Patient Safety Incident Response Policy (N-075)

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1. Policy Statements

Humber Teaching NHS Foundation Trust is committed to delivering high-quality, safe care for patients, service users, and staff. The Trust recognises that patient safety incidents and near misses will occur and is committed to identifying why they happen and using this learning to reduce the risk of recurrence.

Under this policy, all responses to patient safety incidents follow a systems-based methodology, in line with the Patient Safety Incident Response Framework (PSIRF). The focus is on understanding how systems and processes contributed to the incident, working in partnership with patients, families, carers, and staff to identify meaningful learning and strengthen future safety.

The Trust will ensure that:

- Immediate safety actions are taken when required.
- Patients, families, carers, and staff affected by incidents receive appropriate and compassionate support.
- Learning is captured, shared, and embedded across services.
- Improvements to practice, systems, and processes are implemented to prevent recurrence.

We open this policy with a set of clear policy statements that establish the Trust's overarching principles, expectations, and commitments in relation to patient safety incident response. These statements provide the foundation for how Humber Teaching NHS Foundation Trust approaches learning, accountability, openness, and support following patient safety incidents. Their purpose is to set the tone for the policy, guide consistent decision-making, and ensure all staff understand the values and standards that underpin our incident response framework.

1.1. Patient Safety Incident Response Plan (PSIRP)

This policy should be read in conjunction our Patient Safety Incident Response Plan 2026-2029.

Humber Teaching NHS Foundation Trust's *Patient Safety Incident Response Plan 2026-2029* sets out how the Trust will respond to patient safety incidents over the next three years.

The PSIRP is a dynamic plan and will be updated as required; it is not a fixed or inflexible set of rules. The Trust will adapt its approach based on the specific circumstances of each incident, the needs and preferences of those affected, and new or emerging risks.

The priorities within the PSIRP will be reviewed regularly through established quality governance and surveillance processes to ensure they remain current, evidence-based, and responsive to unforeseen or emerging risks.

1.2. Patient Safety Culture

Within the Patient Safety Incident Response Plan, we outline in detail our commitment to continually strengthening our patient safety culture.

Humber Teaching NHS Foundation Trust encourages and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients or staff.

A positive patient safety culture is essential in reducing harm to patients. Cultures underpinned by fear and blame have consistently demonstrated the detrimental impact they have on

learning and improvement and patient safety. We are committed to a culture that is built on compassionate leadership and psychological safety.

At Humber Teaching NHS Foundation Trust, we recognise that patient safety incidents are usually signs of underlying systemic issues that require wider system-level action and that focusing on an individual is rarely appropriate. Treating staff fairly supports a culture of openness, equity and learning where staff feel confident speaking up when things go wrong. Supporting staff to be open allows valuable lessons to be learnt and prevents incidents from being repeated. In rare circumstances an incident may raise concerns about an individual's conduct or fitness to practice. In such circumstances the *'Being fair' tool* will support decision-making and ensure that staff are not treated unfairly after a patient safety incident. Being Fair Tool

1.3. Involving and Engaging Patients and Families

Humber Teaching NHS Foundation Trust is committed to meaningful and compassionate engagement and involvement of those impacted by patient safety incidents.

This policy, alongside our Engaging and Involving Patients Families and Staff following a Patient Safety Incident Policy sets out the Trust's commitment to ensuring that everyone affected by a patient safety incident is treated with openness, compassion, dignity and respect. Our policies supports staff to engage confidently and empathetically with patients and families, ensuring they are listened to, kept informed, and able to contribute to understanding what happened.

For more information see the Engaging and Involving Patients and Families (N-074) and Duty-of-Candour Policy N-053 and Section 7.0 of this policy.

1.4. Involving Staff, Colleagues, and Partners

The Trust will ensure staff, partners, and colleagues involved in incidents are engaged from the outset, supporting a holistic, inclusive, and restorative learning culture.
Staff involvement is not limited to high-harm incidents; all incidents and near-misses are valued as opportunities for learning and improvement.
All staff involved in incidents requiring investigation will be provided with the Trust's Navigating Difficult Events at Work booklet, and managers must ensure this resource is readily available across teams.
Staff will be supported in reporting incidents and near-misses without fear of blame, reinforcing a culture of safety and continuous improvement

1.5. Addressing Health Inequalities

Humber Teaching NHS Foundation Trust is committed to delivering on its statutory obligations under the Equality Act, (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. We strive to ensure that all safety improvements will consider health inequalities and any disproportionate risk to patients with specific characteristics.

2. Scope

All responses under this policy use a system-based approach, recognising that patient safety is shaped by interactions within the wider healthcare system, rather than the actions of any one individual. Responses will not assign blame, determine liability, or judge the preventability or cause of death. Other processes such as claims handling, HR investigations, professional standards processes, coronial investigations, and criminal inquiries exist for those purposes and sit outside the remit of this policy.

Information arising from a patient safety incident response may be shared with those leading other formal processes where appropriate. However, these external processes must not influence the purpose, scope, or findings of a patient safety learning response.

This Policy applies to all staff, including permanent, temporary, agency, bank, voluntary workers, and students, whether clinical or non-clinical.

This policy replaces the Serious Incidents and Significant Events Policy and Procedure (N-031)

3. Definitions

For definitions see Appendix 1.

4. Duties and Responsibilities

Chief Executive and Trust Board:

- Hold overall accountability for safe, high-quality services.
- Ensure that the Trust meets all statutory and contractual obligations
- Ensure robust systems and governance processes exist for managing patient safety incidents and near misses.

Executive Director of Nursing, Quality and Professions:

- Strategic lead for patient safety, responsible for implementing and monitoring this policy.
- Joint decision-maker (with Medical Director) for declaring Patient Safety Incident Investigations (PSIIs)
- Approves all Patient Safety Incident Investigations (PSIIs) and Patient Safety Incident Analysis (PSIAs) reports where a death has occurred. The approval process includes in the Executive Medical Director and/ or the Chief Operating Officer.

Medical Director:

- Jointly responsible (with Executive Director of Nursing, Quality and Professions) for declaring PSIIs and approving investigation reports.

Chief Operating Officer:

- Jointly responsible (with Executive Director of Nursing, Quality and Professions) for approving investigation reports.
- Ensures learning from incidents is shared and embedded across Divisions.
- Oversees communication/media handling where required.

Deputy Director of Nursing, Quality and Professions is responsible for:

- Strategic implementation and monitoring of this policy and evaluation of organisational learning, alongside the Executive Director of Nursing, Quality and Professions
- Review of the Patient Safety Incident Response Plan
- Chair and oversight of the Clinical Risk Management Group
- Escalating to the Executive Director of Nursing, Quality and Professions and/or the Medical Director incidents which require consideration for a Patient Safety Incident Investigation.

- Ensuring that all external legal processes are in place and for coordinating information and notification to external bodies, e.g., police, CQC, NHS England, Local Authority, to meet the Trust's statutory duties
- Commissioning of Initial Incident Reviews (IIRs)
- Reviewing and approving draft PSIA and PSII reports

Heads of Nursing/Safeguarding

- Participate in reviews of patient safety incidents via the corporate safety huddle ensuring requests for learning responses/reviews are proportionate and in line with the Trust's Patient Safety Incident Response Plan.
- Commission IIRs in the absence of the Deputy Director of Nursing, Quality and Professionals.
- Escalate incidents requiring further review to senior leadership team.
- Facilitate swarm huddles and coordinate external notifications where required.
- Act as Buddy to Investigation Leads and provide, as required, family liaison.
- Deputise as chair for CRMG in the absence of the Deputy Director of Nursing, Quality and Professionals.
- Review draft PSIA and PSII reports prior to the final approval process.

Divisional Clinical Leads and General Managers

- Promote a culture of learning and continuous improvement were staff feel confident and safe to report incidents and raise concerns.
- Ensure oversight of incident reporting, review and management within their divisions
- Ensure IIRs are completed within 72 hours unless agreed otherwise by DDoN
- Ensure Duty of Candour requirements are met.
- Ensure staff have access to appropriate post incident support
- Ensure sufficient staff are trained in system based investigation methods to support the completion of patient safety reviews and investigations and other learning responses.
- Support the allocation of reviewers and investigators, ensure reports are completed on time, to a high quality, and focus on system based learning and improvement.
- Ensure robust governance systems are in place within the division to monitor improvement actions and quality improvement related to learning from patient safety events and that learning is disseminated and embedded within the Division.

Quality and Patient Safety Team

- Provide administrative support to the daily huddle and weekly CRMG
- Coordinate the end to end process for patient safety reviews/investigations, tracking and reporting performance to the Clinical Risk Management Group and the Quality and Patient Safety Group.
- Ensure patients or families/carers receive correspondence from the Trust in relation to patient safety incident analysis/investigations ensuring this meets the requirements under Duty of Candour.
- Provide support and guidance to reviewers/investigators throughout the process
- Ensure investigations meet required standards and timescales, reporting and escalating delays via to the Nursing and Quality senior leadership team as required.
- Ensure reports are quality checked before sharing with patients, families/carers, coroners or other third parties.
- Disseminate learning and support training in patient safety processes.
- Captures themes from learning from patient safety events and triangulate with learning from complaints, legal and safeguarding processes.

