Great Western Hospitals NHS Foundation Trust

Patient Safety Incident Response Plan (PSIRP)

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1. Introduction

This patient safety incident response plan (PSIRP) explains Great Western Hospital NHS Foundation Trust's (hereafter, 'GWH' or 'the Trust') approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The plan will detail how GWH will respond to patient safety incidents for the next twelve to eighteen months. It may be reviewed at any time in response to emerging patient safety issues, or any local, regional or national changes which affect GWH.

The systems and processes described in this plan will integrate the four key aims of the Patient Safety Incident Response Framework (PSIRF):

- compassionate engagement and involvement of those affected by patient safety incidents;
- use of a range of system-based approaches to learning from patient safety incidents;
- considered and proportionate responses to patient safety incidents;
- supportive oversight focused on improving how our systems work.

The key principles of the Patient Safety Incident Response Framework (PSIRF) are closely aligned to our values as a healthcare provider. Our Executive Board values the support PSIRF gives in achieving our strategic aims and objectives.

2. Our services

Great Western Hospitals NHS Foundation Trust (GWH) along with the Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust form the Acute Hospital Alliance. The Acute Alliance was formed in 2025 in recognition that we can achieve more by working together than by acting as individual organisations. We are working to rationalise our corporate functions, but also to deliver improvements to our clinical outputs particularly how we manage waiting lists across the Alliance.

The Acute Hospital Alliance is part of the Bath and North East Somerset, Swindon and Wiltshire Integrated Care System. This system was set up in 2022 to improve health and care services in our region with a focus on prevention, better outcomes, and reducing health inequalities.

Within the Alliance, GWH is registered with the Care Quality Commission to provide a wide range of emergency, specialist and general medical services in the Great Western hospital. We serve a population of over 243,000 people in Swindon and the surrounding areas.

We are guided by our vision and by our underpinning values and behaviours:

3. Scope

Our priority is to learn from patient safety events so we can improve our healthcare system. This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across GWH. It will explain the different responses we will take to learn from patient safety events. In all responses we will focus on taking effective actions to improve.

There is no remit within PSIRF, or this plan, to apportion blame, determine legal liability, professional misconduct/fitness to practise, criminality preventability, or cause of death, in a response conducted for the purpose of learning and improvement. Other processes exist to deal with these e.g. complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroner's inquests, and criminal investigations. The aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan.

4. Our patient safety culture

Our aim is to make patient care in the Trust as safe and effective as is reasonably practicable.

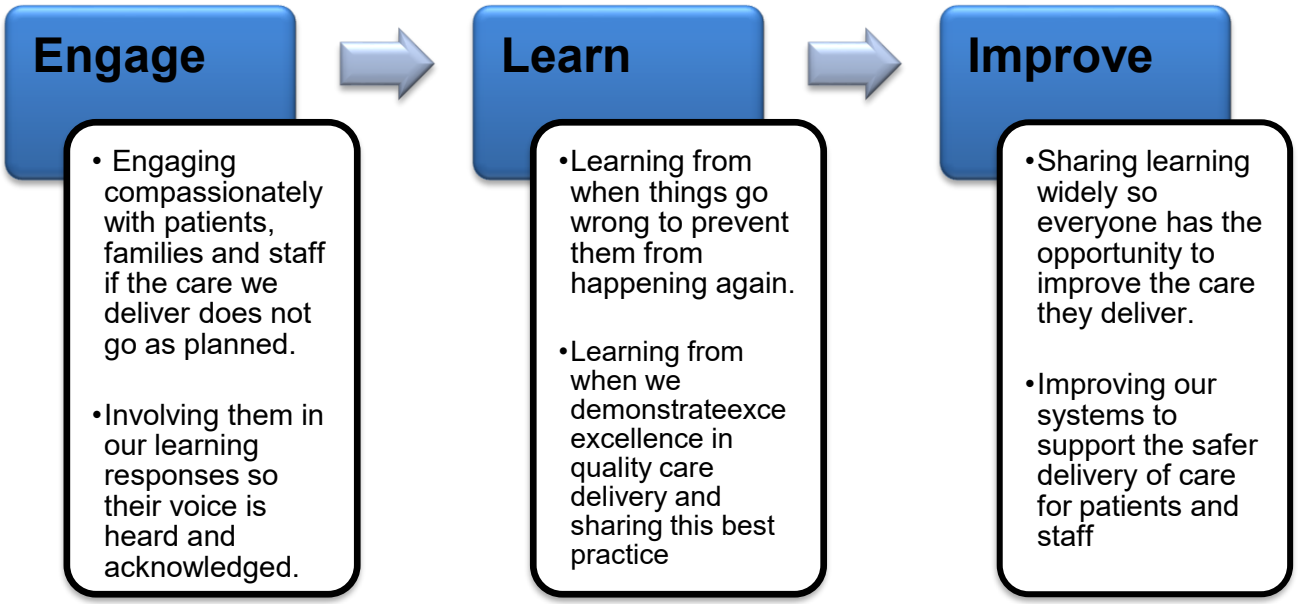
We are committed to reducing the overall number and severity of harms caused when patient care does not meet planned, or mandatory standards.

We will ensure our PSIRP recognises and meets the needs of those affected by patient safety incidents and will treat all those involved in a just and fair way. This will encourage a reporting and learning culture in our staff and help us to make further safety improvements.

How will we achieve our aim?

Our patient safety culture is underpinned by our commitment to: ***engage, learn, improve***. This encompasses the following principles:

Learning in patient safety is more than just understanding how the care we delivered was not as intended, it is also about understanding why it happened and how elements of our local healthcare systems and processes contributed to an incident.



We will work with staff, patients, their loved ones, carers, and anyone else affected by patient safety incidents to achieve this. In doing so, we can improve the quality of care we deliver and to try to prevent similar situations recurring. We will monitor the effectiveness of any actions we take to make sure they continue to achieve this.

