominated to be the key contact for communication with patients, families and carers during a patient safety incident review.

6.2 The Patient Experience and Patient Advice and Liaison Service

The Trust has a Patient Experience and Patient Advice and Liaison Service (PALS). Our Patient Experience and PALS work with patients to find solutions early in patient pathways that contribute towards avoiding safety events and reducing the need to complain, accepting that when this occurs, we have failed to take the action required to prevent an adverse experience. People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of the care team. Should the care team be unable to resolve the concern then PALS can provide support and advice to patients, families, carers, and friends.
Our Patient Experience and PALS team provide confidential support to patients, their families and carers and can:

- Actively listen and respond to concerns, suggestions or queries to help improve patients' experiences.
- Provide information on NHS Services.
- Offer advice on the NHS Complaints process and provide information on how to seek independent advice if you wish to make a complaint.
- Feedback views to relevant staff, including the Chief Executive.
- Help the organisation learn from feedback and concerns to improve your experience.

Our Patient Experience and PALS team can be contacted Monday to Friday, 9am – 4pm (excluding Bank Holidays). The team can be contacted by calling 01772 522972 or emailing PALS@lthtr.nhs.uk.

Further information about how to raise a concern or complaint can be found on our website.

6.3 Information resources for patients, families and carers

The information provided to patients and their relatives has also been reviewed with new resources created, including a new PSIRF page on the Trust's website along with a series of public facing PSIRF resources to make it easy for patients, families and their carers to understand PSIRF and our local priorities. These resources have been developed in conjunction with the Trust's Patient Experience and Involvement Group and other advocacy groups who have contributed to the design and development of these resources.

6.4 National sources of support

We recognise that there might also be other forms of support that can help those affected by a patient safety incident and will work with patients, families, and carers to signpost to their preferred source for this. The table below provides an overview of the additional support available:

Support Available	Link	Detail
Learning from Deaths – Information for Families	NHS England >> Learning from deaths: Information for families	This will explain what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Help is at Hand – For those Bereaved by Suicide	https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf	This guidance is specifically for those bereaved by suicide and offers practical support and guidance to those who have suffered loss in this way.
Mental Health Homicide Support	NHS England – London >> Mental health homicide support	This guidance is aimed at staff and families. This information has been developed by the London region's independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.
Child Death Support	Grieving for a child of any age| Child Bereavement UK Bereavement support after the death of a baby or child – The Lullaby Trust	Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.
Complaint's Advocacy	VoiceAbility | NHS complaints advocacy	The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given

		during the complaints process.
Healthwatch	https://www.healthwatch.co.uk/ You can find your local Healthwatch from the listing (arranged by council area) here: https://www.healthwatch.co.uk/your-local-healthwatch/list	Healthwatch are an independent statutory body who can provide information to help make a complaint - including sample letters.
Parliamentary and Health Service Ombudsman	https://www.ombudsman.org.uk/	**T**he Parliamentary and Health Service Ombudsman makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations
Citizens Advice Bureau	https://www.citizensadvice.org.uk/	The Citizens Advice Bureau provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

6.5 Supporting staff following Patient Safety Events

The Trust is committed to the principles of the NHS Just Culture Guide for ensuring the fair, open and transparent treatment of staff who are involved in patient safety events. The Trust recognises the significant impact being involved in a patient safety event can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place.

All staff with knowledge of the events being reviewed are encouraged to actively participate in learning responses. That may be through submitting written information, joining a debrief meeting or a one-to-one conversation with the incident review team.
Review teams will agree with staff the timescales for feedback of progress and findings in accordance with the type of review method being utilised. All contact with staff will involve the collection of their account of the events along with their views and opinions on how systems can be improved.

When a colleague reports a patient safety event or is providing their insights into the care of a patient for an investigation, the Trust will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement, using the nationally recognised National Patient Safety Agency (NPSA) Just Culture Guide to ensure fair and equitable treatment when undertaking learning responses.

Local managers, with support from our multi-professional governance teams, will advise and signpost staff involved in patient safety events to the most appropriate information about the patient safety incident review process and further support functions.
There are a variety of psychological interventions available for staff at the Trust through the Trust's Health and Wellbeing Service, which includes a Psychological Wellbeing Service. Information on how to access these services can be found in the **Trust's Work Related Incidents and Staff Debrief and Support Policy.**

The Trust's Freedom to Speak Up Guardian also provides a confidential service for staff if they have concerns about the organisation's response to a patient safety event. Appendix 1 within this document describes how staff can raise concerns to the Freedom to Speak Up team.

Second Victim (https://secondvictim.co.uk) is a website resource for healthcare staff and managers involved in patient safety events.

6.6 Information resources for staff

The information provided to staff has also been reviewed with new resources developed in line with the national resources to support staff in understanding their role in PSIRF and our local priorities. This includes a series of supporting policies, templates and standard operating procedures which will sit alongside the PSIRF Policy and this plan.

Going forward, updates, training and information for staff will continue to be cascaded through the PSIRF Oversight Panel, Always Safety First Learning and Improvement Group, the weekly Nursing, Midwifery and Allied Health Professions meeting, the Clinical Reference Group, Trust wide communications and via a range of governance professionals through Divisional Forums. The Trust is also committed to a programme of wider engagement on the implementation of PSIRF and future local priorities with plans for these captured within the Trust's PSIRF stakeholder engagement plan.

7.0 Patient safety incident response planning

The PSIRF supports organisations to respond to patient safety events and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety events relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The Trust will take a proportionate approach to its response to patient safety events to ensure that the focus is on maximising improvement. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our PSIRP details how this has been achieved, as well as how the Trust will meet both national and local focus for patient safety incident responses and any specific contractually required variations to these.

7.1 Resources and training to support patient safety incident response

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

Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant Division and the Trust Safety and Learning Team. A learning response lead will be nominated by the Division, and the individual should have an appropriate level of seniority and influence within the Trust, this may depend on the nature and complexity of the incident and response required-.

The Trust will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. Divisional leadership leads will manage the selection of an appropriate learning response lead to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation. The Trust Safety and Learning team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety events will be afforded the necessary managerial support and be given time to participate in learning responses. All Trust managers will work within our just and restorative culture principles and utilise other teams such as Health and Wellbeing to ensure that there is a dedicated staff resource to support such engagement and involvement. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

7.2 Training

The Trust recognises that meaningful learning and improvement following a patient safety event can only be achieved if supportive systems and processes are in place. To do this effectively, appropriate training and education will be provided to staff to ensure safety events are investigated in line with PSIRF guidance and the experiences of those affected by patient safety events is managed in line with best practice.