Service Managers, Matrons, Team Leaders, Ward Managers, and Clinical Leads

- Ensure staff understand and follow this policy.
- Support staff in incident reporting and provide appropriate level of support post incidents.
- Ensure Datix reports and IIRs are completed promptly.
- Ensure local Duty of Candour is completed and that those impacted by patient safety incidents/events are offered a meaningful and timely apology.
- Support staff to attend swarm huddles/PSII panels when required.
- Ensure actions and learning are implemented and evidenced.

All Other Trust Staff

- Report incidents and near misses promptly.
- Participate in investigations when required.
- Complete mandatory Level 1 Patient Safety training

5. Procedures relating to the policy

This policy should be read in conjunction with our Patient Safety Incident Response Plan 2026-2029 which highlights the range of learning tools and the methodologies that we use to undertake and support learning under the Patient Safety Incident Response Framework.

It is not within the scope of this policy document to provide full details of the operational procedures of all our learning responses These can be found in supporting standard operating procedures listed in Section 9 and through the links in this policy. However, key processes are outlined below and supported by several process flowcharts which can be found in the appendices.

5.1. Responding to patient safety incidents

All patient safety incidents must be reported on Datix within 24 hours. Incident reports should include a clear description of the event, any actual harm caused, and details of the immediate safety actions taken to protect patients, staff, or the remove risk from the environment. See Incident Reporting Policy-N-038

All incidents reported will be reviewed at the Corporate Safety Huddle the following working day (on a Monday for incidents reported on a Friday). The huddle is attended by members of the Quality and Patient Safety senior leadership team, divisional representatives, and key specialist colleagues such as safeguarding, medicines safety, and mental health legislation representatives. This multi-disciplinary approach enables timely identification of risks and ensures that appropriate advice and support can be provided.

An additional level of review may be requested via the Corporate Safety Huddle, typically an **Initial Incident Review** (IIR) or an **After Action Review** (AAR).

5.2. After Action Reviews

Divisional representatives may request an AAR for incidents where there is clear opportunity for learning; these are generally suited to incidents resulting in no harm, low harm, or near misses, and support timely, team-based reflection and improvement. After Action Reviews should be completed within 3 working days following the incident being reviewed by the corporate huddle, with the AAR report being submitted to the Patient Safety Team within 5 working days of the AAR meeting. The learning will be shared thorough the Clinical Risk Management Group. See After Action Reviews SOP24-022

5.3. Initial Incident Reviews

An Initial Incident Review will be requested where there are concerns about the level of harm, potential for future harm, or where there is a clear opportunity for learning and improvement. All incidents resulting in moderate or above harm will be considered for an IIR and duty of candour will be completed. See Duty-of-Candour Policy N-053

While the Safety Huddle can request an Initial Incident Review, all IIRs requests must be formally reviewed and approved prior to commissioning by the Deputy Director of Nursing, Quality and Professions or the Head of Nursing and Patient Safety Specialist (or other delegated Head of Nursing). This ensures that IIRs are commissioned proportionately, aligned with PSIRF principles, and undertaken only where they will meaningfully contribute to organisational learning.

The Initial Incident Review provides a rapid assessment of the care provided and the chronology of events, enabling teams to identify immediate safety actions and capture key early learning. In some cases, the IIR may provide sufficient assurance to remove the need for a more detailed review or investigation. The IIR must be completed and submitted to the Patient Safety Team within 3-5 working days (dependant on the complexity of the incident and the breadth of services involved in the patient's care). Where it is anticipated that additional time may be required to undertake initial fact finding, then authorisation for an extension must be sought from the Deputy Director of Nursing, Quality and Professions or the Head of Nursing and Patient Safety Specialist (or other delegated Head of Nursing). Approval will be by exception. All IIRs are reviewed at the weekly Clinical Risk Management Group (CRMG), where decisions regarding any further action or investigation are made.

All Initial Incident Reviews will be considered at CRMG, where a collaborative decision will be made on whether further learning is required and if a more detailed learning response, such as a Patient Safety Incident Analysis (PSIA) or Patient Safety Incident Investigation (PSII), should be commissioned. CRMG has the authority to commission a PSIA where appropriate; however, the commissioning of a PSII requires escalation to, and approval from, the Executive Director of Nursing, Quality and Professions or the Medical Director.

For additional detail see Incident Reporting Policy-N-038

5.4. Patient Safety Incident Analysis using Swarm huddle methodology (PSIA)

Whilst a swarm is typically a rapid, team-based review methodology we have integrated swarm methodology into our Patient Safety Incident Analysis, which is a more comprehensive review allowing additional time for meaningful engagement with our staff, the patient and/or their family/carers.

This methodology uses the SEIPS which is a framework that examines how systems, environments, tasks, tools, and people interact to influence safety, performance, and outcomes.

The Trust commissions two types of Patient Safety Incident Analysis (PSIA) to ensure learning responses are proportionate to the complexity and sensitivity of each incident. A *Short-Form PSIA* is used for non-complex, non-death-related events where the issues are clearly defined, and the scope of learning is narrow. These reviews focus on a concise examination of the chronology, system factors, and immediate learning, enabling timely identification of actions within shorter completion timescales.

In contrast, a *Full PSIA* is reserved for more complex incidents and all death-related cases that require deeper exploration but do not meet the conditions under which a PSII may be appropriate. Full PSIAs allow more time for comprehensive analysis, including a detailed review of care, human-factors considerations, and broader system influences, supporting a

more thorough understanding of what happened and why. This tiered approach ensures that learning is both meaningful and proportionate, while maintaining timely organisational responses.

Feature	Short-Form PSIA	Full PSIA
Suitable for	Non-complex, non-death incidents	Complex incidents and all death-related requiring further review but cases not requiring a PSII
Timescales	Shorter; rapid turnaround	Longer version, allows detailed exploration
Depth of Analysis	Focused and concise	Comprehensive and systemic
Review of Chronology	High-level summary	Detailed chronology and care review
Critical Review	Targeted learning points	In-depth analysis of multiple/systemic factors
Engagement	Proportionate involvement. Single service or team. Non-complex process/systems issues. Patient and/or family involvement essential.	Broader MDT involvement required, may involve multiple services or external agencies. Multifaceted complex system issues.
Purpose	Rapid, proportionate learning	Thorough understanding to inform system improvements

For full operating and process details see our Patient Safety Incident Analysis-using-swarm-huddle-methodology SOP23-039 and the process flowcharts in Appendix 2 and 3

5.5. Patient Safety Incident Investigation (PSII)

As outlined in our Patient Safety Incident Response Plan, a PSII is reserved for an in-depth investigation of a single patient safety incident or a cluster of incidents that may be complex, such as those involving multiple teams or services. A PSII is commissioned when significant learning is required to fully understand what happened and why, using systems-based methodology to identify good practice, contributory factors, and any improvements needed in care delivery. Only the Executive Director of Nursing, Quality and Professions and Medical Director have the authority to declare and commission a Patient Safety Incident Investigation.

There are some specific categories of patient safety incidents for which the Trust is **required** to undertake a Patient Safety Incident Investigation (PSII). These are set out in our Patient Safety Incident Response Plan and include, but are not limited to, incidents that meet the Never Event criteria, deaths in custody, and cases of homicide committed by a patient who is currently receiving services or has been recently discharged.

5.5.1. Reporting and Investigating Homicides by Patients in Receipt of Mental Health Care

Where a patient currently receiving mental health services, or who has been in receipt of services within recent months, commits a homicide, the Trust will complete an Initial Incident Review within 72 hours and formally declare the incident as a Patient Safety Incident Investigation (PSII). A full investigation will then commence and will be completed within the identified timescales, with appropriate flexibility to incorporate the views and needs of the patient, family and carers, the bereaved family, and to reflect the complexity and sensitivity of the case.

The Trust will work closely with the police and with all those affected to ensure that questions and concerns are addressed within the internal PSII process. Further detail on roles, responsibilities, and joint-working expectations can be found in the Standard Operating Procedure following notification of a serious assault by a mental health patient SOP22-016
In parallel, NHS England will consider whether an independent investigation is required, and, if commissioned, this will be overseen by the NHS England Regional Investigation Team. The Trust will cooperate fully with this process to support transparency, learning, and meaningful system-wide improvement. This will also require formal escalation to the ICB as described under Section 5.71

5.5.2. Reporting and Investigating Deaths in Custody Under the Mental Health Act (MHA)
Deaths occurring while a person is detained under the Mental Health Act, or on authorised leave must be reported immediately to the Coroner and notified to the Care Quality Commission (CQC) under statutory reporting duties.
In accordance with PSIRF, all such deaths will be declared as a Patient Safety Incident Investigation (PSII) to ensure a thorough, systems-based review of what happened, why, and what learning is required. Investigations will run alongside any external processes and must be conducted sensitively, maintaining close liaison with the police and Coroner to ensure alignment and avoid duplication.
The Trust will cooperate fully with statutory bodies and safeguard the involvement of families, ensuring timely, compassionate communication throughout. See Death-of-a-detained-patient SOP20-014

The death of a patient detained under the Mental Capacity Act 2005 under a Deprivation of Liberty Safeguards authorisation will also be considered a death in custody.