In the rare circumstances where a learning response may raise concerns about an individual's conduct or fitness to practise that requires onward referral to People Operations we will apply the just culture principles laid down in the NHS Being fair tool to ensure our staff are treated fairly after an incident occurs.

4a. Equality, Diversity and Inclusion (EDI) considerations

It is important that in any patient safety investigation that we consider whether EDI issues may be a relevant factor. This will include the impact of any protected characteristics[1] on the delivery of care, or outcomes for the patient. Any issues are to be explicitly addressed in our investigations and addressed directly in the body of the report with appropriate recommendations made.

4b. Improving Together

Through collaboration with the Improving Together Team, learning from patient safety events will use the Improving Together methodology at ward or service level to embed change.

The improvement groups that are leading the PSIRF priorities will also use the Improving Together methodology. The Improving Together team will develop processes for providing oversight to Trust wide improvement, working in collaboration with the Insights and learning team to ensure no duplication of effort.

[1] Race, age, disability, sex, gender, sexual orientation, marital status, religion or belief in accordance with the Equality Act (2010).

5. Defining our patient safety incident profile

We recognise that our primary source of learning will come from reported patient safety incidents. However, this means that our safety culture will be more reactive than proactive. To become more proactive we will need to develop an organisational culture of identifying and reporting near misses and system vulnerabilities.

This is an ongoing development of our learning culture which we are addressing through supportive leadership, engagement strategies, staff training, and relevant safety and learning groups. The aim is to embed PSIRF concepts and processes at all levels in all our day to day work across the Trust.

6. Producing our patient safety priorities 2025-26

This plan, and subsequent PSIRPs will consider, but not be limited to, identifying patient safety themes from:

Incidents, near misses, and system vulnerabilities identified in GWH learning responses.
Incidents and patient safety themes identified locally (ie. within BSW group); regionally (south west of England); and nationally (by other NHS Trusts, NHS England);
Any of our five specialist improvement groups (Falls; Pressure ulcers; Medication management; Infection prevention and control; Communication).
Executive and Non-executive board members safety visits;
Complaints received by our Patient Advice and Liaison Service (PALS);
Civil and criminal proceedings involving the Trust
Outcomes of coronial inquests
Outcomes of criminal investigations
Reports from the Care Quality Commission (CQC) - other Healthcare bodies eg. the Health Services Safety Investigation Board (HSSIB) or Maternity and Newborns Safety Investigations (MNSI).
Outcomes of professional conduct investigations by recognised healthcare bodies eg. Nursing and Midwifery (NMC), Healthcare Professionals Council (HCPC), General Medical Council (GMC) etc;
Outcomes of GWH disciplinary investigations conducted by People Operations;
Emergent national patient safety themes including national patient safety alerts;
Changes in legislations, national guidelines, and practices that have led to, or have the potential to impact patient safety. This can include recognising positive as well as negative impacts on safety and risk.

To produce our priorities we took into account patient safety incidents, near misses and areas for improvement in our systems from a variety of sources. The analysis of our patient safety data for financial year 2024-25 (FY24/25) is below. This, viewed through the lens of the Board of Directors' key drivers and metrics, gave us our initial safety priority areas.

These were then passed to our five specialist improvement groups who were set up to respond to our major safety concerns. These groups are :

- Falls improvement;
- Pressure ulcer improvement;
- Communications improvement;[2]
- Medication management;
- Infection prevention and control.

Each group produced their specific objectives for FY25/26. Where applicable, these were aligned with the Trust's key drivers and metrics. The priorities and specific objectives were then agreed by the Trust Board.

[2] The Communications Improvement group is in the process of being established at time of publishing.

