Patient Safety Incident Response (PSIRF) Policy

[Mandatory Read]

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1. Purpose

1.1 Introduction

At The Children's Trust, our dedication to delivering outstanding care and support for children with brain injuries and their families is at the heart of everything we do. This commitment extends beyond treatment alone, to encompass the assurance of safety, the promotion of healing, and the pursuit of excellence in all our services. Recognizing the inherent risks in healthcare, we are proactively engaged in mitigating both clinical and non-clinical risks through comprehensive, clear, and effective systems. These systems are designed not only to identify and manage incidents that may harm patients, families, or staff but also to foster an environment where learning and improvement are constant.

The cornerstone of our approach is a culture rooted in transparency, accountability, and respect. We believe in the power of open communication to heal, improve, and strengthen the bonds of trust between our patients, their families, and our team. This commitment to openness is not just a policy but a practice—embedded in our daily interactions and our strategic initiatives, including our adherence to the Duty of Candour. This principle guides us in being forthright about mistakes, learning from them, and preventing their recurrence, thereby reinforcing our dedication to the safety and well-being of all we serve.

Acknowledging that healthcare is ever evolving, The Children's Trust embraces a proactive stance on patient safety. Our PSIRF policy has been developed to address the complexities of patient care, ensuring a structured response to incidents with a focus on systemic improvement and accountability. In shaping this policy, we have actively sought insights and contributions from a diverse group of stakeholders to create a robust and effective framework.

It is important to recognise that our PSIRF policy is dynamic, evolving with advancements in healthcare and the specific needs of our community. Through this adaptive approach, we affirm our commitment to meet the highest standards of patient care and safety, ensuring that The Children's Trust remains a centre of excellence in paediatric brain injury rehabilitation and neurodisability support.

1.2 Patient Safety Incident Response Framework

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out The Children’s Trusts 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 that integrates the four key aims of the PSIRF:

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

In this document, we will outline the key components, objectives, and procedures of the PSIRF policy.

This policy encompasses the roles and responsibilities of staff involved in incident management, the reporting process, and the steps to be taken when responding to patient safety incidents.

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2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement at The Childrens Trust and all its associated community services.

The policy, therefore, is for all employees and agency workers as we collectively have a responsibility to identify and support responding to patient safety events.

The scope of this policy is grounded in a systems-based approach to patient safety, recognizing that safety emerges from the complex interplay among various components of the healthcare system rather than being attributable to any single element. This perspective underscores our commitment to fostering an environment where safety is cultivated through continuous learning and improvement, not through assigning blame.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

This policy is designed to ensure that all responses to patient safety incidents are conducted within this framework, maintaining a clear focus on systemic improvement, and safeguarding the well-being of our patients, their families, and our staff.

Although non-patient safety incidents are outside of the scope of this policy much of the theory and approach can be employed in other incidents and investigations including the use of the PSIRF's investigative methodologies, templates, and the systems thinking model. By adopting this comprehensive approach, we ensure a consistent, robust response across various incident types, emphasizing our commitment to systemic improvement and resilience. This inclusive application of our methodologies underscores our dedication to enhancing all aspects of care and operational excellence.

3. Our patient safety culture

Patient Safety Culture at The Children's Trust is defined as the collective values, beliefs, and behaviours that prioritise safety in our healthcare environment. It encompasses a shared commitment among staff to continuously identify and mitigate risks, ensuring the highest standards of care and support. This culture is underpinned by openness, mutual respect, and a continuous pursuit of improvement, where learning from every incident is seen as an opportunity to enhance our care for children with brain injuries/neurodisability and their families.

Core Principles

Our patient safety culture is guided by the following principles:

- **Transparency:** Openly sharing information about safety incidents and learnings.
- **Accountability:** Holding ourselves responsible for maintaining and improving safety standards.
- **Learning:** Viewing incidents as opportunities for learning rather than assigning blame.
- **Support:** Encouraging and empowering staff to report safety concerns without fear of retribution.