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

The Trust has already implemented a series of patient safety training packages to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety events and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows:

Level 1 - Essentials of Patient Safety	The Trust provides Essentials of Patient Safety for all training via the Trusts eLearning platform. It is a mandated training requirement for all staff, including substantive, bank and agency staff and focuses on the essentials for creating patient safety. The content includes: • 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 do not go well. • creating a just culture that prioritises safety and is open to learning about risk and safety.
Level 1 - The Essentials of Patient Safety for Boards	The session builds on the Essentials of Patient Safety for All' session and introduces patient safety measurement, monitoring, and governance for patient safety to Board and Senior Leaders. It is mandated training requirement for all staff 8a and above or

and Senior Leadership teams	equivalent including middle grade medical staff, Consultants and Board members and captures the following: • 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 events on staff at all levels. The training can be accessed via the Trust's e-learning platform.

As part of the Trust's Training Needs Analyses all staff, including substantive, bank and agency staff are mandated to complete Speak Up – Core Training' via the Trusts E-learning platform.

The table below provides an overview of the specific mandated training requirements for staff involved in patient safety investigations:

Topic	Minimum Duration	Content	Learning Response Leads	Engagement Leads	PSIRF Oversight Role Leads
Systems approach to learning from patient safety events**	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,	**Yes**		**-**

		measurement, and monitoring.			
Oversight of learning from patient safety incidents	1 Day / 6 Hours	- NHS Patient Safety Incident Response Framework and associated documents - Effective oversight and supporting processes - Maintaining an open, transparent and improvement focused culture - PSII commissioning and planning.			**Yes**
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.		**Yes**	
Patient safety syllabus level 1: Essentials for patient safety	eLearning – mandatory for all Trust staff	- 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	**Yes**	**Yes**	**Yes**

		things do not go well. - Creating a just culture that prioritises safety and is open to learning about risk and safety			
Patient safety syllabus level 1: Essentials for patient safety (for boards and leadership teams)	eLearning – mandatory for board and senior leadership team	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			Yes
Patient safety syllabus level 2: Access to practice	eLearning - mandatory for all Trust staff	- Introduction to systems thinking and risk expertise: Human factors Safety culture	**Yes**	**Yes**	**Yes**
Continuing professional development (CPD)	At least annually	- To stay up to date with best practice (e.g., through conferences, webinars etc.) - Contribute to a minimum of two learning responses	**Yes**	**Yes**	**Yes**

Staff must be compliant with the above training requirements to fulfil their respective roles within a patient safety investigation. A training delivery plan is in place, with training compliance records being held centrally by the Trust's Education and Training team and being monitored at both Corporate and Divisional Level.

Board members will also receive specific face-to-face training from the Healthcare Services Safety Investigation Body (HSSIB) on Safety Investigation for Strategic Decision Makers and Senior Leaders in Healthcare.

**Due to availability of national accredited training programmes, 'Systems approach to learning from patient safety events' and 'Involving those affected by patient safety incidents in the learning process' training will be prioritised for those leading Patient Safety Incident Investigations. Those leading other learning responses or involved in engaging with patients and families will receive local level guidance to support them in their roles, with an intention to offer the national training more widely to these individuals when capacity permits in the future.

7.3 Our patient safety incident response plan

Our plan sets out how **Lancashire Teaching Hospitals NHS Foundation Trust** intends to respond to patient safety events over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

7.4 Reviewing our patient safety incident response policy and plan

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

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

8.0 Responding to patient safety events

8.1 Patient safety incident reporting arrangements

All staff are responsible for recording and reporting potential or actual patient safety events on our Trust incident reporting system (Datix) when it is identified. This includes safety events that may have been identified during mortality or coronial processes. Further information on the reporting and management of safety events can be found in our **Adverse Incident Reporting, Management and Investigation Policy and Procedure.**

Support and advice are available from the Divisional governance teams, who will also share reminders on key timescales and support interpretation of the Trust's Standard Operating Procedures.

Divisions will highlight to the Trust Safety and Learning Team any incident which appears to meet the requirement for external referral. This will allow the Trust to work in a transparent and collaborative way with our ICB or regional NHS teams if an incident meets the national criteria for a Patient Safety Incident Investigation (PSII) of if supportive co-ordination of a cross-system learning response is required.

The Trust Safety and Learning Team will act as a liaison with external bodies and partner providers to ensure effective communication.

The Trust has a defined Governance Structure which details the decision-making process for patient safety incidents. This is detailed in Appendix 2.

8.2 Patient safety incident response decision-making

8.2.1 Daily Triage

The Trust will have daily review mechanisms in place to ensure that patient safety events are responded to proportionately and in a timely manner and will involve a two tier approach. This will include consideration and prompting to service teams where Duty of Candour applies.

Triage – Level 1 (Divisional Level – led by the Divisional Governance Teams)	All reported patient safety events will be reviewed at the next working day's 'Daily Triage' meeting for each Division by their respective Governance Teams. All patient safety events meeting the local and national priorities will - be escalated to a weekly Trust wide PSIRF Triage meeting led by the Trust Safety and Learning Team. All other remaining patient safety events will be assessed to determine whether the event will be managed locally or whether a 'learning response' is required and a summary of decision-making presented to the to the weekly Trust wide PSIRF Triage meeting led by the Trust Safety and Learning Team as required
Triage – Level 2 (Trust wide Level – led by the Trust Safety and Learning Team)	The Trust wide PSIRF Triage meeting will discuss decisions made by the Divisional Governance Teams and will also allow for consideration of any concerns raised via other processes (e.g., complaints, coronial processes, or safeguarding events) that may also require a learning response. The meeting will enable staff to escalate events of concern and will agree whether a safety event will be managed at a local level or agree the appropriate learning response. The group will also discuss cases for consideration of a PSII if appropriate. Events of concern will

	be escalated to the Trust's weekly PSIRF Oversight Panel for oversight, challenge, and support. If a safety critical event occurs outside of meeting timeframe, this will be escalated immediately to the Chief Nursing Officer, Chief Medical Officer, Associate and Deputy Associate Director for Safety and Learning and Patient Safety Specialists.

8.2.2 Learning Response Types

Learning Responses available include:

Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety event or cluster of safety events to understand what happened and how. These will be undertaken using Systems Engineering Initiative for Patient Safety (SEIPS) methodology.
Multidisciplinary (MDT) Team Review	An MDT review supports health and social care teams to identify learning from multiple patient safety incidents (including incidents were multiple patients were harmed or where there are similar types of incidents). This could include 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	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 safety events. **It is based around four questions:** 1. What was the expected outcome/expected to happen? 2. What was the actual outcome/what actually happened? 3. What was the difference between the expected outcome and the event? 4. What is the learning?
Thematic Review	A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative (I.e., Incident reports, Complaints data etc.) rather than quantitative data to identify safety themes and issues. Thematic Reviews can be used for multiple purposes, including: • Developing or revising our Safety Improvement Profile • Aggregating information from many diverse sources of safety intelligence datasets. • Gathering insight about gaps / safety issues across a pathway or as part of an overarching safety theme to direct further analysis • Aggregating findings from multiple incident responses to identify interlinked contributory factors to inform / direct improvement efforts.