6a. Reported Patient Safety Incidents by Category 2024-25

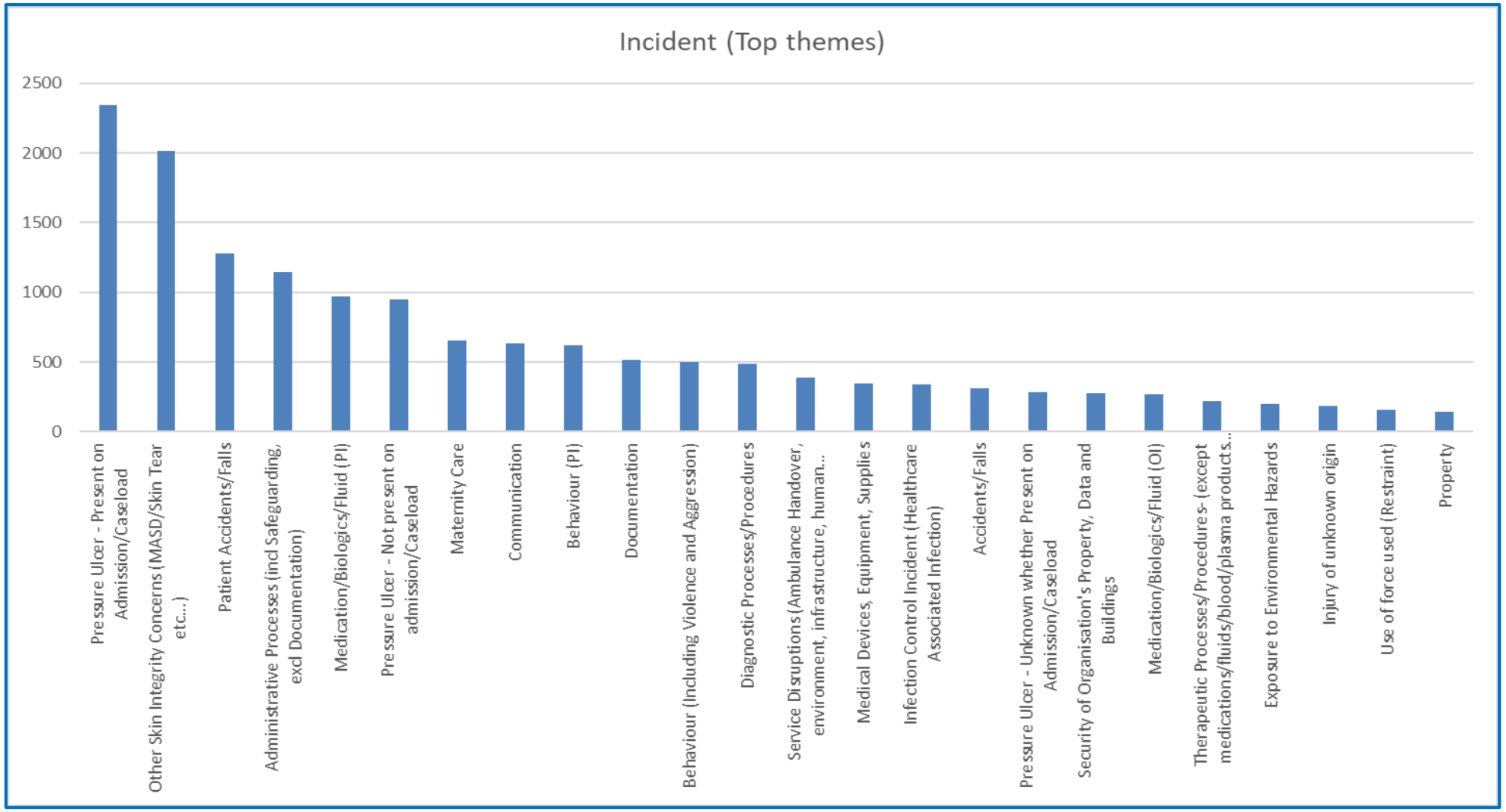


Figure 1 – Reported Patient Safety Incidents by Category 2024-25

7. Our patient safety incident response plan: local priorities and objectives

The following are our local patient safety priorities for 2025-26:

Priority	We will aim to reduce…..
Reduce inpatient falls	- The number of inpatient falls over the reporting year 2025/26 in line with GWH's Breakthrough Objectives. - The number of patients having multiple inpatient falls in the same admission in line with GWH's Breakthrough Objectives.
Reduce hospital acquired pressure ulcers and harms	- The incidences and severity of pressure ulcers sustained during inpatient admissions. - The incidences of pressure ulcers which are present on admission, deteriorating whilst under our care.
Improve our communication during transfers of care	- The incidences of patient harm where ineffective communication has been indicated, especially during transfers of care. - The incidences where we do not recognise, or escalate deterioration appropriately, leading to harm.
Improve our medication management	- The incidences of medicine being administered to a patient it has not been prescribed for. - The incidences of incorrect administration of medication to patients related to prescribing errors in our EPMA (Electronic prescribing system). - The incidences of unintentional delays in, or omissions of, doses of insulin, or time-critical medication for Parkinson's disease.
Reduce hospital acquired infections	- The incidences of hospital-acquired Methicillin-Susceptible Staphylococcus Aureus (MSSA) bloodstream infections. - The incidences of hospital-acquired Gram-negative bloodstream infections.

7. Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by, or referral to, another body or team, depending on the nature of the event. National requirements relevant to GWH are listed below.

Event	Action Required	Improvement route
Deaths thought more likely than not due to problems in care. Incidents meeting the learning from deaths criteria for PSII[3]	GWH-led Patient Safety Incident Investigation (PSII)	Learning response to be presented at Learning to Improve Group (LIG). Actions appropriate for the organisation to be agreed, allocated, and a timescale for completion set. Actions to be tracked by relevant division.
Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	GWH-led PSII	Learning response to be presented at LIG. Actions appropriate for the organisation to be agreed, allocated, and a timescale for completion set. Actions to be tracked by relevant division.
Incidents meeting the Never Event Criteria 2018	GWH-led PSII	Learning response to be presented at LIG. Actions appropriate for the organisation to be agreed, allocated, and a timescale for

[3] Unless the death falls under another more specific category in this table, in which case that response must be followed.

		completion set. Actions to be tracked by relevant division.
Mental health related homicide	- Refer to the relevant NHS England Regional Independent Investigation Team (RIIT) for consideration. - A GWH PSII may be required.	If a learning response is deemed necessary it is to be presented at LIG. Actions appropriate for the organisation to be agreed, allocated, and a timescale for completion set. Actions to be tracked by relevant division.
Maternity and Neonatal meeting Health Services Safety Investigations Body (HSSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place (see Annex B)	- Refer to HSSIB or SpHA for independent PSII - An appropriate GWH learning response may also be required at the discretion of the LIG.	If a learning response is deemed necessary it is to be presented at LIG. Actions appropriate for the organisation to be agreed, allocated, and a timescale for completion set. Actions to be tracked by relevant division.
Child deaths	- Refer for Child Death Overview Panel (CDOP) review. - A GWH learning response may be required alongside the panel review, so organisations should liaise with the CDOP. The outcome of this should be presented at LIG for oversight and final decision.	If a learning response is deemed necessary it is to be presented at LIG. Actions appropriate for the organisation to be agreed, allocated, and a timescale for completion set. Actions to be tracked by relevant division.

Deaths of persons with learning disabilities	- Refer for Learning Disabilities Mortality Review (LeDeR) - A GWH learning response may be required alongside the review, so organisations should liaise with the LeDeR lead. The outcome of this should be presented at LIG for oversight and final decision.	The outcome of this should be presented at LIG for oversight and final decision. If a learning response is deemed necessary it is to be presented at LIG. Actions appropriate for the organisation to be agreed, allocated, and a timescale for completion set. Actions to be tracked by relevant division.
Safeguarding incidents in which: • babies, children, or young people on a child protection plan; looked after plan, or are a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) who have their care and support needs met by their local authority • the incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery and human trafficking, or domestic abuse/violence	- Refer to GWH Safeguarding lead - A GWH learning response may be required alongside the review, so organisations should liaise with the LeDeR lead about this. The outcome of this should be presented at LIG for oversight and final decision.	If a learning response is deemed necessary it is to be presented at LIG. Actions appropriate for the organisation to be agreed, allocated, and a timescale for completion set. Actions to be tracked by relevant division.