5.5.3. Reporting and Investigating Never Events
Never Events are serious, preventable patient safety incidents that meet the national criteria set by NHS England.

Although the Never Events Framework is currently undergoing significant review, the existing framework and reporting requirements remain active. NHS England has confirmed, following its 2024 consultation, that the framework will be revised, with a new system being developed. Until the new approach is finalised, organisations must continue to use the current Never Events list (2021) and the 2018 policy and framework. [england.nhs.uk]

Providers must continue to record Never Events under the dedicated Never Event category in LFPSE. [england.nhs.uk], [pslhub.org]

A full PSII remains the mandated approach while the 2018/2021 framework is still active.

5.5.4. Executive Oversight and Escalation During PSIIs
All Patient Safety Incident Investigations are subject to clear and structured executive oversight to ensure organisational assurance, quality, and the timely management of risks. The Executive Director of Nursing, Quality and Professions, Medical Director and Chief Operating Officer receives updates from the lead investigator/PSII buddy at the interim executive meeting and via the Complex Case Oversight Group, enabling monitoring of progress and early discussion of emerging themes.

Should any immediate safety concerns, quality issues, or new risks emerge during the course of the investigation, the lead investigator has a responsibility to escalate these promptly so that appropriate immediate actions can be taken. This oversight ensures that PSIIs not only generate meaningful learning but also maintain vigilance and organisational safety throughout the investigative process

Formal executive approval is required at the final stage prior to completion and dissemination of the report.

For full operating and process details see our Patient Safety Incident Investigation Standard Operating Procedure and the process flowchart in Appendix 4

5.6. System-Level Escalation and Cross-Provider Coordination

5.6.1. Escalation and Notification - ICB

The Trust maintains clear processes for escalating significant patient safety incidents both within the organisation and across the wider health and care system. In line with national expectations and Integrated Care Board (ICB) requirements, incidents with broader system implications must be escalated promptly to ensure coordinated responses, timely risk management, and transparency.

Significant patient safety incidents or events must be escalated to the ICB where any of the following circumstances apply:

- There is, or is likely to be, MP, ministerial, political, or media attention.
- There is NHS Executive interest.
- Multiple national bodies are involved.
- The issue spans multiple regions or organisational boundaries.
- A provider's ability to operate as normal may be affected.
- Significant numbers of patients, or particularly vulnerable patients, are impacted.

Escalation to the ICB will be agreed by the Executive Director of Nursing, Quality and Professions or the Medical Director, and actioned by the Patient Safety Specialist as described in the Trust's Incident Reporting Policy-N-038

5.6.2. Cross-Provider Coordination

The Patient Safety Team will support the coordination of cross-organisational incidents, sharing relevant information directly with other providers via their established reporting processes. Where helpful, summary reporting may be used to share learning and insights with partners to enhance understanding of system-level patient safety trends.

Humber Teaching NHS Foundation Trust will work closely with partner providers and relevant ICBs to maintain robust procedures for the timely flow of information and to reduce delays in managing cross-system patient safety events. The Patient Safety Team acts as the single access point for coordinating such activity and maintains supportive internal procedures to ensure consistent and effective management.

Where a cross-system event is too complex for a single provider to coordinate, Humber Teaching NHS Foundation Trust will engage the ICB to support system-wide coordination. In these circumstances, the ICB may assist with identifying an appropriate reviewer and ensuring suitable oversight, facilitating a collaborative and proportionate response across the organisations involved.

These arrangements ensure that significant or complex events receive the appropriate level of scrutiny, system coordination, and support, promoting shared learning and maintaining high standards of patient safety across the health and care system.

5.7. Requirements for Lead Invesigators of Patient Safety Incident Investigation and Patient Safety Incident Analysis.

Patient Safety Incident Analysis and Patient Safety Incident Investigation within the Trust are undertaken by trained and competent investigators/reviewers to ensure high-quality, robust, and compassionate learning responses.

All investigators must have completed the recognised two-day systems-based investigation training, equipping them with the skills required to apply human-factors principles and systems thinking.

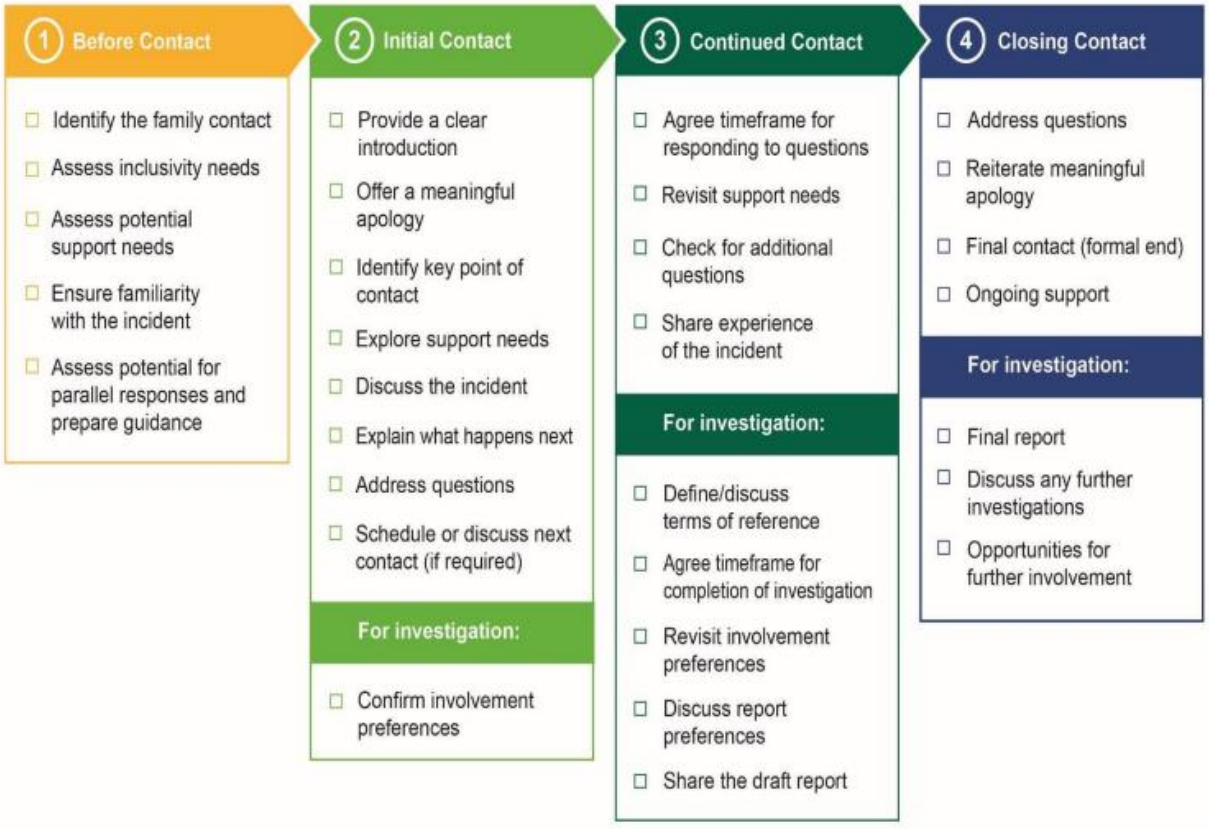
Investigators must be independent of the service where the incident occurred and must not have had direct involvement in the patient's care, ensuring objectivity and reducing potential conflicts of interest. They are required to possess the clinical knowledge and expertise needed to critically analyse the care pathway, as well as excellent report-writing skills to articulate findings clearly and accurately.

Investigators are also expected to work collaboratively and sensitively with staff, patients, and families, supporting an open, compassionate, and learning-focused culture throughout the process.

5.8. Engaging and Involving Patient and Family

Our Engaging and Involving Patients and Families (N-074) sets out the Trust's commitment to ensuring that everyone affected by a patient safety incident is treated with openness, compassion, dignity and respect following a patient safety incident. The Engaging and Involving Patients and Families policy emphasises meaningful, timely and sensitive communication, recognising that involvement is central to healing, trust, and learning. It supports staff to engage confidently and empathetically with patients and families, ensuring they are listened to, kept informed, and able to contribute to understanding what happened.

The policy outlines the stages of contact from initial acknowledgement and apology, through ongoing communication, involvement in learning responses, and feedback on findings ensuring a consistent and transparent approach.



Engagement Principles
Nine principles should be followed for engaging and involving those affected by patient safety incidents.

1. **Apologies are meaningful.**
   Apologies need to demonstrate understanding of the potential impact of the incident on those involved, and a commitment to address their questions and concerns. Ideally, an apology communicates a sense of accountability for the harm experienced, but not responsibility for it ahead of investigation. Getting an apology right is important - it sets the tone for everything that follows. Apologising is also a crucial part of the Duty Of Candour Policy and Procedure.

2. **Approach is individualised.**
   Engagement and involvement should be flexible and adapt to individual and changing needs. These needs could be practical, physical, or emotional. Engagement leads should recognise that every response might need to be different, based on an understanding of the different needs and circumstances of those affected by an incident.

3. **Timing is sensitive.**
   Some people can feel they are being engaged and involved too slowly or too quickly, or at insensitive times. Engagement leads need to talk to those affected about the timing and structure of engagement and involvement, and any key dates to avoid (e g., birthdays, funeral dates. anniversaries), particularly where someone has lost a loved one.