Leadership and Accountability

Leadership at all levels champions our safety culture by:

- **Modelling Patient Safety-Focused Leadership:** Our leaders set the standard for patient safety by embodying a leadership style that is rooted in curiosity, sensitivity, and honesty. They approach patient safety challenges with an open mind and a commitment to understanding the nuances of each incident, promoting a culture where learning and improvement are prioritised.
- **Proportionate Responses and Methodologies:** Leadership ensures that responses to safety incidents are proportionate and appropriate, employing the right methodologies and actions to address the underlying issues effectively. This includes utilising best practices in patient safety and quality improvement to ensure that corrective measures are both effective and sustainable.
- **Compassion and Support:** Treating individuals involved in incidents with compassion is a cornerstone of our approach. Leaders ensure that everyone affected by a safety incident, including patients, families, and staff, receives the engagement and support they need throughout the process. This compassionate approach fosters a supportive environment that encourages open reporting and participation in safety initiatives.
- **Accountability and Resource Allocation:** Our leaders take responsibility for the safety culture, ensuring that sufficient resources are allocated to support safety improvements. They oversee the implementation of safety actions to completion, reviewing evidence of

their impact to ensure that the desired improvements are achieved and sustained. Accountability mechanisms are in place to track progress and ensure that lessons learned lead to meaningful changes in practice.

Continuous Improvement and Learning

Our approach to continuous improvement involves:

- **Structured incident analysis for continuous Learning**: We integrate a comprehensive process that utilises data from incidents, complaints, and compliments, alongside regular input from teams and feedback from children, families, and staff. This approach enables us to identify effective practices, sense potential risks, and address near misses, fostering a culture of proactive safety enhancement and continuous improvement.
- **Regular engagement with the teams** utilising the quality improvement and clinical education teams to disseminate learning and ensure actions are translated into improvements in care. Actions and learning feed into education and training programmes and inform policy creation and updates.
- **Engagement with families:** Patient safety and Quality improvement leads are responsible for engaging with the families and staff involved in patient safety incidents as well as working with the teams in a proactive manner to sense and address risk before things go wrong.
- **Sharing learnings across the organisation:** to prevent future incidents, facilitated by the patient safety meeting structure as outlined below. As well as developing a system for regularly communicating patient safety learning, investigation updates and news across site in a sensitive manner.

Recognition and Response to Safety Concerns

At The Children's Trust, we take a proactive and thoughtful approach to responding to safety concerns, underpinned by our commitment to learning, transparency, and improvement. Our response process is designed to not only address immediate issues but also to foster a deeper understanding of underlying factors, ensuring comprehensive and sustainable safety enhancements.

- **Acknowledging and Investigating Concerns:** Upon receiving a report of a safety concern, we initiate a structured process that begins with acknowledging the report to the submitter, ensuring they feel heard and valued. Investigations are carried out with a spirit of curiosity, aiming to understand "work as done" rather than just "work as imagined." This approach helps us grasp the realities of our care environment, recognizing the complexities and challenges faced by our staff and patient.
- **Meeting Structure and Triage:** Safety concerns are systematically triaged through our meeting structures, ensuring they are escalated in a proportionate and timely manner. This process allows us to prioritise issues based on their impact on patient safety and the

potential learning that could be acquired, ensuring that critical concerns are addressed with urgency.

- **Duty of Candour and External Reporting:** In line with our Duty of Candour, we maintain transparency with patients, families, and regulatory bodies about incidents that occur, including escalating concerns to relevant external bodies such as Surrey Heartlands ICB or the Local Authority Designated Officer (LADO) and Local Authority Safeguarding Lead for safeguarding concerns when appropriate. This commitment to openness is fundamental to building and maintaining trust with those we serve and work alongside.
- **Quality Improvement and Safety Actions:** Outcomes from investigations are translated into actionable improvements, informed by quality improvement methodologies and patient safety principles. Examples of how learnings are applied include revising care protocols, enhancing staff training programs, and implementing new safety measures. These actions are monitored and evaluated regularly to ensure that learnings are effectively embedded within our practices, leading to tangible improvements in patient care and safety.

4. Patient safety partners

A Patient Safety Partner (PSP) is an individual from outside the organisation, such as a patient, carer, or a member of the public, who brings their personal experience, perspective, and insight into the healthcare setting to help improve patient safety. PSPs are involved in a range of activities including membership on safety and quality committees, contribution to patient safety improvement projects, collaboration with organization boards on safety strategies, participation in staff patient safety training, and involvement in investigation oversight groups. The role of PSPs is pivotal in ensuring that patient safety initiatives are informed by real-world experiences and perspectives, fostering a culture of safety that is truly patient-centred.

The Children's Trust is dedicated to weaving the voices and experiences of patients, their families, and the broader community into the fabric of our safety culture and initiatives. To this end, we are establishing a Patient Safety Partner (PSP) working group, led by our PSIRF oversight team. This group will aim to draw together a diverse mix of children/young people, parents, carers, former patients, and professionals to play an active role in our patient safety framework. Through this inclusive approach, we aspire to create a safety structure that is not only comprehensive but deeply reflective of the needs and insights of those we serve.