Incidents involving NHS screening programmes	- Refer to: Guidance for managing incidents in NHS screening programmes - Complete NHS England Screening Incident Assessment Form (SIAF) - Refer to local screening quality assurance service for consideration of locally-led learning response. - A GWH learning response may be required alongside the review. This should be presented at LIG for oversight and final decision.	If a learning response is deemed necessary it is to be presented at LIG. Actions appropriate for the organisation to be agreed, allocated, and a timescale for completion set. Actions to be tracked by relevant division.
Death of patients in custody/prison/probation where health provision is delivered by the NHS	- Report to Prison and Probation Ombudsman or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. - GWH is required to fully support any investigations by these bodies where required to do so.	The outcome of this should be presented at LIG for oversight. Actions appropriate for the organisation to be agreed, allocated, and a timescale for completion set. Actions to be tracked by relevant division.
Domestic Homicide (including domestic suicide)	Report to police for investigation.	The outcome of this should be presented at LIG for oversight. Actions appropriate for the organisation to be agreed, allocated, and a

		timescale for completion set. Actions to be tracked by relevant division.

8. Our patient safety incident response plan: our local focus

The Trust will provide a locally-led response for incident types that are not included in the national list by applying the PSIRF principles of a proportionate response that balances learning and improvement activity, alongside compassionate engagement with patients and their families/carers and with staff.

The type of response will depend on a number of factors which include:

- the views of those affected, including patients and their families
- capacity available to undertake a learning response
- what is known about the factors that lead to the incident(s)
- whether improvement work is underway to address the identified contributory factors
- whether there is evidence that improvement work is having the intended effect/benefit
- if an organisation and its ICB are satisfied risks are being appropriately managed.

As part of the transition away from the Serious Incident Framework, the Trust will no longer respond to incidents according to the level of actual harm that occurred. However, the Trust will still maintain compliance with the legal requirements around the Duty of Candour. This formal duty applies where the level of harm is moderate or above.

The table below provides additional guidance to support selection of the appropriate level of learning response for specific incident themes seen across the Trust. It cannot cover every type of incident that may occur and so further guidance should be sought from the Insights & Learning team:

Patient safety incident type	Planned response	Improvement route
Suspected/completed/ attempted suicides by inpatients receiving care from the Trust's acute services, including where patients have absconded from GWH.	- After Action Review (AAR) (1st or isolated incident with no wider or complex learning) - PSII (if 2 or more incidents of the same nature have occurred in any 6 month period, or where there is wider cross-agency, or complex learning)	LIG
Medication errors involving missed, or omitted time, critical medications for Parkinson's disease and diabetes	- Reviewed by Medicines Safety Officer to decide learning response: - AAR (1st or isolated incident with no wider or complex learning) - Thematic review (if 2 or more incidents of the same nature have occurred in any 3 month period - PSII (if incidents reviewed by thematic analysis continue to occur, or where there is wider, or complex learning)	- Effectiveness of actions to be monitored by Medications management group. - Themes identified, actions taken and the effectiveness of actions to be presented at LIG on rotational basis. - Urgent issues can be tabled for any LIG.

Delays in, or omission of, outpatient consultations, follow ups, or treatment, where harm, or potential harm is identified.	AAR (1st or isolated incident with no wider or complex learning) Multi-disciplinary Team (MDT) review (if 2 or more incidents of the same nature have occurred in any 3 month period, or improvement actions from the AAR are not effective). PSII (if incidents continue to occur, or where there is wider, or complex learning)	- Effectiveness of actions to be monitored by Communications Improvement group. - Themes identified, actions taken and the effectiveness of actions to be presented at LIG on rotational basis. Urgent issues can be tabled for any LIG.
Delays in, confusion over, or omission of, inpatient referrals between inpatient specialities where harm, or potential harm is identified.	AAR (1st or isolated incident with no wider or complex learning) - Thematic review (if 2 or more incidents of the same nature have occurred in any 3 month period, or improvement actions from the AAR are not effective). PSII (if incidents continue to occur, or where there is wider, or complex learning)	Effectiveness of actions to be monitored by Communications Improvement group. Themes identified, actions taken and the effectiveness of actions to be presented at LIG on rotational basis. Urgent issues can be tabled for any LIG.

Delays in recognising, or failure to recognise deterioration of an inpatient. Delays in escalating, or failure to escalate, deterioration of an inpatient.	AAR (1st or isolated incident with no wider or complex learning) Multi-disciplinary Team (MDT) review (if 2 or more incidents of the same nature have occurred in any 3 month period, or improvement actions from the AAR are not effective enough). PSII (if incidents continue to occur, or where there is wider, or complex learning)	
Pressure ulcers acquired during admission to GWH which result in a delay to discharge or an increase in length of stay of >7days, impact significantly on mobility and/or ability to conduct activities of daily life, or cause moderate to severe harm, or death. Pressure ulcers present on admission to GWH which deteriorate and result in a delay to discharge or result in an increase in length of stay of >7days, impact significantly on mobility	Reviewed by Pressure Ulcer Improvement group to decide learning response: AAR (1st or isolated incident with no wider or complex learning) Thematic review (if 5 or more incidents of the same nature have occurred in any 3-month period in the same ward or clinical area, or	Effectiveness of actions to be monitored by Pressure ulcer improvement group. Themes identified, actions taken and the effectiveness of actions to be presented at LIG on rotational basis. Urgent issues can be tabled for any LIG.

and/or ability to conduct activities of daily life, or cause moderate to severe harm, or death.	improvement actions from the AAR are not effective enough) PSII (if incidents reviewed by thematic analysis continue to occur, or where there is wider, or complex learning)	
Delays in, or inappropriate, or omitted care, as a result of internal or external communication issues which lead to harm to patients. This can include, but is not limited to, communication issues during handovers, discharges, and internal and external patient transfers.	AAR (1st or isolated incident with no wider or complex learning) Multi-disciplinary Team (MDT) review (if 2 or more incidents of the same nature have occurred in any 3 month period, or improvement actions from the AAR are not effective enough). PSII (if incidents continue to occur, or where there is wider, or complex learning)	Effectiveness of actions to be monitored by Communications Improvement group. Themes identified, actions taken and the effectiveness of actions to be presented at LIG on rotational basis. Urgent issues can be tabled for any LIG.
All inpatient slips, trips and falls	Multi-Disciplinary Team (MDT) swarm huddle (1st or isolated incident with no wider or complex learning)	Effectiveness of actions to be monitored by Falls Reduction group.