	• • Presenting summary data to show the impact of ongoing safety improvement work.

The Trust's weekly PSIRF Oversight Panel will ensure all safety events are assessed against the PSIRP. The PSIRF Oversight Panel will assess safety events against the focus areas and take a decision on which merit the additional resource a systems level response requires. This meeting will support the identification and dissemination of learning.

Where decision making is not clear, this will be escalated to the Chief Nursing Officer and Chief Medical Officer.

8.3 Responding to cross-system safety events/issues

As a tertiary service, the Trust is committed to taking a system wide approach to learning from patient safety events and this, on occasion, may involve working closely with other organisations.

If it is identified that a patient safety incident requires input from another organisation, this will be flagged immediately to the Trust's Safety and Learning Team. The Safety and Learning Team will contact the organisation in question and arrange for a cross-system review to take place.

When contacting another organisation for input into a patient safety event staff must provide the following:

- A clear rationale for involving the organisation.
- A clear explanation as to why we are making contact – This could be for information sharing purposes or for collaborative working on an investigation.
- Any questions should be clearly articulated by the staff member requesting involvement.

The Trust will also support any organisation that requires our involvement. The Safety and Learning Team will agree an appropriate response time with the partner organisation which staff across the Trust must adhere to.

The Trust will also support any organisation that requires our involvement. The Patient Safety Team will agree an appropriate response time with the partner organisation which staff across the Trust must adhere to.

Wherever possible the Trust will work collaboratively with local partners to ensure system wide learning.

As a Trust we are committed to the ICB cross organisation patient safety event operating principles which are outlined below:

- We will all commit to one learning response rather than silo working for cross organisational patient safety events. We will agree collaboratively through a multidisciplinary approach how to allocate defined roles and responsibilities across all organisations involved including leadership/oversight, co-ordination and will agree a method of escalation.
- We will ensure patient, family and staff involvement as part of cross Trust delivery of the PSIRF, ensuring co-design of a jointly owned safety culture within a well-functioning safety system.
- We will promote openness and transparency to share concerns and allow for growth with clearly defined roles/leads for each area to promote consistency and adapt as required.
- We will be flexible and adapt our communication methods to ensure that everyone is included and has access and will encourage sharing of information and ideas, promoting kind provocation.
- We will create a safe space where we can have open and honest discussions and we will demonstrate mutual respect focussing on the collective goal embracing what other organisations can bring.
- We will provide a safe environment for all to be open/transparent to share learning from safety events.
- Compassion and empathy will underpin our approach, ensuring we provide support with kindness when interacting with patients, families, staff and colleagues.

- We will commit to being honest and disclose all relevant information. We will be upfront about challenges we have faced and what we have learned and make our goals and outcomes visible to all who are affected.
- We will agree our shared goals and the principles and values we need in place to make these happen and we will adapt as we learn and progress.
- We will actively connect and collaborate on these shared goals. To help us achieve this we will collectively create a safe, responsive space where a culture of civility and constructive feedback is the norm.
- We will continue to reflect on and respond to the lessons we learn to ensure we are continuously improving our health system at scale.

8.4 Timeframes for learning responses

Timeframes must be set where possible for all response methods. A response must start as soon as possible after an event is identified. The specific timeframe must be agreed with the patient, family or carers in line with timeframes set out in the PSIRP.

The timeframe for completing a Patient Safety Incident Investigation (PSII) should be agreed with those affected by the incident, including patients, families and carers as part of setting the terms of reference – assuming they are willing to be involved in that decision.

PSIIs should take no longer than 6 months and not exceed timeframes agreed with those affected. If these are exceeded processes must be reviewed to understand how timeliness can be improved.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused), a longer timeframe may be needed to respond to an event. In this case, any extension should be agreed with those affected (patient, family, carers and staff).

The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the event. This should also consider the risk that for as

long as findings are not described, action may not be taken to improve safety or further checks will be required to ensure the recommended actions remain relevant.

Where external bodies (or those affected by patient safety events) cannot provide information, to enable completion within six months or the agreed timeframe, the local response leads should work with all the information they have to complete the response to the best of their ability. The response may be revisited later, should new information indicate the need for further investigative activity.

8.5 Safety action development and monitoring improvement

The Trust adopts the view that the first step when embarking on a process to learn and improve after a patient safety incident is to make efforts to understand the context and develop a deep understanding of work processes. A thorough understanding of the work system using a learning response method is therefore vital but only the first step.

Trust templates will support staff to take the next step from identifying the learning to implementation of the lessons. The final stages of investigation will therefore focus on the process for designing, implementing, and monitoring safety actions, alongside how to reduce risk and limit the potential for future harm.

After identifying and agreeing those aspects of the system where change could reduce risk and potential for harm, learning actions to reduce risk will be generated in relation to each defined area for improvement. Following this, measures to monitor safety learning actions will be defined. The term ‘areas for improvement’ will be used instead of ‘recommendations’ to reduce the likelihood of alighting on a solution at an early stage of the safety action development process.

Understanding contributory factors and work as done should not be confused with developing safety actions. Areas for improvement set out where improvement is needed without defining how that improvement is to be achieved. Safety actions in response to a defined area for improvement depend on factors and constraints outside the scope of a learning response.

The Trust emphasises the importance of a collaborative approach throughout, including involvement of those beyond the immediate professional groups involved in the event and working closely with those with improvement expertise, particularly the Safety and Learning and Continuous Improvement Teams. The Trust is clear that imposed solutions fail to engage staff and lack sustainability as a result.

8.6 Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety events and issues. The Trust has several improvement and transformation groups in place, many of which are aligned to Always Safety First Programmes of work or Continuous Improvement workstreams and have been adapted to respond to the outcomes of improvement efforts and other influences such as national safety improvement programmes.

The Trust's PSIRP has outlined local priorities for focus or response under the 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 risk or harm.

All final PSII reports and other learning response reports where indicated will be presented to the Trust PSIRF Oversight Panel for discussion of the improvement plan and agreement on whether 'areas for improvement' will be monitored at local or organisational level. The trust will use the outcomes from existing patient safety reviews and any relevant learning response to inform future improvement plans and Divisions and Corporate Teams will work together to ensure there is an aligned approach to development of plans and resultant improvement efforts.

In response to safety events where complex organisational learning and improvements are needed, the PSIRF Oversight Panel may delegate responsibility to the Always Safety First Learning and Improvement Group to commission new Always Safety First Improvement Groups or triangulate learning with existing groups. Existing groups may include existing Always Safety First Improvement Groups, Flow Coaching Academy Big Rooms, Microsystem Coaching Academy Big Rooms or existing Transformation

Programmes. The Always Safety First Learning and Improvement Group will review organisational Improvement Plans, provide appropriate support and ensure appropriate Improvement methodology is used.