4. **Those affected are treated with respect and compassion.**
   Everyone involved in a learning response should be treated respectfully. There should be a duty of care to everyone involved in the patient safety incident and subsequent response, and opportunities provided for open communication and support through the process. Overlooking the relational elements of a learning response can lead to a breakdown of trust between those involved (including patients, families, and healthcare staff) and the organisation.

5. **Guidance and clarity are provided.**
   Patients, families, and healthcare staff can find the processes that follow a patient safety incident confusing. Those outside the health service, and even some within it, may not know what a patient safety incident is, why the incident they were involved in is being investigated or what the learning response entails. Patients, families, and healthcare staff can feel powerless and ill-equipped for the processes following a patient safety incident.

6. **Those affected are 'heard'.**
   Everyone affected by a patient safety incident should have the opportunity to be listened to and share their experience. They will all have their individual perspective on what happened and each one is valid in building a comprehensive picture to support learning. Importantly. the opportunity to be listened to is also part of restoring trust and repairing relationships between organisations and staff, patients, and families.

7. **Approach Is collaborative and open.**
   An investigation process that is collaborative and open with information, and provides answers, can reduce the chance litigation will be used as a route for being heard. The decision to litigate is a difficult one. Organisations must not assume that litigation is always about establishing blame - some feel it is the only way to get answers to their questions.

8. **Subjectivity is accepted.**
   Everyone will experience the same incident in different ways. No one truth should be prioritised over others. Engagement leads should ensure that patients, families, and healthcare staff are all viewed as credible sources of information in response to a patient safety incident.

9. **Strive for equity.**
   The opportunity for learning should be weighed against the needs of those affected by the incident. Engagement leads need to understand and seek information on the impact of how they choose response types on those affected by incidents and be aware of the risk of introducing inequity into the process of safety responses.

5.9. Writing a High-Quality Patient Safety Report

Patient safety reports must be clear, compassionate, and centred on the patient and their experience and the experience of their family. Reports should be written in plain, accessible language and must avoid jargon, acronyms, or technical terminology that could be confusing for patients, families, or staff. The narrative must be sensitive, respectful, and grounded in **systems-based learning**, ensuring that contributory factors are explored without apportioning blame to individuals.

Each report must include a completed by the lead investigator/reviewer and evidence-informed action plan, setting out specific, measurable improvements. Reports must be fully quality-checked prior to submission by the division, ensuring all required elements are present, findings are coherent, and any concerns raised by patients, families, or carers are clearly and directly addressed.

As part of the final submission, a Learning From template must be completed by the Lead reviewer/investigator to support organisational sharing and improvement.

Additional guidance, review support, and advice are available from the Patient Safety Team and through the allocated PSII or PSIA investigation buddy

5.10. Developing and Monitoring Safety Actions

Safety actions arising from learning responses must be developed in line with PSIRF principles and grounded in patient safety science, systems thinking, and recognised Quality Improvement (QI) methodology. Actions should focus on addressing system-level contributory factors rather than individual performance, avoiding low-impact or poor-quality solutions such as reminders, generic training refreshers, or requests for increased vigilance. Instead, actions must be designed to deliver meaningful and sustainable improvement, strengthen processes, and reduce the likelihood of recurrence.

All safety actions must be specific, measurable, achievable, realistic, and time-bound, with clear ownership, defined outcomes, and explicit measures for assessing impact. The full Plan–Do–Study–Act (PDSA) cycle should be applied to test and refine changes, ensuring they become fully embedded in routine practice and deliver demonstrable improvement. Where relevant, safety actions may align with broader divisional quality improvement programmes and the Trust's strategic objectives, supporting shared learning and wider system enhancement.

Progress against safety actions will be monitored through Divisional Patient Safety Governance Meetings, with updates escalated to the Quality and Patient Safety Group for organisational oversight. Performance will also be monitored and reported through CRMG and via the Divisional Accountability Reviews, ensuring visibility, accountability, and timely intervention where actions are delayed or not delivering the expected improvement.

This policy includes within the appendices process flowcharts outlining the key stages of reviews and approximate timescales for completion. Timeframes are designed to allow for thorough, system-based reviews rather than rushing to meet arbitrary deadlines.

5.11. Timeframes for learning responses – PSIAs and PSIIs.

Timeframes are designed to allow for thorough, system-based reviews rather than rushing to meet arbitrary deadlines**.** PSIRF does not impose rigid investigation timescales; however, it is recommended that investigations should not exceed six months wherever possible.

Under the Patient Safety Incident Response Framework (PSIRF), the organisation aims to complete full Patient Safety Incident Investigations (PSIIs) and PSIAs within 24 weeks, and short-form PSIIs (non-death related) within 16 weeks.

These timeframes should be agreed through collaborative discussion between the investigating team and the Quality and Patient Safety leadership team, ensuring that expectations remain realistic and proportionate to the complexity of each case. Factors that may legitimately influence and extend investigation timelines include the presence of concurrent processes such as safeguarding enquiries, complaint responses, or HR investigations as well as the expressed wishes and level of involvement of patients, families, or carers. Additionally, the organisation must remain responsive to external requirements, including ensuring that reports are available within timeframes specified by bodies such as the coroner. Proposed timelines should therefore balance thoroughness, compassion, and statutory or regulatory obligations.

5.12. Interface between Safeguarding processes and PSIRF

The Trust has statutory duties under both child and adult safeguarding legislation to cooperate fully with safeguarding investigations and reviews led by the local authority. Where safeguarding concerns arise, the incident must be referred to the local authority safeguarding lead, who will determine whether a statutory review is required, such as a Safeguarding Adult Review (SAR), Safeguarding Practice Review (SPR), Domestic Homicide Review (DHR), or Joint Targeted Area Inspection (JTAI).

Healthcare providers must contribute to these investigations as requested, supplying timely information, participating in multi-agency meetings, and supporting the development of system-level learning. Alongside this, the Trust will consider the need for an internal PSIRF learning response, ensuring that safeguarding issues relevant to patient safety are reviewed proportionately and without duplication. Where safeguarding and patient safety processes overlap, the Safeguarding and Patient Safety Teams work collaboratively to align learning, maintain statutory compliance, and ensure that actions taken lead to improved outcomes for children, adults, and families.

5.13. Interface between Complaints and PSIRF

The Trust is committed to strengthening the alignment of learning from patient safety incidents and formal complaints and has developed a more robust reporting processes to support effective triangulation. When a complaint includes concerns related to patient safety, it is reviewed alongside any corresponding Datix incident to ensure that themes, risks, and system issues are identified consistently across both pathways.This developing approach aims to create a clearer and more integrated understanding of patient experience and safety.

Triangulation of learning from complaints, patient safety incidents, and wider quality intelligence is overseen through the Clinical Risk Management Group (CRMG) and the Quality, Patient Safety and Experience Group (QPAS). These forums provide strengthened governance, enabling the organisation to review cross-cutting themes, identify emerging patterns, and prioritise improvement actions that are meaningful, system-focused, and designed to enhance outcomes for patients, families, and staff.

5.14. Health Care Acquired Infections Incident and Outbreak

To standardise patient safety incident responses, Infection Prevention and Control (IPC) related reviews are aligned to the PSIRF (NHS England, 2023). Previous governing responses to Healthcare Associated Infection (HCAI) i.e. to conduct a Post Infection Review (PIR) and/or Root Cause Analysis (RCA) no longer apply.

All infection related incidents are reported and managed through the Trust Datix system. An After Action Review (AAR) will be completed for reportable bloodstream infections including MRSA, MSSA and E. coli. AARs are reviewed with consideration given to requesting a PSIA or PSII where significant learning is identified or where infection is considered to have contributed to a patient death.

Individual HCAI cases are monitored and reviewed as a focus to support the actions to reduce the risk of the infections and patient outcomes across the Humber and North Yorkshire Integrated Care Board (ICB).

Clostridioides difficile infection (CDI) cases are reported and subject to an AAR when a stool specimen yielding a toxin positive C.diff result is taken on or post day 3 of admission.

An AAR will be completed following each outbreak of communicable disease incident. Further investigation may be required dependent on the adversity of the incident/outbreak and outcome.

5.15. Medication safety incidents

Medicine safety incident such as prescribing errors, administration mistakes, dispensing issues, and near-misses represent an important source of learning within the Trust. While many medication-related incidents result in no harm or low harm, they often highlight weaknesses in processes, communication, or system design that, if unaddressed, could lead to more serious outcomes. To support rapid, proportionate, and meaningful learning, the Trust uses After Action Reviews (AARs) as the primary learning response for most medication safety incidents where potential for learning is identified.

AARs are particularly valuable in this context because they enable teams to reflect promptly on what happened, what was expected to happen, the factors that influenced the outcome, and what improvements are needed to strengthen medication safety. The structured, collaborative nature of an AAR supports open discussion without blame, helping staff identify system-level issues such as workflow pressures, documentation gaps, unclear instructions, interruptions, or equipment and technology challenges.