	MDT AAR (if same patient has repeated falls or there are >2 inpatient falls in the same ward/area in a rolling 1 month period Multi-disciplinary Team (MDT) review (if additional falls occur in the same ward/clinical area in any 1 month period despite AAR actions being implemented PSII (if incidents continue to occur, or where there is wider, or complex learning)	Themes identified, actions taken and the effectiveness of actions to be presented at LIG on rotational basis. Urgent issues can be tabled for any LIG.

9. PSIRF Learning Responses: local standards

The following table explains the different learning responses available under PSIRF. The underpinning premises of each methodology is consistent, and focuses on learning from where care diverged from planned and taking action to prevent recurrence. However, in accordance with the PSIRF principle of proportionate response each of the available tools will require differing levels of time, training and resource to complete. Advice on the appropriate level of learning response can be sought from Insights & Learning, divisional governance structures, and from LIG.

GWH-specific templates available via the Trust intranet in the Patient Safety Learning Zone and are to be accessed from there for the latest versions.

Swarm Huddle		
Who	**What?**	**When?**
Any team lead, senior nurse or AHP, ward or speciality doctor, or equivalent who wasn't directly involved in the incident. Band 6 or above.	The team involved get together to discuss why the incident occurred and to identify immediate learning and actions to take forward. Uses the four questions from the After Action Review template to explore the issue. Record on DATIX with relevant incident.	Immediately after an incident, but not >48 hours later.

After Action Review (AAR)		
Who	**What?**	**When?**
Any team lead, senior nurse or AHP, ward or speciality doctor, or equivalent who wasn't directly involved in the incident. This could be anyone from within the multi-disciplinary team, local or remote to the participants at Band 6 or above. An AAR facilitator must have completed the GWH mandated initial training course and continuation training.	A structured and facilitated discussion of an event drawing on the different perspectives of the members of the multi-disciplinary team who were involved in the incident. Explores why 'work as done' differed from planned or expected. Generates local learning to improve and prevent recurrence. An AAR can recommend learning for other areas to consider and can be shared with other teams. It can also recommend a further learning response if the issues identified are complex or wide reaching.	As soon as possible after the incident, but not >15 working days later.

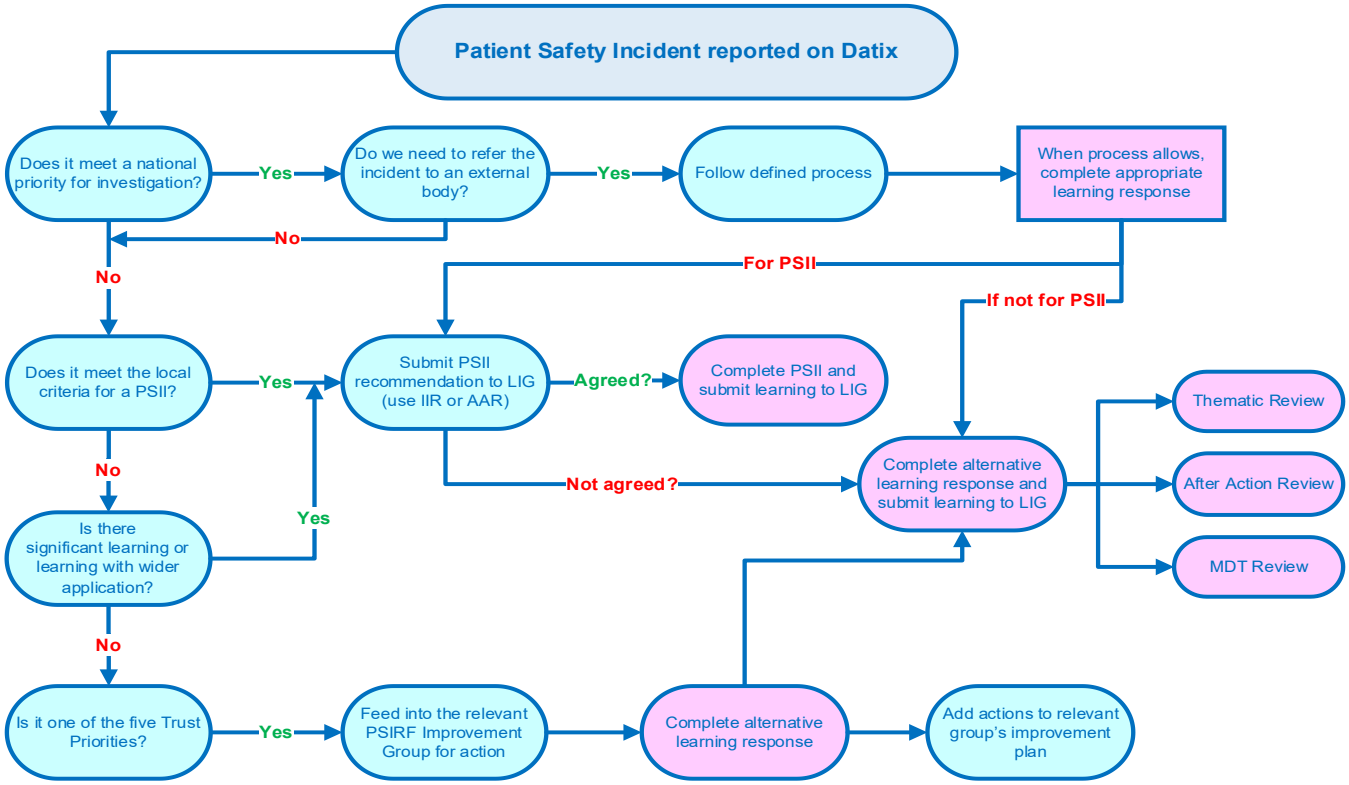
Patient Safety Incident Investigation (PSII)		
Who	**What?**	**When?**
A qualified patient safety investigator(s) nominated by respective Divisional triumvirates. Must not have been involved in the incident, or be direct line management for any staff involved. A PSII investigator must have completed Levels 1 and 2 of the Patient Safety Syllabus and the GWH mandated PSII investigator training course or equivalent eg. HSSIB course, 'A systems approach to investigating and learning from patient safety incidents'. Investigation leads must contribute to at least 2 learning responses per year to maintain currency and competency.	A structured investigation drawing on discussions with those involved, the clinical narrative, as well as any other appropriate sources of information, including, observations, process analyses. Provides an explanation of how an organisation's systems and processes contributed to a patient safety incident. such as the tools, technologies, environments, tasks and work processes involved.	Ideally <3 months, but no > 6 months.