We will look to include our PSPs in the following patient safety activities:

- **Active Involvement in Oversight Committees:** We intend to invite PSPs into our oversight committees to ensure that our incident response processes benefit from diverse perspectives.
- **Contribution to Design and Development:** PSPs will play an integral role in the future design and development of our incident response processes. Their engagement ensures that our approaches are patient-centred, addressing real-world needs and priorities for safety improvements.
- **Continuous Engagement and Feedback:** Our policy development and maintenance process are dynamic, benefiting from ongoing feedback from PSPs. This includes regular review sessions where PSPs can share insights and suggestions for enhancing our safety protocols and practices.
- **Training and Empowerment:** we will look to offer our PSPs relevant training in PSIRF, and the approaches and methodologies utilised by the organisation. We will invite them to help design, participate in and contribute to future training programmes for our staff.
- **Promotion of an Open and Just Culture:** The involvement of PSPs underscores our commitment to a culture that values transparency, accountability, and compassion. We ensure that responses to safety concerns are proportionate and that all individuals involved in incidents are treated with respect and understanding.

5. Addressing health inequalities

The Children's Trust is committed to promoting health equality and reducing inequalities through our patient safety incident response processes. Our approach is designed to ensure that all patients, regardless of their specific characteristics, receive safe and equitable care. We achieve this by:

- **Tools for Equity:** The tools and frameworks we use to respond to patient safety incidents are designed to prompt consideration of inequalities. This includes developing safety actions that are mindful of diverse needs, ensuring everyone has access to the highest standards of care.
- **Engagement and Involvement:** Following a patient safety incident, we engage and involve patients, families, and staff, considering their varied needs and perspectives. This approach helps us understand and address any specific concerns related to health inequalities.
- **System-Based Approach and Training:** Upholding a system-based approach to patient safety, we ensure our staff receive relevant training and skill development. This supports the cultivation of a just culture, reduces disparities in disciplinary actions across the workforce, and addresses the root causes of health inequalities.

Through these measures, The Children's Trust aims to continuously monitor and address diversity and inequality, ensuring our patient safety incident response processes contribute to the well-being and equitable treatment of all our patients and staff.

6. Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

6.1 Children/young people and families

The Children's Trust places paramount importance on the active engagement and involvement of children, young people, and their families in our patient safety incident (PSI) response processes. Led by our PSIRF oversight team, our approach is anchored in the principles of the Duty of Candour, ensuring that families are informed in a timely manner whenever incidents occur. We are committed to clear communication, providing specific timeframes, and maintaining follow-up communication to ensure families are kept informed and involved throughout the entire process.

Meaningful apologies need to demonstrate understanding of the potential impacts of the incident on those involved, and a commitment to address their questions and concerns.

Upon recognizing a patient safety incident, The Children's Trust extends an initial apology to those affected, conveying our genuine regret for the harm and its repercussions. This gesture, crucial in maintaining trust and compassion, does not imply liability or assign blame, particularly before thorough investigations are concluded. It reflects our commitment to empathy and accountability, recognizing the distress experienced by patients, families, and our staff.

Our oversight team, serving as dedicated engagement leads, supports this commitment by facilitating access to the learning response leads and ensuring that families are updated on timelines and the progress of investigations. This approach is designed to be compassionate and respectful, prioritising the needs and experiences of those affected.

Monitoring and support by the PSIRF oversight team ensures that our engagement practices are both effective and sensitive to the individual needs of patients and families, embodying our commitment to a just and learning-focused culture.

Furthermore, we actively seek feedback from those involved after the conclusion of the incident investigation process, as part of our continuous effort to improve. This engagement extends beyond the investigation, with the Trust committed to communicating how feedback has been incorporated and improvements have been made to practice, ensuring that our community is aware of the steps taken to enhance safety and care.

National sources of support include:

- National guidance for NHS trusts engaging with bereaved families
- Learning from deaths – Information for families - explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers can comment on care received.
- These two websites offer support and practical guidance for those who have lost a child in infancy or at any age death support:
    - Child bereavement UK.
    - Lullaby Trust
- Complaints advocacy - The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings, and review information given during the complaints.
- Healthwatch - an independent statutory body who can provide information to help make a complaint, including sample letters. You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site
- The Parliamentary and Health Service Ombudsman - makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.
- The Citizen's Advice Bureau provides UK citizens with information about healthcare rights, including how to make a complaint about care received.
- The Child Death Overview Panel The panel review all child deaths in the region and provide guidance, resources and news related to child deaths.