Insights from medication-related AARs are shared through the Medication Safety Group and triangulated with data from clinical audits, incidents, and pharmacy safety reports. Where significant themes emerge, or where an incident suggests potential for serious harm, an AAR may be escalated to a PSIA or PSII in line with Trust processes. This approach ensures that learning from medication safety incidents is timely, proportionate, and focused on strengthening systems, reducing variation, and improving outcomes for patients

5.16. Using PSIRF Learning Responses to learning form incident of self-harm.

Self-harm is our highest reporting patient safety incident category. Ensuring we have insight through proportionate learning responses will strengthen our commitment to reducing harm caused through self-harm and support our Trust's Suicide and Self-Harm Prevention Strategic Plan.

After Action Reviews (AARs), Initial Incident Reviews (IIRs), and thematic analysis are valuable learning response tools to support us in identifying themes and trends, supporting us to develop improvement action and improve patient safety. AARs offer a rapid and

proportionate opportunity to understand no-harm/low harm incidents and near-misses. Through IIRs and thematic reviews, the Trust can more systematically examine known high-risk themes, including transfer between services, discharge, changes in medication, poor adherence to medication, substance misuse, social adversity, and significant life events such as bereavement. System based tools and methodology supports this analysis by focusing on systems thinking, human factors, and identifying how organisational processes can better anticipate and mitigate these risks.

Where there is opportunity for significant learning a PSIA or PSII may be commissioned, the decision for which will be made as outlined in this policy and will be a proportionate, learning focused response.

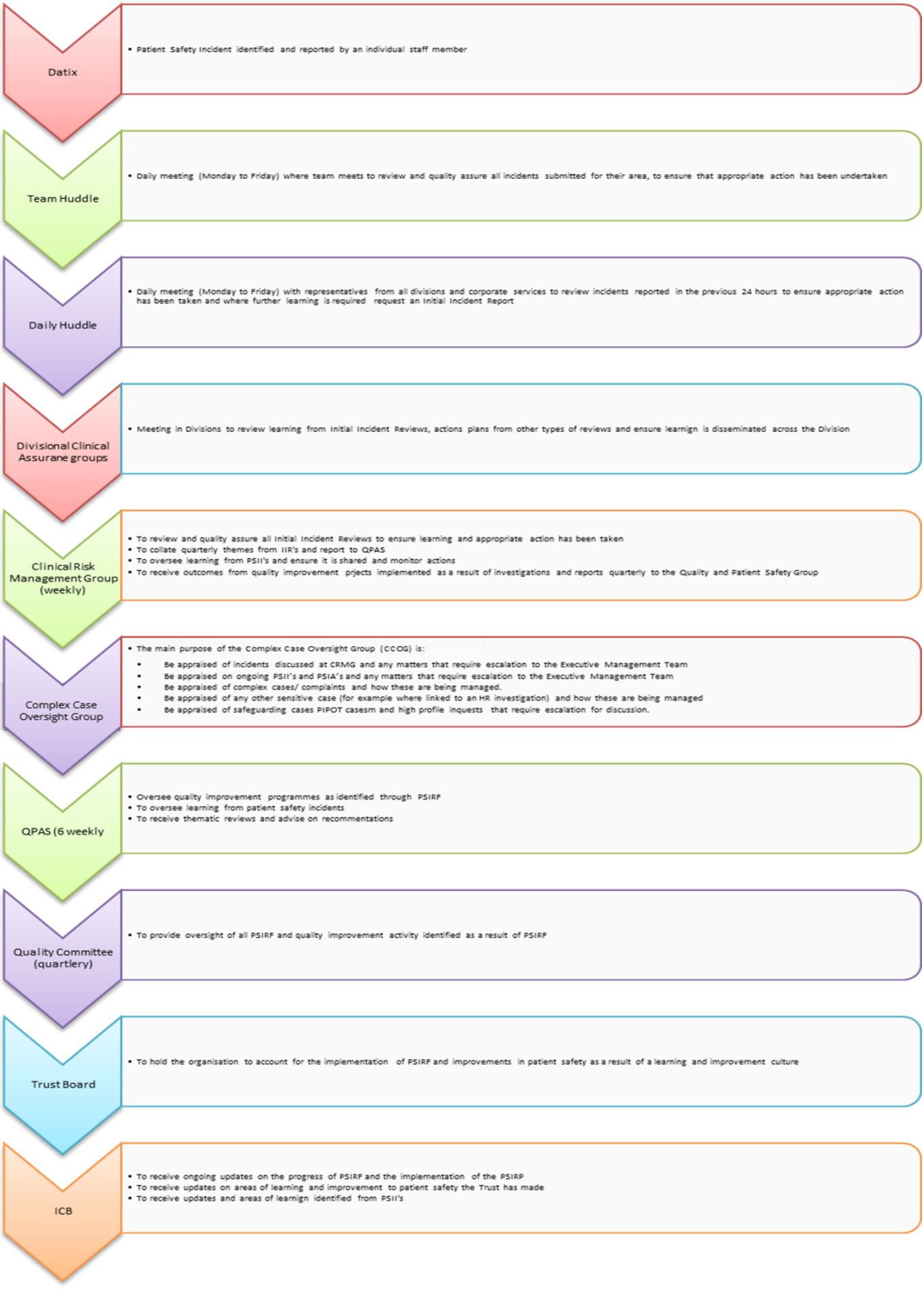
These insights help build a clearer picture of emerging risks and themes across the patient pathway.

Learning from these reviews will be triangulated through divisional governance, CRMG and QPAS, informing both local practice improvements and the wider strategic plan. This creates a feedback loop that strengthens our intelligence about self-harm and suicide risk patterns, supports targeted quality improvement activity, and enables the Trust to implement tangible, evidence-informed changes to improve safety and outcomes for people at elevated risk.

5.17. Patient Safety incident Reporting and Governance arrangements

The Trust has an internal structure in place to oversee the reporting, investigation and learning from patient safety incidents along with opportunities to collaborate with system partners, patients, and their families.

The diagram on the next page describes the process and arrangements we have in place for the reporting, management and learning from patient safety incidents. Additional information can be found within our Patient Safety Incident Response Plan.


Datix
• Patient Safety Incident identified and reported by an individual staff member
Team Huddle
• Daily meeting (Monday to Friday) where team meets to review and quality assure all incidents submitted for their area, to ensure that appropriate action has been undertaken
Daily Huddle
• Daily meeting (Monday to Friday) with representatives from all divisions and corporate services to review incidents reported in the previous 24 hours to ensure appropriate action has been taken and where further learning is required request an Initial Incident Report
Divisional Clinical Assurane groups
• Meeting in Divisions to review learning from Initial Incident Reviews, actions plans from other types of reviews and ensure learnign is disseminated across the Division
Clinical Risk Management Group (weekly)
• To review and quality assure all Initial Incident Reviews to ensure learning and appropriate action has been taken
• To collate quarterly themes from IIR's and report to QPAS
• To oversee learning from PSII's and ensure it is shared and monitor actions
• To receive outcomes from quality improvement prjects implemented as a result of investigations and reports quarterly to the Quality and Patient Safety Group
Complex Case Oversight Group
• The main purpose of the Complex Case Oversight Group (CCOG) is:
Be appraised of incidents discussed at CRMG and any matters that require escalation to the Executive Management Team
Be appraised on ongoing PSII's and PSIA's and any matters that require escalation to the Executive Management Team
Be appraised of complex cases/ complaints and how these are being managed.
Be appraised of any other sensitive case (for example where linked to an HR investigation) and how these are being managed
Be appraised of safeguarding cases PIPOT casesm and high profile inquests that require escalation for discussion.
QPAS (6 weekly
• Oversee quality improvement programmes as identified through PSIRF
• To oversee learning from patient safety incidents
• To receive thematic reviews and advise on recommentations
Quality Committee (quartlery)
• To provide oversight of all PSIRF and quality improvement activity identified as a result of PSIRF
Trust Board
• To hold the organisation to account for the implementation of PSIRF and improvements in patient safety as a result of a learning and improvement culture
ICB
• To receive ongoing updates on the progress of PSIRF and the implementation of the PSIRP
• To receive updates on areas of learning and improvement to patient safety the Trust has made
• To receive updates and areas of learnign identified from PSII's

6. Training

To ensure organisational compliance with the national Patient Safety Syllabus and PSIRF standards. The following training is required:

- All Trust staff must complete Patient Safety Level 1 – Essentials for Patient Safety, available via ESR.
- All Board members and Senior Leaders must complete Patient Safety Level 1b.
- All staff undertaking Patient Safety Incident Investigations must complete the Systems Approach to Learning from Patient Safety Incidents (2-day course) or equivalent

In addition to national training, the Trust also provides local training in the facilitation of After-Action Reviews (AARs) and SWARM learning responses. This ensures staff are confident in leading rapid, proportionate and supportive learning conversations and can support teams effectively following incidents.

7. Dissemination and Implementation

This policy will be disseminated by the method described in the Document Control Policy (C-003). This policy will be shared with all clinical and operational teams and made accessible via the Trust intranet. Divisional leaders and clinical governance forums are responsible for ensuring the policy is communicated, understood, and embedded within local processes.

Implementation will be supported through established patient safety governance structures, with key changes highlighted at CRMG, QPAS, and divisional governance meetings.