Multi-Disciplinary Team (MDT) review		
Who?	**What?**	**When?**
Any senior team lead, senior nurse or AHP, ward or speciality doctor, or equivalent from within the multi-disciplinary team, local or remote to the participants Band 8a or equivalent. An MDT review must have completed the GWH mandated AAR Facilitator initial training course and continuation training. Leads must also have completed Levels 1 and 2 of the Patient Safety Syllabus. Completion of the GWH mandated PSII investigator training course or equivalent eg. HSSIB course, 'A systems approach to investigating and learning from patient safety incidents' is encouraged.	The multidisciplinary team (MDT) review supports teams to identify through open discussion, the contributory system factors and themes across multiple patient safety incidents (including incidents where multiple patients were harmed, or where there are similar types of incidents); It can also be use to explore a safety theme, pathway, or process. - gain insight into 'work as done' in a health and social care system, especially where work bridges several specialties, teams or agencies. Exploring 'Work as Done, can be through observation in the workplace, or discussion with those who perform and/or prescribe the tasks, or a combination of both. An optional Process Walkthrough Analysis template is included below to explore specific tasks and tools in greater detail.	3 months from commissioning date.

Thematic review		
Who?	**What?**	**When?**
Any senior team lead, senior nurse or AHP, ward or speciality doctor, or equivalent from within the multi-disciplinary team, local or remote to the participants Band 8a or equivalent. There is no specific training to qualify as an MDT review lead. The HSSIB course 'Demystifying thematic analysis provides a useful overview. Leads must have completed Levels 1 and 2 of the Patient Safety Syllabus. Completion of the GWH mandated PSII investigator training course or equivalent eg. HSSIB course, 'A systems approach to investigating and learning from patient safety incidents' is encouraged.	An in-depth process of review, with input from multiple data sources, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. The review will try to understand how care is delivered in the real world i.e. work as done. A thematic review is used to identify patterns in data to help answer questions, show links or identify issues. From this analysis, recommendations are made and actions taken to address key safety issues impacting patient safety. Collating and analysing data from numerous incidents and sources generates more effective and robust improvements. Thematic reviews typically use qualitative data (eg. free text survey responses, incident reports and interviews) rather than quantitative data (eg. audit results, closed survey responses) to identify safety themes and issues. A mixed methodology using both qualitative and quantitative data is perfectly acceptable.	30-60 working days from commissioning date.

10. The learning response decision making tool

The national and local priorities described above provide a useful starting point, but the complexity of incidents may require a more nuanced and multifaceted approach to optimise learning. As such, all patient safety incidents are to be reviewed in line with the learning response flowchart to ensure the most appropriate response(s) is/are selected to meet national and/or local PSIRF priorities and the Trust's objectives. If in any doubt, then Divisional governance staff are to contact Insights & Learning for guidance.



11. How we will oversee our learning responses

Effective oversight and governance is required for all levels of patient safety investigation. Oversight provides assurance to the Trust and to patients that incidents are investigated thoroughly, and we make valid and effective recommendations to increase patient safety and prevent recurrence. The PSIRF standards (link) specify the level of training and experience required for all of those with oversight responsibilities.

Divisions are to specify the governance structures and processes they will put in place to achieve effective oversight for all investigations. The exception to this are PSIIs which always require additional Trust level scrutiny. The oversight responsibilities for key roles involved in PSIIs are as below.

Investigator	**Is responsible for:** • Meeting with Patient Safety Specialist (PSS) to discuss case, PSIRF requirements, methodology, and agree courses of action. (The PSS is available for advice throughout the investigation). • Consulting local and national PSIRF guidance and templates (PSIRF toolkit). • Conducting investigation using agreed methodology. • Drafting the initial report and sharing with PSS for final review. • Submitting the draft report to the Divisional Governance team within 3-6 months. • Preparing a summary slide and presenting it at the Learning to Improve Group.
Divisional Governance	**Are responsible for:** • Nominating a suitably qualified lead investigator for divisional triumvirate approval. • Ensuring duty of candour is completed by senior clinician involved in incident • Briefing the lead investigator on investigation requirements and patient engagement. • Ensuring the PSII is completed within the 3-6 month timescale. Escalating any overdue reports to the divisional triumvirate. • Reviewing the draft report for use of plain English, formatting compliance, and any spelling, or grammatical errors.

	• Ensuring that no individuals are identifiable in the report. The patient's name may be used if agreed with them or their representatives. • Submitting the report to the divisional triumvirate for approval and providing advice to triumvirate on validity of findings and recommendations made. • Once approved by the triumvirate, submitting the report to the Learning to Improve group administrator for inclusion on agenda. • Checking the summary slide for the Learning to Improve group is completed. • Tracking actions from PSIIs and advising if completed by due date and their ongoing effectiveness is being checked..
Divisional Triumvirate	**Are responsible for:** • Reviewing the draft report to ensure all learning is identified from the incident and valid findings and recommendations have been made. • Considering if any actions need to be implemented immediately are in place to prevent recurrence. • Ensuring there has been appropriate patient engagement and involvement during the investigation. • Approving report for submission to the Learning to Improve Group. • Considering appropriate leads for recommendations within own divisional area. • Ensuring actions are completed by due date and their effectiveness is reviewed.