Once processes are matured, the PSIRF Oversight Panel will receive assurance on PSIRF Improvement Plans relating to the Trust's Patient Safety Priorities and will receive assurance on progress against agreed learning actions and outcomes to ensure effective improvements are implemented and sustained. Where necessary, if factors relating to culture and leadership are identified, the PSIRF Oversight Panel and Always Safey First Learning and Improvement Group will work with the workforce and organisational development or appropriate colleagues to triangulate or identify new learning.

This will also enable Trust-wide lessons to be identified and agreement made on how best to facilitate cascade of relevant information across the Trust. This may include the use of Always Safety-First Bulletins or learning through corporate governance meetings, Divisional Always Safety First meetings, Divisional Safety and Quality meetings, Speciality Governance meetings, Ward meetings, Safety Huddles and a range of improvement groups. This may begin from the point a patient safety incident is reported.

Where appropriate, local monitoring of actions via audit should be considered when improvement plans are complete, to ensure that changes are embedded and continue to deliver the desired outcomes.

9.0 Oversight roles and responsibilities

The leadership and management functions of PSIRF oversight are wider and more multifaceted compared to previous response approaches. When working under PSIRF, organisations are advised to design oversight systems to demonstrate improvement rather than compliance with centrally mandated measures.

The Trust will work with partners to develop a local board-led and commissioner and integrated care system assured architecture around investigations and seek alternative responses to patient safety events, which promote ownership, rigour, expertise and efficacy. The Trust will adhere to NHS England's specification on oversight roles and responsibilities.

9.1 Roles and responsibilities

In order to meet these ambitions, the Trust has identified a number of key internal roles and responsibilities:

Role	Responsibility
Chief Executive Officer	The Chief Executive Officer has the ultimate responsibility for all aspects of patient safety which includes the management of safety events. This includes ensuring that appropriate structures are in place to enable appropriate investigation, analysis and learning and ensuring resources are available to comply with this policy. The Chief Executive is responsible for the provision of appropriate policies and procedures for all aspects of health and safety (Health and Safety at Work Act 1974).

Chief Nursing Officer	The Chief Nursing Officer is the Executive Lead for PSIRF and responsible for ensuring the organisation meets national patient safety incident response standards. The Executive Lead will ensure PSIRF is central to overarching safety governance arrangements and is responsible for ensuring there is an Executive review of all PSII reports in line with the patient safety incident response standards and that each is signed off as finalised. The Executive Lead alongside the Chief Medical Officer will also provide direct leadership, advice, and support in complex/high profile cases, and liaise with external bodies as required.
All Other Executive / Non-Executive Directors	All Directors who sit on the Trust Board (either Executive or Non-Executive) have responsibility for adhering to, championing and supporting the implementation of this patient safety policy within the remits of their identified portfolios.
Associate Director of Safety and Learning (also Patient Safety Specialist)	The Associate Director of Safety and Learning will support the Chief Nursing Officer with all elements of their portfolio in relation to Patient Safety and Learning. The Associate Director of Safety and Learning has overall responsibility as the lead manager for the Trust's Patient Safety and Learning function and will provide strategic direction in relation to the development and implementation of this policy. This includes: • defining the Trust's patient safety and safety improvement profile, • ensuring thorough review of available patient safety incident insight, • engagement with internal and external stakeholders,

	• ensuring the voice of patients, families and carers is heard at all levels of the organisations in relation to patient safety activity, • ensuring necessary training is sourced in relation to PSIRF, • ensuring sufficient support is given to those undertaking patient safety incident investigations and learning responses. They will also provide leadership and direction to the Trust Safety and Learning Team to maintain this policy and ensuring emerging themes and trends relating to patient safety are incorporated into this document.
Patient Safety Specialists (Deputy Chief Nursing Officer and Deputy Chief Medical Officer)	The Patient Safety Specialists will support the Associate Director of Safety and Learning with all elements of their portfolios and provide senior day-to-day leadership in relation to patient safety and learning which includes ensuring the successful implementation of this policy.
Associate Director of Risk and Assurance and Deputy Associate Director of Risk and Assurance,	The Associate Director of Risk and Assurance and Deputy Associate Director of Risk and Assurance will support the Associate Director of Safety and Learning with all elements of their portfolios in relation to the successful implementation of this policy. This will include identifying patient safety priorities based on current and emerging risks to the organisation.
Deputy Associate Director of Safety and Learning and Head of Investigation and Learning	The Deputy Associate Director of Safety and Learning and Head of Investigation and Learning will operationally manage the patient safety and learning function within the Trust. This includes ensuring an appropriate system is in place for staff to report, manage and investigate patient safety events in line with this policy. They will also be responsible for maintaining this policy and ensuring emerging themes and trends relating to patient safety are incorporated into this document. They will

	also provide senior day-to-day leadership to the Associate Director of Safety and Learning in relation to patient safety and learning which includes ensuring the successful implementation of this policy.
Head of Datix and Risk Systems and the Corporate Governance and Risk Team	The Head of Datix and Risk Systems and the Corporate Governance and Risk Team are responsible for ensuring the Learning From Patient Safety Events (LFPSE) system functions effectively in line with expectations whilst working in partnership with Divisional Management Teams and governance professionals to implement PSIRF within the organisation.
Head of Safeguarding	The Head of Safeguarding will be responsible for operationally leading the Trust's established Safeguarding processes. In addition to this, the Head of Safeguarding will be responsible for ensuring appropriate safeguarding cases, which meet the national requirements for investigation are identified and escalated as appropriate.
Medical Examiners / Deputy Chief Medical Officer (leading Mortality)/ Head of Mortality and Coronial Management	The Medical Examiners and Deputy Chief Medical Officer (leading Mortality) and Head of Mortality and Coronial Management will ensure deaths are reviewed in accordance with national policy. Any learning identified through these processes will feed into established processes and any deaths felt to be preventable will be escalated for review in line with the national priorities set out in this policy.
Associate Director of Quality and Experience	The Associate Director of Quality and Experience will support the Safety and Learning Team with the implementation of this document by ensuring the voice of patients, families and carers is heard at all levels of the organisations in relation to patient safety activity. They will also support the Associate Director of Safety and Learning with all elements of their portfolios in relation to the successful implementation of this policy.