8. Monitoring and Compliance

Monitoring of this policy and its implementation will take place through the Trust's established governance structure. Improvement actions arising from PSIRF learning responses will be reviewed through Divisional Patient Safety Governance Meetings and monitored via Divisional Accountability Reviews to ensure progress, effectiveness, and sustainability.

A monthly performance report summarising PSIRF activity, investigations, actions, and emerging themes will be reviewed at CRMG. In addition, a comprehensive quarterly patient safety report will be presented to QPAS and shared with the ICB to support system-level oversight and assurance.

Organisational oversight is provided through the Quality Committee, Executive Management Team (EMT), and the Trust Board, ensuring that compliance, performance, and improvements are regularly scrutinised and that the policy continues to drive meaningful, measurable improvements in patient safety

9. References / Related Trust Documents

Incident Reporting Policy-N-038

After Action Reviews SOP24-022

Patient Safety Incident Analysis-using-swarm-huddle-methodology SOP23-039

duty-of-candour-policy-and-procedure-n-053.pdf

engaging-with-patient-and-families-policy-n-074.pdf

Death-of-a-detained-patient SOP20-014

Standard Operating Procedure following notification of a serious assault by a mental health patient SOP22-016

Being Fair Tool

Revised-Never-Events-policy-and-framework-FINAL.pdf

NHS England (2023) Alignment of Infection Prevention and Control (IPC) with the Patient Safety Incident Response Framework (PSIRF) Publication reference: PRN00689

Appendix 1: Definitions

Patient Safety Incident Response Framework (PSIRF) PSIRF is the NHS framework for responding to patient safety incidents, focusing on compassionate involvement, systems-based learning, proportionate responses, and supportive oversight to improve safety across healthcare services

Initial Incident Review (IIR) A rapid, early review to gather initial facts, assess immediate safety concerns, and identify urgent actions and early learning following a patient safety incident

Patient Safety Incident Investigation (PSII) An in-depth systems-based investigation conducted when an incident or near miss indicates significant safety risk or learning potential.

Patient Safety Incident Analysis (PSIA) using Swarm Huddle methodology Patient Safety Incident Analysis uses a Swarm Huddle is a safe, non-punitive, discussion to understand what happened, why, and what immediate actions are needed to reduce risk. Learning is shared, and a report is produced for patients, families, carers, or coronial processes if required.

After Action Review (AAR) A structured, facilitated reflective discussion held shortly after an event to understand what happened, why it happened, and what can be learned. AARs are recognised within PSIRF as one possible learning response.

Patient Safety MDT A PSIRF-supported learning response that uses a multidisciplinary approach to analyse incidents

SEIPs A system-based human factors framework used to understand how system components interact to influence outcomes. PSIRF endorses system-based approaches such as SEIPS

Clinical Risk Management Group (CRMG) The Clinical Risk Management Group (CRMG) promotes a positive patient safety culture across the Trust by overseeing all patient safety incident investigations, analyses, and mortality reviews in line with the Patient Safety Incident Response Framework and related Trust policies.

Definitions of Harm Harm is any unintended or unexpected injury, deterioration, or negative impact arising from healthcare that could have or did lead to harm for one or more patients. This is aligned with the national definition of a patient safety incident (could have or did lead to harm)

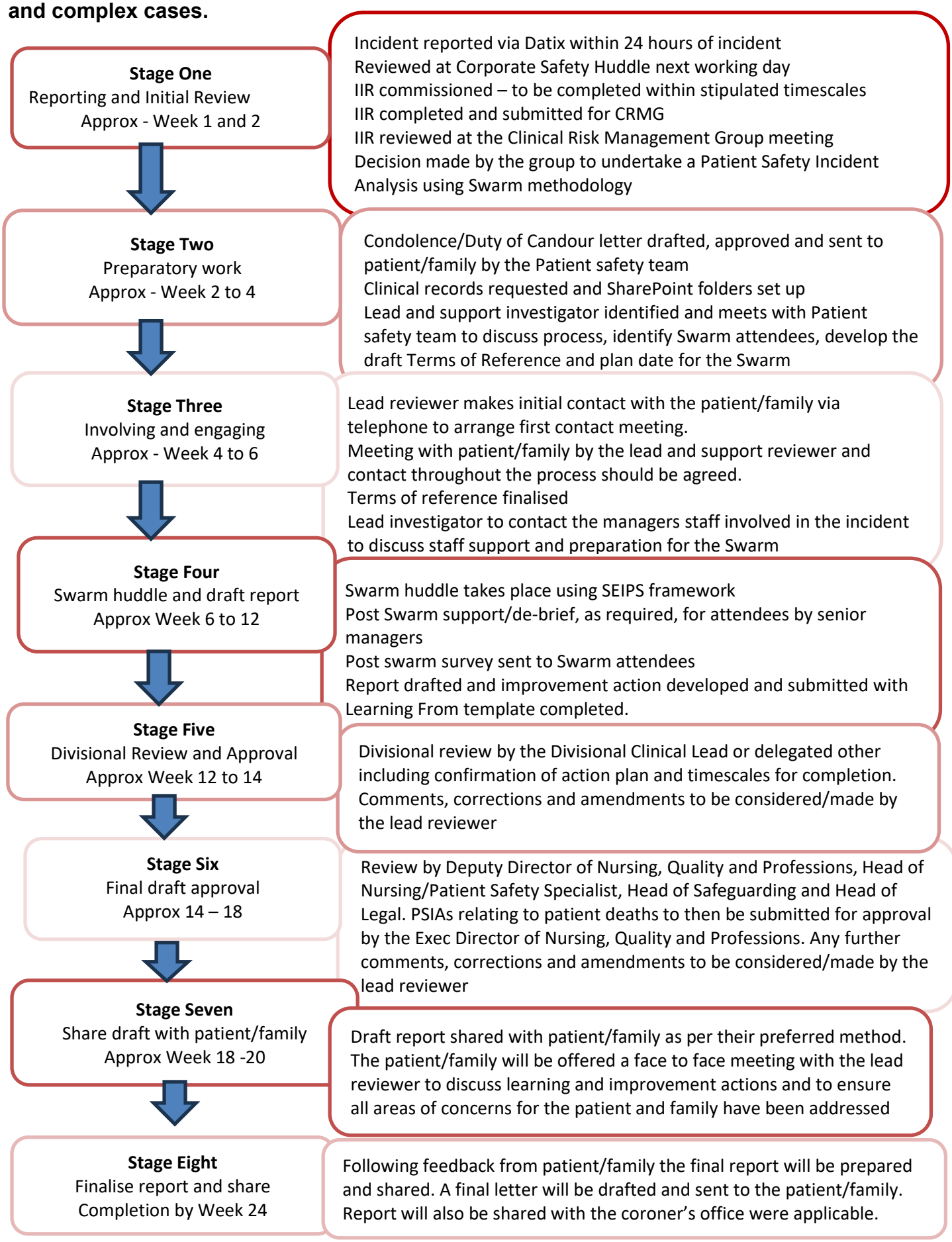
Near Miss - An unintended event that did not result in harm but had the potential to do so. Near misses (sometimes referred to as a ‘good catch’) are important to report and learn from to prevent future harm.

Duty of Candour A statutory requirement to be open, honest, and transparent with patients and families when something has gone wrong that has led to moderate or more severe harm

Never Events A nationally recognised category of serious, preventable incidents that should not occur if national guidance and safety controls are followed

PSII Buddy Role A supportive senior role that advises investigators, monitors progress, escalates urgent safety concerns, and ensures timely, high-quality investigations

Appendix 2: Patient Safety Incident Analysis Flowchart — Full PSIA – patient deaths and complex cases.



Appendix 3: Short Form PSIA - Non-Complex Cases and Non-Patient Deaths

Stage One
Reporting and Initial Review
Approx - Week 1 and 2

Incident reported via Datix within 24 hours of incident
Reviewed at Corporate Safety Huddle next working day
IIR commissioned – to be completed within stipulated timescales
IIR completed and submitted for CRMG
IIR reviewed at the Clinical Risk Management Group meeting
Decision made by the group to undertake a Patient Safety Incident Analysis using Swarm methodology

Stage Two
Preparatory work
Approx - Week 2 to 4

Condolence/Duty of Candour letter drafted, approved and sent to patient/family by the Patient safety team
Clinical records requested and SharePoint folders set up
Lead and support investigator identified and meets with Patient Safety team to discuss process, identify Swarm attendees, develop the draft Terms of Reference and plan date for the Swarm

Stage Three
Involving and engaging
Approx - Week 4 to 6

Lead reviewer makes initial contact with the patient/family via telephone to arrange first contact meeting.
Meeting with patient/family by the lead and support reviewer and contact throughout the process should be agreed.
Terms of reference finalised
Lead investigator to contact the managers staff involved in the incident to discuss staff support and preparation for the Swarm

Stage Four
Swarm huddle and draft report
Approx Week 7-8

Swarm huddle takes place using SEIPS framework
Post Swarm support/de-brief, as required, for attendees by senior managers
Post swarm survey sent to Swarm attendees
Short form report drafted, and improvement action developed and submitted with Learning From template completed.