Learning to Improve Group

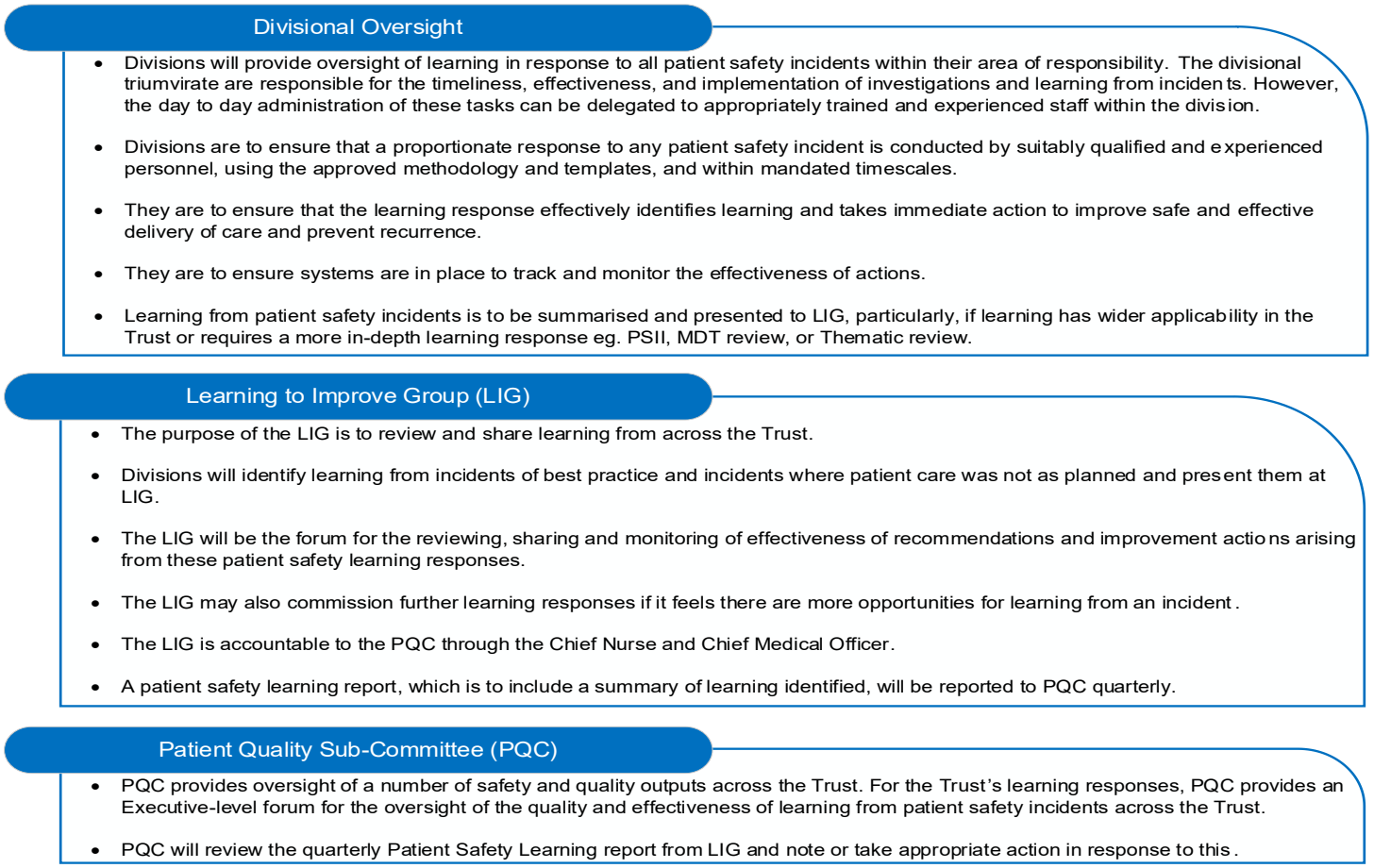
Is responsible for:

- Reviewing the report in advance of a meeting to ensure all learning has been identified from the incident and valid findings and recommendations made.
- Considering if any additional recommendations or learning are needed.
- Supporting division(s) with development of action plan.
- Ensuring learning is shared across the Trust and external agencies via the group's core attendees.
- Approving the PSII and associated action plan on behalf of the Trust. (This is a function of the specified quorum members only).

12. How we will oversee the effectiveness of our learning

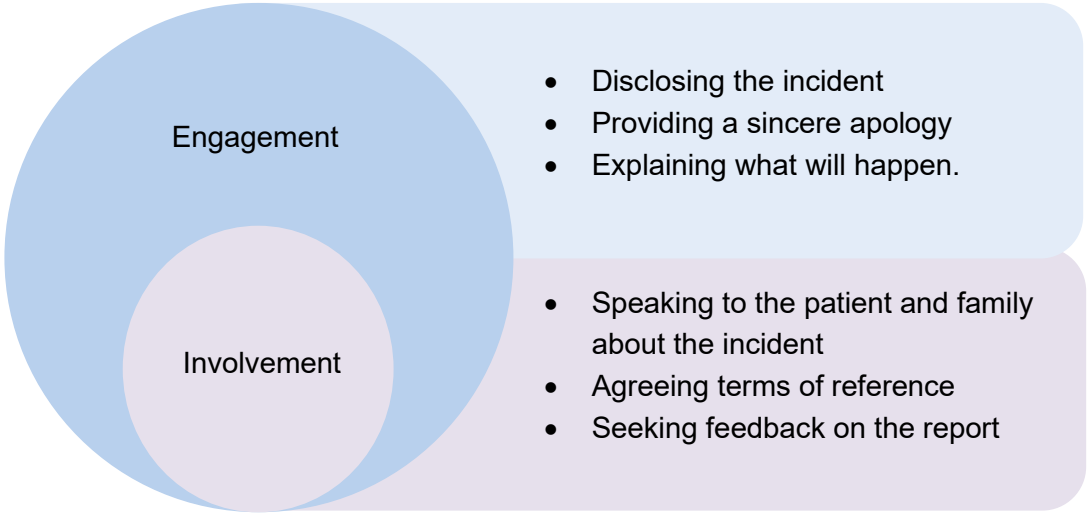
The PSIRF governance structures are in place to ensure that there is oversight of learning responses at every level of the organisation.