Patient Safety Partners (PSPs)	The Patient Safety Partners (PSPs) will play a pivotal role in the implementation of this policy by ensuring the voice of patients, families and carers is heard at all levels of the organisation in relation to patient safety activity. Patient Safety Partners will: • Participate and join key conversations and meetings within the Trust that address patient safety. • Support compliance monitoring and how safety issues should be addressed, providing appropriate challenge to ensure learning and change. • Represent the patient's/family voice, to ensure the Trust is 'walking in the patient's shoes.' • Co-design the developments of Patient Safety initiatives. Ensure that learning responses consider and prioritise the service user, patient, carer and family perspective and champion a diversity of views
Divisional Leadership Team and other senior leaders	The Divisional Leadership Team and other senior leaders have responsibility for adhering to, championing and supporting the implementation of this policy within the remits of their identified portfolios.
Divisional Governance and Risk Managers/Leads	Divisional Governance and Risk Managers/Leads are responsible for acting as the conduit between their allocated Division and the Trust Safety and Learning Team. They will proactively champion the policy and will flag any emerging themes. The Divisional Governance Risk Managers/Leads will ensure Divisions proactively respond to patient safety events appropriately and proportionately. Any learning identified as part of any patient safety activity will be assessed and shared through established routes as appropriate.

Divisional Governance Professionals	Divisional Governance Professionals are responsible for promoting an open, honest, just and fair culture and ensuring that the Policy is implemented consistently throughout their sphere of responsibility. Divisional Governance and Risk Managers/Leads will provide practical support during the identification of suitable incident, review learning responses, support investigations, monitor implementation of safety actions and ensure relevant learning is discussed at local meetings and disseminated. Emerging themes and trends will be escalated as and when appropriate
Learning Response Leads (Lead Investigator)	Learning response leads are responsible for completing appropriate training and continuous professional development in incident response skills and knowledge. Learning response leads will contribute to a minimum of two learning responses per year, gathering qualitative and quantitative information from a wide range of sources and summarising their findings in a clear and logical report.
Engagement leads	Engagement leads are responsible for completing appropriate training and continuous professional development in incident response skills and knowledge. Engagement leads will communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way. They will maintain clear records of contact with those affected, identify key risks affecting the involvement of patients, families, and staff and will recognise when those affected by patient safety events require onward signposting or referral to support services.
All Other Staff	All staff across the organisation are responsible: • For promoting an open, honest, just and fair culture.

	• completing all relevant training in relation to PSIRF for their role. • ensuring any patient safety incident is reported within 24 hours of occurrence or becoming aware of the incident. • adhering to this policy.

9.2 Committee/Group Roles and Responsibilities

Committee/Group	Responsibility
Trust Board	The Trust Board has a responsibility to ensure that it receives assurance that the PSIRF policy and plan is being implemented, that lessons are being learnt, and areas of vulnerability are improving. The Trust Board will receive assurance on the implementation of PSIRF and ongoing and emerging issues from the PSIRF Oversight Panel by escalation through monthly chairs reports to the Safety and Quality Committee and by escalation from the Safety and Quality Committee to the bi-monthly Trust Board meeting. The Trust Board will also receive assurance regarding the implementation of PSIRF and associated standards through an annual PSIRF report to the Trust Board of Directors meeting. This will contain sufficient information to ensure that the Trust Board has a formative and continuous understanding of organisational safety. Where concerns are identified relating to the implementation of PSIRF, compliance with PSIRF standards and robustness of lessons learned and associated improvement plans, the Trust Board will seek assurances that these concerns are being acted upon.
Safety and Quality Committee	The Safety and Quality Committee is responsible for providing assurance to the Board of Directors that PSIRF is being implemented, that lessons are being learnt, and areas of

	vulnerability are improving. The Trust Board will receive assurance on the implementation PSIRF and ongoing and emerging issues from the PSIRF Oversight Panel by escalation through monthly chairs reports and a quarterly report to the Trust Safety and Quality Committee. The quarterly reports will contain a summary of learning from patient safety incident investigations and assurance regarding the implementation of PSIRF and associated standards. Where concerns are identified relating to the implementation of PSIRF, compliance with PSIRF standards and robustness of lessons learned and associated improvement plans, the Safety and Quality Committee will seek assurances that these concerns are being acted upon. Where there are remaining concerns, these will be escalated to the Trust Board.
PSIRF Oversight Panel	The Trust weekly PSIRF Oversight Panel ensure that 'learning responses' are conducted to the highest standards and will support the executive sign off processes for learning responses and ensure that learning is shared, and safety improvement work is adequately directed. The PSIRF Oversight Panel will oversee the implementation of PSIRF, associated policies and the PSIRP and provide assurance to the Trust Safety and Quality Committee of its progress and escalate any ongoing or emerging issues.
Always Safety First Learning and Improvement Group	In response to incidents where complex organisational learning and improvements are needed, the PSIRF Oversight Panel may delegate responsibility to the Always Safety First Learning and Improvement Group to commission new Always Safety First Improvement Groups or triangulate learning with existing groups. Existing groups may include existing Always Safety First Improvement Groups, Flow Coaching Academy Big Rooms, Micro-coaching Academy Big Rooms or existing Transformation Programmes. The Always Safety First

	Learning and Improvement Group will review organisational Improvement Plans, provide appropriate support and ensure appropriate improvement methodology is used.
Divisions	Divisions will report their patient safety event learning responses and outcomes at the weekly PSIRF Oversight Panel. This will include reporting on ongoing monitoring and delivery of safety actions and improvement. Divisions will have arrangements in place to manage the local response to patient safety events and ensure that escalation procedures as described in the patient safety incident response section of the PSIRF policy are effective. Divisions will also be responsible for sharing identified learning.
Integrated Care Board (ICB)	The ICB is responsible for approving this policy and the PSIRP and ensuring collaborative work across the local integrated care system (ICS). The ICB will act as a key stakeholder providing oversight and support to the Trust in the implementation of this plan. A representative from the ICB will attend the Trust's PSIRF Oversight Panel to oversee and ensure the quality of investigations undertaken by the Trust.

The Trust 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 staff in supporting an effective organisational response to safety events.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years to comply with Trust guidance on policy development alongside a review of all safety actions.

9.3 Quality assuring learning response outputs.

The Trust weekly PSIRF Oversight Panel will ensure that 'learning responses' are conducted to the highest standards and will support the executive sign off processes and ensure that learning is shared, and safety improvement work is adequately directed.

A representative from the ICB will attend the Trust's PSIRF Oversight Panel to oversee and ensure the quality of investigations undertaken by the Trust.

10.0 Complaints and appeals.

Lancashire Teaching Hospitals NHS Foundation Trust always aim to provide excellent care with compassion and communicate effectively with all our patients, their relatives and carers in line with our Trust values.

Although the Trust works hard to offer a high standard of service, sometimes things do not always go to plan and patients, their relatives and carers may have questions that need answers. If this happens, we welcome the opportunity to make things better and ask that patients, their relatives and carers tell us about what their concerns are, and we will do our best to make things better. This includes affording the opportunity for complaints and appeals relating to the organisation's response to patient safety events.