Stage Five
Divisional Review and Approval
Approx Week 9-10

Divisional review by the Divisional Clinical Lead or delegated other including confirmation of action plan and timescales for completion.
Comments, corrections and amendments to be considered/made by the lead reviewer

Stage Six
Final draft approval
Approx 11-12

Review by Deputy Director of Nursing, Quality and Professions, Head of Nursing/Patient Safety Specialist, Head of Safeguarding and Head of Legal. Any further comments, corrections and amendments to be considered/made by the lead reviewer

Stage Seven
Share draft with patient/family
Approx Week 13

Draft report shared with patient/family as per their preferred method.
The patient/family will be offered a face to face meeting with the lead reviewer to discuss learning and improvement actions and to ensure all areas of concerns for the patient and family have been addressed

Stage Eight
Finalise report and share
Completion by Week 16

Following feedback from patient/family the final report will be prepared and shared. A final letter will be drafted and sent to the patient/family.
Report will also be shared with the coroner's office were applicable.

Appendix 4: Patient Safety Incident Investigation Flowchart

Stage One
Reporting and Initial Review
Approx - Week 1 and 2

Incident reported via Datix within 24 hours of incident
Reviewed at Corporate Safety Huddle next working day
IIR commissioned – to be completed within stipulated timescales
IIR completed and submitted for CRMG
IIR reviewed at the Clinical Risk Management Group meeting
Decision made to escalate to DoNQP for consideration for a Patient Safety Incident Investigation

Stage Two
Preparatory work
Approx - Week 2 to 4

Condolence/Duty of Candour letter drafted, approved and sent to patient/family by the Patient safety team
Complete PSII notification on STEiS and send to Execs and Divisional Leads
Clinical records requested and SharePoint folders set up
Lead and support investigator identified and meets with PSII Buddy to discuss process, develop the draft Terms of Reference and plan discuss contact with patient/family.

Stage Three
Involving and engaging
Approx - Week 4 to 6

Lead investigator makes initial contact with the patient/family via telephone to arrange first contact meeting.
Meeting with patient/family by the lead investigator and PSII Buddy with contact throughout the process agreed. Terms of reference finalised. Lead investigator to contact the managers staff involved in the incident to discuss staff support and preparation for interviews

Stage Four
Interviews and intelligence
Initial Exec Meeting
Panel meeting
Approx Week 6 to 12

Staff interviews take place. It may be preferrable and appropriate to conduct a Swarm huddle as part of the PSII process.
Post interview/Swarm support/de-brief, as required, for staff by senior managers
Meet with the exec team to discuss progress, initial findings and provide assurance that immediate safety concerns have been addressed. Panel meeting with lead and division. Report and improvement actions drafted

Stage Five
Draft report and action plan
Divisional approval
Approx Week 12-16 weeks

Divisional review of draft report by the Divisional Clinical Lead or delegated other including confirmation of action plan and timescales for completion.
Comments, corrections and amendments to be considered/made by the lead reviewer. Final approval by the Divisional Clinical Lead or delegated other

Stage Six
Final draft approval
Approx 16-20

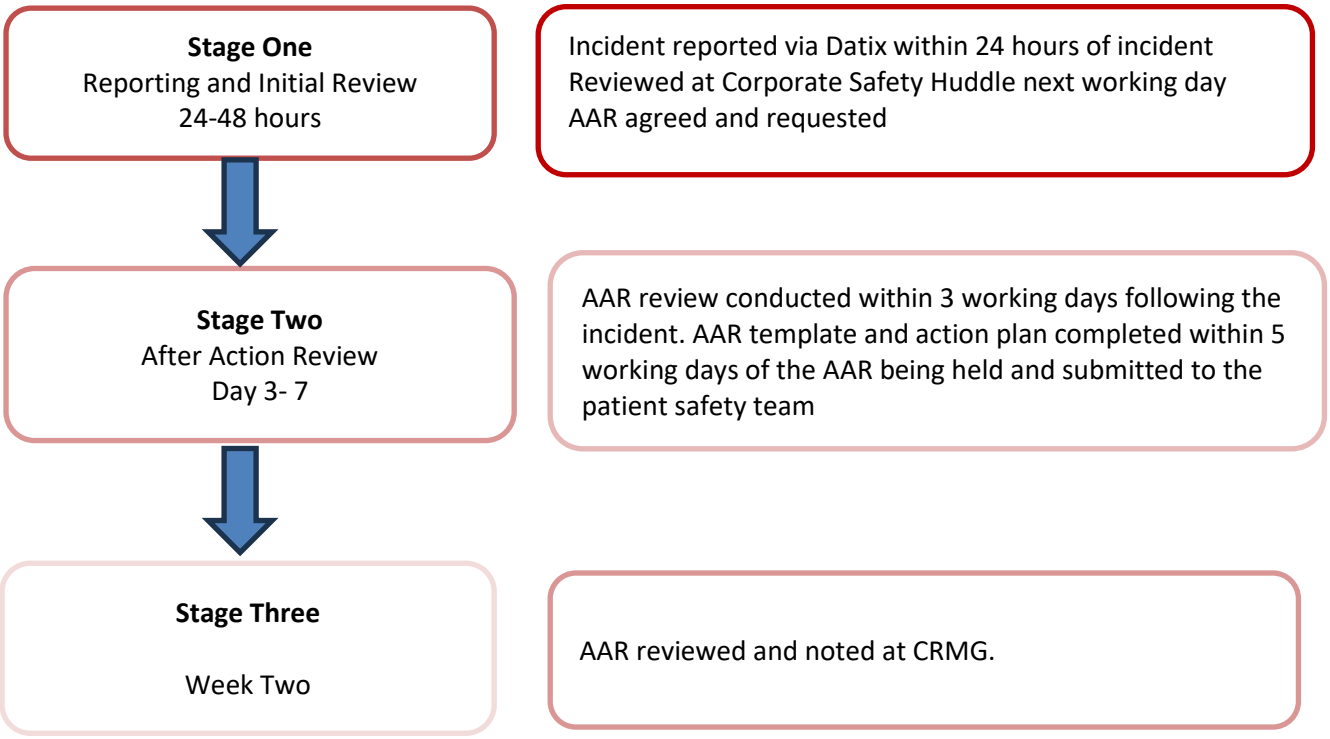
Review by Deputy Director of Nursing, Quality and Professions, Head of Nursing/Patient Safety Specialist, Head of Safeguarding and Head of Legal. Final Exec meeting to approve report at week

Stage Seven
Share draft with patient/family
Approx Week 18 -20

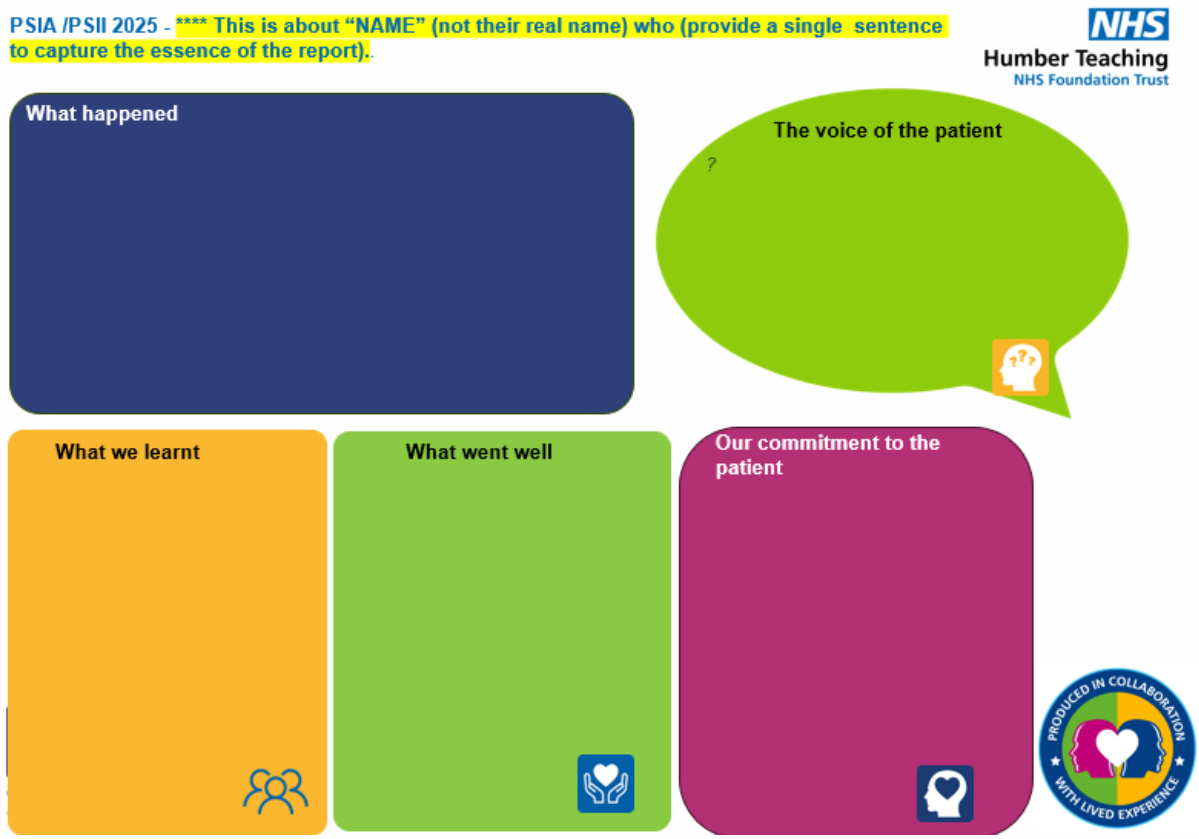
Draft report shared with patient/family as per their preferred method. The patient/family will be offered a face to face meeting with the lead reviewer to discuss learning and improvement actions and to ensure all areas of concerns for the patient and family have been addressed

Stage Eight
Finalise report and share
Completion by Week 24

Following feedback from patient/family the final report will be prepared and shared. A final letter will be drafted and sent to the patient/family. Report will also be shared with the coroner's office were applicable.