Responsibility for oversight of patient safety is held by the Chief Medical Officer and Chief Nurse. The day to day delivery of this responsibility is held by the Deputy Chief Medical Officer and Deputy Chief Nurse. The governance structures put in place to support them in delivering this task are as follows:



13. Engaging and involving those affected by an incident

PSIRF supports development of a patient safety incident response system that prioritises compassionate engagement and involvement with all those affected by patient safety incidents. Those affected include staff and families in the broadest sense; that is: the person, or patient, to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred.



For the purposes of this plan, the following definitions of engagement and involvement (taken from Engaging and involving patients, families and staff following a patient safety incident) are the foundation of our response to incidents:

- **Engagement.** Everything an organisation does to communicate with and involve people affected by a patient safety incident in a learning response. This may include the Duty of Candour notification or discussion, and actively engaging patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened.

- **Compassionate engagement.** An approach that prioritises and respects the needs of people who have been affected by a patient safety incident.

- **Involvement**. Part of wider engagement activity, but specifically describes the process that enables patients, families, and healthcare staff to contribute to a learning response.

GWH is committed to engaging with all of those affected by patient safety incidents in an open and collaborative manner. We will ensure that the voices of all affected are heard and respected in the course of our learning responses. However, engaging and involving those affected is not a blanket process and will need be tailored to the level of learning response and the need to provide psychologically safe environments for all concerned. Examples of this being: the timely completion of a swarm huddle after an incident during the night, or the provision of a psychologically safe space for staff to discuss their role in an emotive incident during an AAR, without family being present.

Overall, engagement and involvement can be complicated and will require sensitive management to avoid compounded harm to all those affected. As such, learning response leads are to seek guidance from their divisional triumvirate, or the Trust's Patient Safety Incident Investigation lead if in any doubt.

Nb. All engagement and involvement activities are to be recorded on DATIX.

The following guides are a useful reference for the process of engaging and involving those affected in a PSII:

- Learn Together - Guide for Engagement Leads

- Learn Together - Guide for Patients and Families

14. Duty of Candour

The Care Quality Commission (CQC) Regulation 20 (CQC Duty of Candour Regulation) puts a legal duty on all health and social care providers to be open and transparent with people using services, and their families, in relation to their treatment and care. This means that providers must be open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It sets out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, and providing truthful information and an apology when things go wrong.

Statutory Duty of Candour legislation applies to all moderate and above harm incidents that have occurred within the provision of a regulated service for physical and prolonged psychological harm.

The non-statutory Duty of Candour guidance applies to all incidents before the threshold of moderate plus harm, supporting the trust to be open and honest with patients, families, and carers regarding any event that has occurred.

Adherence to statutory and non-statutory duty of candour is to be adhered to in all appropriate learning responses in accordance with the policy below.

Nb. All duty of candour contacts with those affected are to be recorded on DATIX.

GWH Duty of Candour Policy v3.0 dated 13 Dec 2023

15. Supporting staff following patient safety incidents

It is recognised that staff are also affected when involved, either directly or indirectly, in a patient safety incident. First and foremost we owe a duty of care to our staff to support their physical and psychological needs if an incident has caused them harm. This harm may not always present directly after the incident, but may occur, or recur, at a later date, particularly, when they are involved in the investigative process. In addition, the prospect of, or actual involvement in, additional processes arising from the incident eg. coronial or criminal investigations, complaints, litigation, or professional conduct investigations lead by GWH, or professional bodies are likely to place additional pressure on our staff.

It is imperative that line managers recognise the impact these may have on staff members and ensure staff are offered support to complete their clinical duties. In addition, staff are to be signposted to appropriate psychological wellbeing services if they feel they need it. Referrals to Occupational Health may also be appropriate regardless of any periods of absence.

During all investigative processes, investigators are to ensure that they provide a psychologically safe environment for staff involved in patient safety incidents. Psychological safety is the, “belief that one will not be punished, or humiliated for speaking up with ideas, questions, concerns, or mistakes, and that the team is safe for interpersonal risk-taking.”[4] During investigations this means that our staff are not the subject of undue blame in accordance with the principles of a Just and Learning culture[5]. It also means that their views of events are respected, acknowledged and their identities are protected, unless legal exigencies dictate otherwise. Overall, we want to develop a safety culture underpinned by openness, transparency and a determination to learn from our errors and omissions. To achieve this requires us to support our staff when things go wrong and to provide them the level of psychological safety they will need to help the Trust continue to improve the quality of care we deliver.

[4] Prof E,. Edmondson (2025) *Psychological Safety*. Accessed at https://amycedmondson.com/psychological-safety on 16 Sep 2025.
[5] NHS Resolution (2023) *Just and Learning Culture*. Accessed at https://resolution.nhs.uk/just-and-learning-culture-charter.pdf on 16 Sep 2025.

16. Summary

This PSIRP explains GWH's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The plan details how GWH will respond to patient safety incidents for the next twelve to eighteen months. It brings together a wide range of concepts and processes, that are still embryonic within the NHS and GWH. In doing this, the PSIRP will need to be subject to iterative review as the organisational safety culture of GWH evolves and we become more familiar with the practical application of PSIRF principles and processes in the Trust. It may also be reviewed at any time in response to emerging patient safety issues, or any local, regional or national changes which affect GWH. Feedback on the contents of this plan; subsequent changes will be made through the respective safety committees and executive leads.