In the event a patient, carer or relative has concerns regarding any aspect of the investigation process, it is recommended that the following steps are followed:

1. If appropriate, seek to resolve the matter locally through a discussion between the patient, family or carer, the Patient Safety Incident Investigator and the nominated engagement lead.
2. Escalate the concern to the Divisional Leadership Team for local resolution.
3. Refer the matter to the Trust's Patient Experience and PALS Team.

Further information is available on the Trust's website.

11.0 AUDIT AND MONITORING

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report and act on findings.	Group / committee / individual responsible for ensuring that the actions are completed
Entire Document	Report	Associate Director of Safety and Learning or appropriate deputy	Quarterly Report	Safety and Quality Committee	PSIRF Oversight Panel
Entire Document	Report	Associate Director of Safety and Learning or appropriate deputy	Annual	Trust Board	Safety and Quality Committee/ PSIRF Oversight Panel
Learning Responses	Report	Associate Director of Safety and Learning or appropriate deputy	Weekly	PSIRF Oversight Panel	PSIRF Oversight Panel

12.0 TRAINING

TRAINING Is training required to be given due to the introduction of this policy? Yes Please delete as required		
Action by	**Action required**	**Implementation Date**
See Page 27	See Page 27	06 November 2023

13.0 DOCUMENT INFORMATION

ATTACHMENTS	
Appendix Number	Title
1	Raising a Concern Flow Chart
2	Governance arrangements in relation to how the Trust will respond to a Patient Safety
3	Equality, Diversity & Inclusion Impact Assessment Form

OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library

Plan-27	Patient Safety Incident Response Plan
RMP HS 114	Adverse Incident Reporting, Management and Investigation Policy and Procedure
TP-149	Duty of Candour
SOP-394	Complaints Policy and Procedure
HRP-02	Raising concerns at work policy and procedure – freedom to speak up
TP-96	Work Related Incidents and Staff Debrief and Support Policy.
	Always Safety First Strategy 2021–2024 (LTHTR)
	Continuous Improvement strategy 2021-2023 (LTHTR)
	Patient Experience and Involvement Strategy 2022-2025 (LTHTR)
	Equality and Inclusion 2021-2024 (LTHTR)
	Leadership and Organisational Development Our people plan 2023-2026 (LTHTR)
	Mental Health 2021-2024 (LTHTR)
	Learning Disability and Autism 2023-2026 (LTHTR)
	Dementia 2021-2024 (LTHTR)
See Adverse Incident Reporting, Management and Investigation Policy for links to other Associated Documents	

SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full** Checked by library ET 03/11/2023	
Number	References
1	Patient Safety Incident Response Framework (NHS England, 2022)
2	Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident (HSSIB, Learn Together and NHS England, 2022)
3	Regulation 20: Duty of Candour (CQC, 2022)
4	A Just Culture Guide (NHS England)

DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	Definition
AAR	**After Action Review** A learning response tool consisting of a structured facilitated discussion of an event/incident
CQC	**Care Quality Commission** Independent regulator for health and social care in England
CSP	**Community Safety Partnership** Statutory partnerships of organisations who work together in an area to reduce crime and the fear of crime, anti-social behaviour, alcohol, and drug misuse and reducing re-offending
Core20PLUS5	**Core20PLUS5**

	A national NHS England approach to inform action and reduce healthcare inequalities at both national and system levels, focused initially on the experience of adults, but has now been adapted to apply to children and young people
DHR	**Domestic Homicide Review** A review into the circumstances around a death of a person following domestic abuse
HealthWatch	**HealthWatch** A health and social care champion service who obtain the views of people about their needs and experience of local health and social care services
HSSIB	**Healthcare Services Safety Investigation Body** The independent national investigator for patient safety in England
ICB	**Integrated Care Board** A statutory organisation who are responsible for developing a plan for meeting the health needs of the local population, managing the NHS budget, and arranging for the provision of NHS services in a geographical area
ICS	**Integrated Care System** Partnerships of organisations which come together to deliver joined up health care services and improve the lives of people who live in the area
IOPC	**Independent Office for Police Conduct** A non-departmental public body in England and Wales who are responsible for overseeing the system for handling complaints made against police forces in England and Wales
LeDeR	**Learning Disability and Mortality Review** A service improvement programme for people with a learning disability and autistic people who look at key episodes of health and social care the person received that may have been relevant to their overall health outcomes
LFPSE	**Learning from Patient Safety Events** The new national NHS service for the recording and analysis of patient safety events
LTHTR	**Lancashire Teaching Hospitals NHS Foundation Trust**
Magnet4Europe	**Magnet4Europe** A four-year Horizon project that aims to improve mental health and wellbeing among health professionals in Europe
MDT	**Multi-Disciplinary Team** A group of staff from different areas in healthcare
NRLS	**National Reporting and Learning System**

	The current national central database for recording and analysing patient safety incident reports
PALS	**Patient Experience and Liaison Service** The Trust's team which provides support for patients, families, and carers
PPO	**Prison and Probation Ombudsman** A public body that carries out independent investigations into complaints and deaths in custody
PSIRF	**Patient Safety Incident Response Framework** A new and innovative approach to the way the NHS responds to patient safety incidents/events.
PSIRP	**Patient Safety Incident Response Plan** The plan which sets out how NHS organisations intend to respond to patient safety incidents/events under PSIRF
PSP	**Patient Safety Partners** The role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisations' governance and management processes for patient safety
PSII	**Patient Safety Incident Investigation** A learning response tool which is undertaken when an incident or near miss indicates significant patient safety risks and the potential for new learning
Safety I	**Safety I** Identifying causes and contributing factors in patient safety events as the focus point in an attempt to stop them occurring
Safety II	**Safety II** Considering variations in everyday performance to understand how things usually go right
SEIPS	**Systems Engineering Initiative for Patient Safety** A methodology for understanding outcomes within complex socio-technical systems
SIF	**Serious Incident Framework** The current process by which the NHS ensures serious incidents are identified, investigated, and learned from to prevent the likelihood of similar incidents happening again. This framework will be replaced by PSIRF
SOP	**Standard Operating Procedure** A guide/step by step instructions compiled by an organisation to help staff to carry out routine tasks/processes
SpHA	**Special Healthcare Authority** An authority who provides a health service to the whole of England, not solely to a local community

STP	**Sustainability and Transformation Partnership** Where local NHS organisations and Local Authorities draw up shared proposals to improve health and care in the areas they serve