Stage One
Reporting and Initial Review
24-48 hours
Incident reported via Datix within 24 hours of incident
Reviewed at Corporate Safety Huddle next working day
AAR agreed and requested
Stage Two
After Action Review
Day 3- 7
AAR review conducted within 3 working days following the incident. AAR template and action plan completed within 5 working days of the AAR being held and submitted to the patient safety team
Stage Three
Week Two
AAR reviewed and noted at CRMG.

Appendix 6: ‘Learning from’ Template



To obtain a version of the ‘Learning from’ template in an editable format please contact the patient safety team at hnf-tr.humber-patientsafetyincidents@nhs.net

Appendix 7: After-Action Review

Please make sure all sections of the report are completed or write Not Applicable (N/A) in the space provided.
Please make sure that if abbreviations are used within the Initial Incident Review, that the full term is used the first time the abbreviation appears in the report so that all staff reading the report understands what the abbreviation means.

Date AAR Requested	
Date Request for Report Sent Out	
Date Report Received	
After-Action Review Requested By	Choose an item.

Reviewer's Details			
Reviewer's Name		Reviewer's Job Title	
Reviewer's Tel. no		Reviewer's E-mail	
DATIX Web Reference *(includes link to DATIX)*			
Date of Incident			
Date Incident Reported			
Division / Directorate			
Unit / Team / Department			
Type of Incident			

Datix Summary:
Immediate Safety Actions Taken
Scope and focus of the Investigation – if specified (also known as Terms of Reference)

Date of After-Action Review Meeting	
People Present at Meeting	

What was supposed or what did you intend to happen?
What immediate actions have been taken.
What have we learnt about it
What should we do next time/ Any future learning

Area for improvement to be taken to address learning identified

	Safety Action	Accountable Lead	Completion Date	Evidence Required	Monitoring, Audit and Evaluation Arrangements
1					
2					
3					
4					
5					
6					

To obtain a version of the 'Learning from' template in an editable format please contact the patient safety team at hnf-tr.humber-patientsafetyincidents@nhs.net

Appendix 8: Document Control Sheet

This document control sheet, when presented for approval/ratification must be completed in full to provide assurance. The master copy of the document is to be held by the Policy Management Team.

Document Type	Policy		
Document Purpose	This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Humber Teaching NHS Foundation Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety. The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident 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.		
Consultation:	Date:	Group / Individual	
list in right hand columns consultation groups and dates -	Aug-23	PSIRF Working Group PSIRF Working Group	
		PSIRF Steering group	
	May 2024	QPaS	
	September 2025	Staff consultation sessions	
	QPaS	12 March 2026	
Approving Body:	EMT	Date of Approval:	12 May 2026
Date of Board Ratification:	27 May 2026		
Training Impact Analysis:	None [ ]	Minor [x]	Significant [ ]
Financial Impact Analysis:	None [ ]	Minor [x]	Significant [ ]
Capacity Impact Analysis:	None [ ]	Minor [x]	Significant [ ]
Equality and Health Inequalities Impact Assessment (EHIIA) undertaken?	Yes [x]	No [ ]	N/A [ ] Rationale:

Document Change History:			
Version Number	*Type of Change (full/interim review, minor or significant change(s))*	*Date*	*Details of Change and approving group or Executive Director* ***(if very minor changes as per the document control policy)***
1.0	*New document*	*Sept-23*	*New Document required for the Patient Safety Incident Response Framework* *Approved at EMT – 11-Sept-23* *Ratified at Trust Board – 27-Sept-23*
1.1	*Minor changes*	*June 2024*	*Reviewed. Changed Swarm huddle to PSIA using swarm methodology. Removed reference to SEAs and SI. Added more clarity re safety II. Added incident reporting flowchart. Updated timescales for reviews. Approved at QPaS (27 June 2024).*
1.2	*Minor amends*	*25 March 2025*	*Appendix 3 "Learning From Template" added to policy. Approved by director sign-off (Hilary Gledhill - Executive director of Nursing, AHPs and Social Work Professionals – 25 March 2025).Date of next review unchanged.*
2.0	*Full review with significant amendments*	*May 2026*	*Full and comprehensive review. Revised processes for PSIA and PSII – timescales and process flowcharts added/updated. Addition of the governance structure, revised learning from template, revised AAR template. Applied to the new Trust policy template. Aligned with the updated Patient Safety Incident Response Plan 2026-2029. Approved at QPaS (12 March 2026) and EMT (12 May 2026). Ratified at Board (27 May 2026).*

Appendix 9: Equality and Health Inequalities Impact Assessment (EHIIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document of Process or Service Name: Patient Safety Incident Response Policy
2. EHIIA Reviewer (name, job title, base and contact details): Sadie Milner, Head of Nursing and Patient Safety Specialist
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy

Main Aims of the Document, Process or Service
This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Humber Teaching NHS Foundation Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the proforma

Equality Target Groups	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
This toolkit asks services to consider the impact on people with protected characteristics under the Equality Act 2010 as well as the impact on additional groups who may be at risk of experiencing inequalities in access, outcomes and experiences of health and care.	Equality Impact Score Positive = evidence of positive impact Neutral = little or no evidence of concern (Green) Moderate negative = some evidence of concern (Amber) High negative = significant evidence of concern (Red)	• who have you consulted with? • what have they said? • what information or data have you used? • where are the gaps in your analysis? • how will your document/process or service promote equality and diversity good practice?

Equality Target Group	Definitions (Source: Equality and Human Rights Commission, 2024)	Equality Impact Score	Evidence to support Equality Impact Score
Age	A person belonging to a particular age (for example 32-year-olds) or range of ages (for example 18- to 30-year-olds).	Neutral	See summary.
Disability	A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	Neutral	See summary.
Sex	Man/Male, Woman/Female.	Neutral	See summary.
Marriage / Civil Partnership	Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples.	Neutral	See summary.
Pregnancy / Maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a person unfavourably because they are breastfeeding.	Neutral	See summary.
Race	A race is a group of people defined by their colour, nationality (including citizenship) ethnicity or national origins. A racial group can be made up of more than one distinct racial group, such as Black British.	Neutral	See summary.
Religion or Belief	Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	Neutral	See summary.
Sexual Orientation	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	Neutral	See summary.

Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Neutral	See summary.
Poverty	People on welfare benefits, unemployed/low-income, fuel poverty, migrants with no recourse to public funds	Neutral	See summary.
Literacy	Low literacy levels, including includes poor understanding of health and health services (health literacy) as well as poor written language skills	Neutral	See summary.
People with English as an additional language	People who may have limited understanding and/or ability to communicate in written or spoken English	Neutral	See summary.
Digital exclusion	People who can't or don't want to use digital technology due to cost, access to connectivity or devices, digital skills or lack of confidence or trust in digital systems	Neutral	See summary.
Inclusion health groups	People who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes:	Neutral	See summary.
	• People who experience homelessness	Neutral	See summary.
	• Drug and alcohol dependence	Neutral	See summary.
	• Vulnerable migrants	Neutral	See summary.
	• Gypsy, Roma and Traveller communities	Neutral	See summary.
	• Sex workers	Neutral	See summary.
	• People in contact with the justice system	Neutral	See summary.
	• Victims of modern slavery	Neutral	See summary.
Rurality	People who live in remote or rural locations who may have poor access to services.	Neutral	See summary.
Coastal communities	People who live in coastal communities which may experience unemployment, low educational attainment, poor social mobility, poor health outcomes and poorer access to services.	Neutral	See summary.
Carers	Carers and families of patients and service users, including unpaid carers and paid carers	Neutral	See summary.
Children looked after	A child or young person who is being cared for by their local authority. They might be living in a children's home, or with foster parents, or in some other family arrangement.	Neutral	See summary.
Veterans	Anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations.	Neutral	See summary.
Neurodivergence	People with alternative thinking styles such as autism, attention deficit hyperactivity disorder, dyslexia, developmental co-ordination disorder (dyspraxia), dyscalculia.	Neutral	See summary.
Other	Any other groups not specified in this toolkit who may be positively or negatively impacted	Neutral	See summary.

Summary

Please describe the main points/actions arising from your assessment that supports your decision above Humber Teaching NHS Foundation Trust is committed to delivering on its statutory obligations under the Equality Act, (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. We strive to ensure that all safety improvements will consider health inequalities and any disproportionate risk to patients with specific characteristics.
EIA Reviewer: Sadie Milner, Head of Nursing and Patient Safety Specialist

Date Completed: 02-03-26	**Signature:** S.K.Milner