6.2 The Children's Trust Staff

At The Children's Trust, we recognize the pivotal role our staff plays in ensuring patient safety and the emotional and professional challenges they may face, especially when incidents occur. Reflecting this, our approach to engaging and supporting staff includes:

- **Promotion of a Just Culture:** We are committed to fostering a just culture where staff feel supported and confident in reporting safety incidents, knowing that the focus will be on learning and improvement, not blame. This approach is integral to our incident response, complaints, legal, and safeguarding processes, ensuring that staff are treated fairly and with respect.

- **Managerial and Pastoral Support:** Recognising the stress and anxiety that can accompany patient safety incidents, especially those referred to the Local Authority Designated Officer (LADO) or resulting in interim suspension. We will provide comprehensive managerial and pastoral support. This includes access to counselling services, peer support, and clear communication throughout the process to ensure staff feel supported and valued.

- **Sensitive Communication:** We are dedicated to maintaining sensitive and constructive communication with staff involved in incidents and their teams. This

ensures that everyone is kept informed, supported, and involved in the learning and improvement process, reinforcing our collective commitment to patient safety.

- **Continuous Learning and Development:** Staff have access to ongoing training and development opportunities to enhance their skills in patient safety, fostering a culture of continuous improvement and resilience.

By embedding these principles and practices into our patient safety incident response framework, The Children's Trust aims to ensure that staff are not only engaged and involved but also supported and empowered to contribute to a safer, more compassionate care environment.

7. Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, The Children's Trust will explore patient safety incidents relevant to our service and the populations that we serve and identify the potential for learning.

PSIRF guidance specifies the following standards that our plans must reflect:

- A thorough analysis of relevant organisational data
- Collaborative stakeholder engagement
- A clear rationale for the response to each identified patient safety incident type

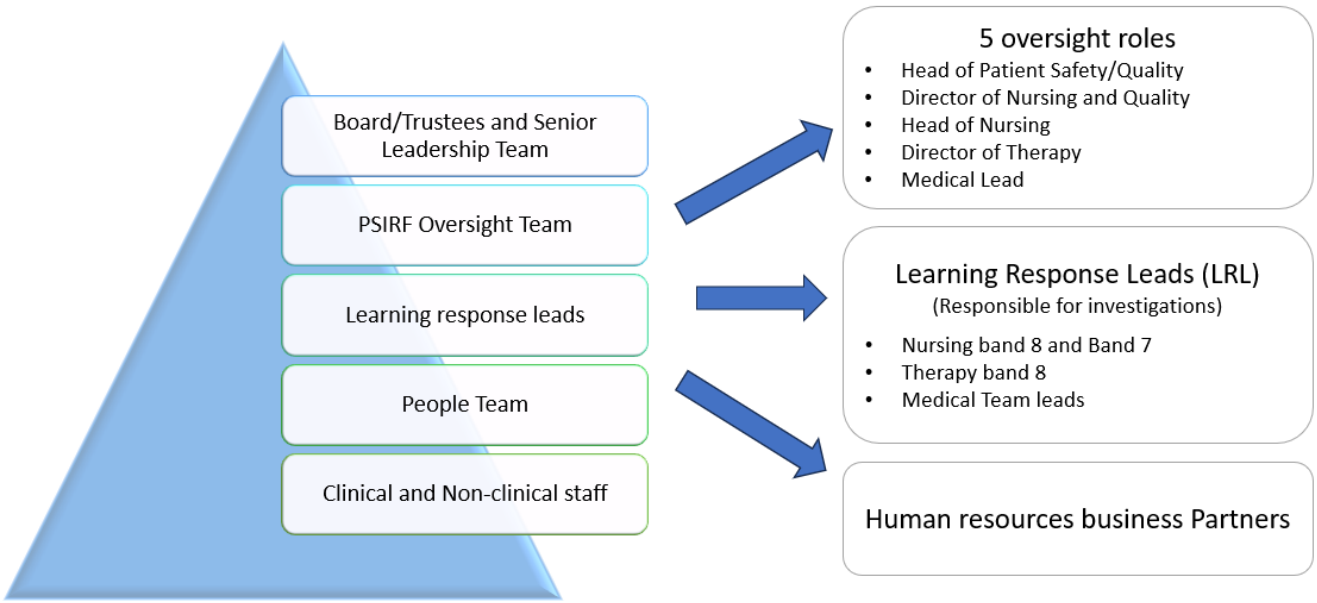
To ensure an effective and proportional response to patient safety, The Children's Trust will integrate careful planning of our existing resources dedicated to patient safety responses and ongoing safety improvement initiatives. This strategic planning will incorporate a broad spectrum of both qualitative and quantitative feedback and intelligence sources, including, but not limited to, incidents, complaints, identified risks, legal claims, safeguarding cases, mortality reviews, and direct feedback from both staff and patients. By taking into collecting this diverse range of inputs, The Children's Trust aims to bolster our patient safety strategies, ensuring they are responsive, comprehensive, and tailored to the specific needs and experiences of those we serve.