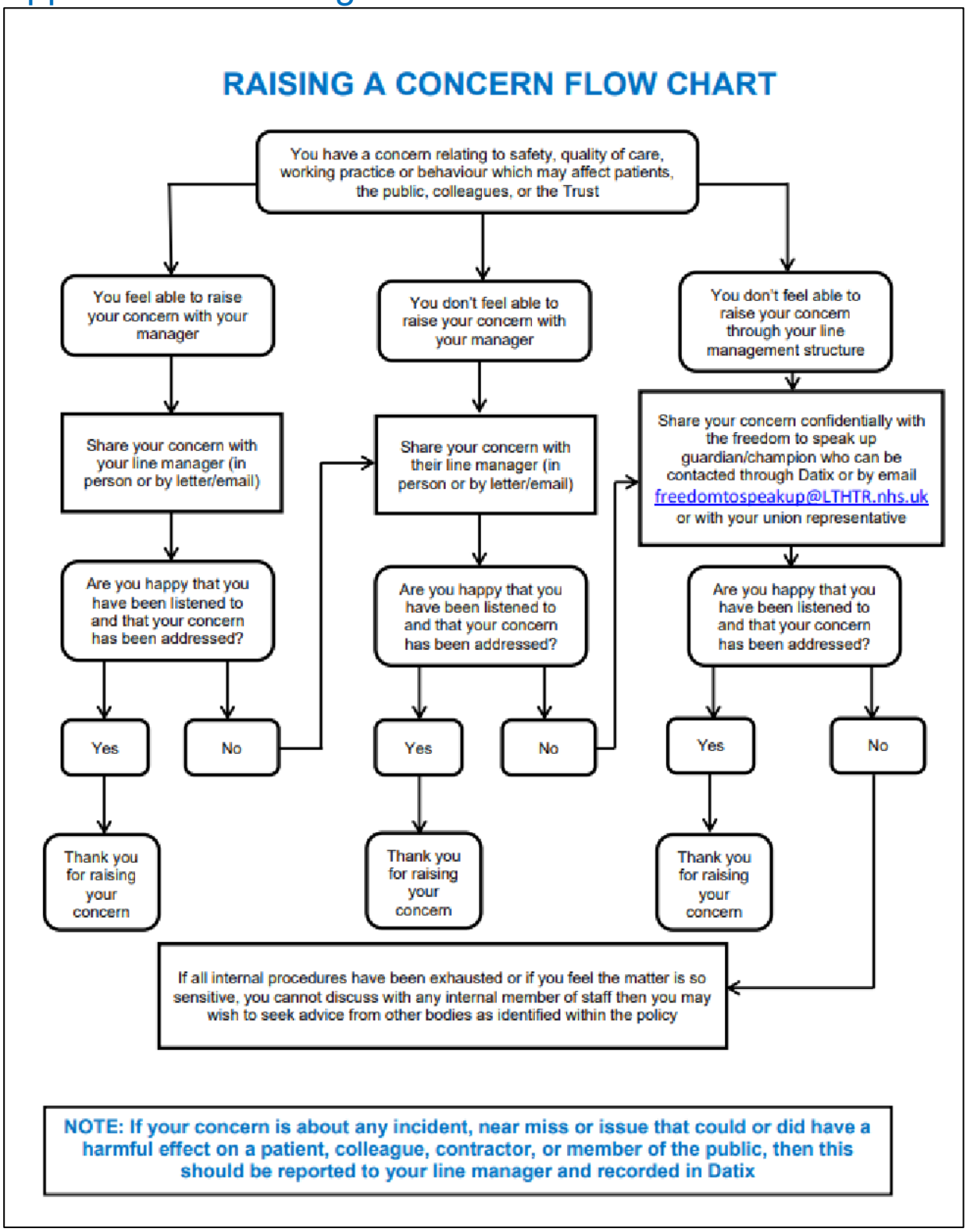
CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	Job Title	Date Consulted
NMAHP group	Senior Nurses, Ward Managers, AHP leads	20/9/23
Visually Impaired Forum	Patients	22/9/23
Clinical Reference Group	Senior Clinicians	25/9/23
Patient Experience and Involvement Group	Staff, Patients and Advocacy Services	26/9/23
Carers forum	Patients	27/9/23
Cancer Forum	Patients	3/10/23
Dementia Strategy Meeting	Staff and Patients	5/10/23
EDI forum	Staff	9/10/23
Safety and Quality Committee	Executives, Non Executives, Senior Leaders	29/9/23
Board of Directors Public Meeting	Directors and Public	5/10/23
Sarah Cullen	Chief Nursing, Midwifery & AHP Officer	15/09/2023
Emma Ashton	Divisional Midwifery Director	15/09/2023
Joanne Connolly	Divisional Nursing Director	15/09/2023
Lisa Elliott	Divisional Nursing Director	15/09/2023
Catherine Gregory	Deputy Chief Nursing Officer	15/09/2023
Rachel Sansbury	Divisional Nursing Director	15/09/2023
Kate Smith-Probert	Deputy Divisional Nursing Director	15/09/2023
Jacqueline Murray	Deputy Divisional Nursing Director	15/09/2023
Cathy Owen	Divisional Clinical Governance Lead	15/09/2023
Rachel Moxham	Divisional Clinical Governance Lead	15/09/2023
Clare Shaw	Compliance & Governance Officer	15/09/2023
Emma Holden	Safety and quality matron for maternity	15/09/2023
Karin Colbeck	Divisional Clinical Governance Lead	15/09/2023
Sarah Howarth	Divisional Clinical Governance Lead	15/09/2023

Joanne Lambert	Deputy Divisional Nursing & Midwifery Director	15/09/2023
Simon Regan	Associate Director of Risk & Assurance	15/09/2023
John Howles	Associate Director of Patient Experience & Engagement	15/09/2023
Anne Kirkham	Head of Community Services	15/09/2023
Katy Clay	Governance & Risk Manager	15/09/2023
Michelle Durkin	Deputy Associate Director of Safety & Learning	15/09/2023
Michael Stewart	Deputy Medical Officer	15/09/2023
Claire Granato	Chief AHP	15/09/2023
Lauren O'Brien	Deputy Director of Education	15/09/2023
Christopher Taylor	Head of Training Performance & Compliance	15/09/2023
Arnab Bhowmick	Deputy Medical Officer	15/09/2023
Lousie Gracie	Deputy Divisional Nursing Director	15/09/2023
Gareth Price	Chief Pharmacist	15/09/2023
Caroline Marshall	Associate Director of Patient Safety, ICB	19/09/2023
Kimberley Ciraolo	Patient Safety Manager, ICB	19/09/2023
Louisa Graham	Deputy Director of Workforce & OD	18/09/2023
Kate Holt	Organisational Development & Culture Lead	18/09/2023
Amanda Davis	Head of Diversity & OD	18/09/2023
Jennifer Carroll	Continuous Improvement Clinical Fellow	18/09/2023
Kurt Bramfitt	Senior Associate Director of Continuous Improvement	18/09/2023
Elizabeth Midwinter	Continuous Improvement Clinical Fellow	18/09/2023
Stuart Clough	Senior Associate Director of Continuous Improvement	18/09/2023
PSIRF Oversight Panel	Members of PSIRF Oversight Panel	24/10/2024

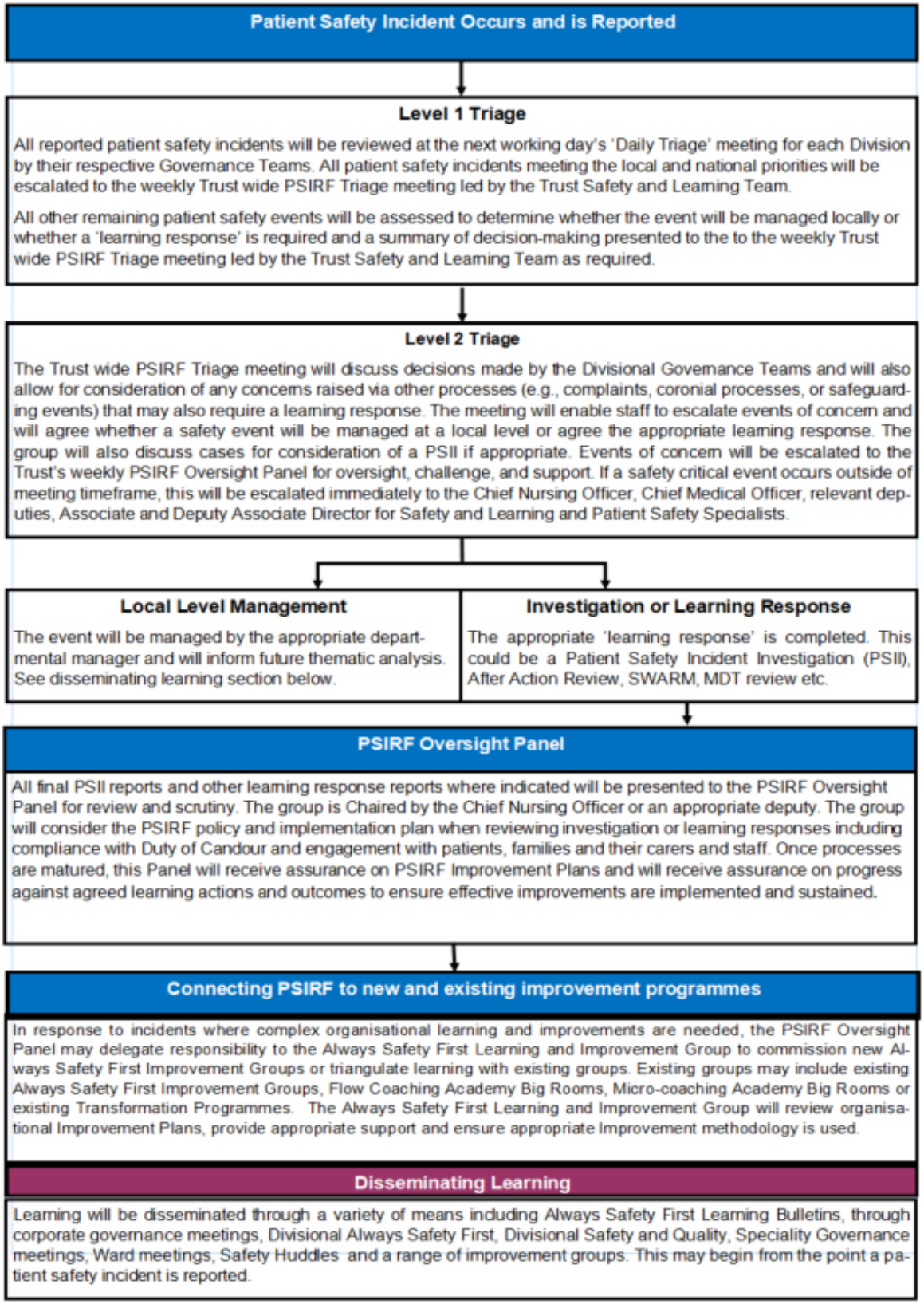
DISTRIBUTION PLAN	
Dissemination lead:	Hajara Ugradar/John Howles/Michelle Durkin
Previous document already being used?	No
If yes, in what format and where?	NA
Proposed action to retrieve out-of-date copies of the document:	NA
To be disseminated to:	Trust wide
Document Library	Yes
Proposed actions to communicate the document contents to staff:	Include in the LTHTR Monthly Procedural documents communication. Document

	uploaded to the Document Library. Circulate via relevant stakeholder groups.

Appendix 1 – Raising a Concern Flow Chart



Appendix 2 – Governance arrangements in relation to how the Trust will respond to a Patient Safety



Lancashire Teaching Hospitals
NHS Foundation Trust

Appendix 3 - Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Corporate			
Lead Assessor	Hajara Ugradar			
What is being assessed?	Impact of document on equality.			
Date of assessment	18/10/2023 (reviewed 16/10/2024 and still appropriate)			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☒
	Service Users	☒	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☒
	Please give details:			

1) What is the impact on the following equality groups?			
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 Groups	**Impact** (Positive / Negative / Neutral)	**Comments:** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?	
Race (All ethnic groups)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.	
Disability (Including physical and mental impairments)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.	
Sex	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected	

		characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Gender reassignment	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Religion or Belief (includes non-belief)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Sexual orientation	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Age	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Marriage and Civil Partnership	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Pregnancy and maternity	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Other (e.g. caring, human rights, social)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.

2) In what ways does any impact identified contribute to or hinder promoting equality and	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions

diversity across the organisation?	and this will inform our system learning and improvement priorities.

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.** ➢ This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups ➢ This should be reviewed annually.

ACTION PLAN SUMMARY		
Action	**Lead**	**Timescale**
NA	NA	NA

HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	√	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	√
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	√	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	√
3. The NHS aspires to the highest standards of excellence and professionalism.	√	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	√
4. The patient will be at the heart of everything the NHS does.	√	4. Provide support and opportunities for staff to maintain their health, wellbeing and safety.	√
5. The NHS works across organisational boundaries.	√	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.	√
6. The NHS is committed to providing best value for taxpayers' money.	☐	6. To have a process for staff to raise an internal grievance.	√
7. The NHS is accountable to the public, communities and patients that it serves.	√	7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	√

WHICH AIMS OF THE TRUST APPLY? Click here for Aims	Tick those which apply	WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions	Tick those which apply
1. To offer excellent health care and treatment to our local communities.	√	1. Consistently deliver excellent care.	√
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria.	√	2. Great place to work.	√
3. To drive innovation through world-class education, teaching and research.	☐	3. Deliver value for money.	☐
		4. Fit for the future.	√