7.1 Resources and training to support patient safety incident response.

At The Children's Trust, we are committed to ensuring that adequate resources are available to respond to patient safety incidents effectively and proportionately, in line with the Patient Safety Incident Response Framework (PSIRF) principles.

As we are a relatively small organisation, we are unable to fund a team exclusively dedicated to patient safety and patient safety investigations, therefore we are in the process of integrating the patient safety role into our existing operational structure. This will be a strategic alignment between patent safety and quality improvement and is expected to be fully implemented within the next six months. It aims to bolster our patient safety initiatives through linking patient safety and quality improvement approaches.

To this end, The Children's Trust will appoint a dedicated patient safety lead responsible for overseeing the implementation of the framework and supporting all individuals engaged in the learning and response processes. This dedicated role will ensure a consistent, informed, and comprehensive approach to managing and learning from patient safety incidents, underpinning our commitment to continuous improvement and the well-being of those we serve. By prioritising the allocation of necessary resources—including staffing, training, and technological support—we strive to maintain a robust and responsive patient safety system that meets the high standards of care our patients and their families expect and deserve.



Key roles and responsibilities

In order to meet the requirements of the new NHS National Standards for Patient Safety Investigation we will:

- Assign an appropriately trained member of the board of trustee's team to oversee delivery of the PSII standards and support the sign off of all Patient Safety Incident Investigations (PSII).
- Assign a lead for patient safety to oversee the framework and support all staff involved in the learning response activities.
- The Patient safety lead will work closely with senior clinical teams and the clinical support and education team to plan and monitor actions and initiatives arising from patient safety learning.
- Provide the appropriate training for all senior leadership and board members. *(See appendix 1: TCT PSIRF Training Plan)*
- Identify an appropriate training provider for training at all levels. *(See appendix 1: TCT PSIRF Training Plan)*
- Ensure all staff groups complete the appropriate e-learning training modules. *(See appendix 1: TCT PSIRF Training Plan)*
- Monitor training compliance through our learning and development department and reporting systems.
- Provide accredited face to face training for all staff that will be delegated learning response investigation duties. *(See appendix 1: TCT PSIRF Training Plan)*
- Ensure learning response leads have the time and resources to conduct thorough investigations.
- Provide access to update training for existing investigators or investigation teams/staff in specific areas.
- Produce new documentation and resources for patients, families and staff members involved in patient safety incidents and ensure they are available on our website.
- Regularly seek feedback on our patient safety framework from a broad variety of sources including patients and families to ensure continuous improvement.

7.2 Our patient safety incident response plan

The Children's Trust's plan outlines our approach to managing patient safety incidents over the next 12 to 18 months. Recognising the dynamic nature of healthcare, this plan is designed to be adaptive, allowing us to respond effectively to the unique aspects of each incident and the specific needs of those involved.

Key components of our plan include adherence to national reporting requirements and addressing our local priorities for investigation. These priorities are identified through safety profile analysis and ongoing engagement with our stakeholders.

Following approval by the Board, the PSIRF Plan will be made publicly available on The Children's Trust website. This transparency underscores our commitment to patient safety and

continuous improvement, ensuring we remain accountable to those we serve and to our broader community.

7.3 Reviewing our patient safety incident response policy and plan

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

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

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

8. Responding to patient safety incidents

8.1 Patient safety incident reporting arrangements

Patient Safety Incident (PSI) reporting will remain in line with the organisation's Incident Reporting and Investigation including Duty of Candour' policy which sets out how we raise and respond to all incidents, not just patient safety. All staff regardless of grade or discipline are responsible for reporting any incident, hazardous situation or near miss as soon as the incident occurs or is discovered. All incidents must be reported and logged on the trusts incident and Risk Assessment Reporting (IRAR) system.

Staff are responsible for recognising and identifying any events that deviate from normal, safe operations, including patient safety incidents, hazardous conditions, or near misses. This encompasses any situation that has the potential to cause harm to patients, staff, or visitors, or that poses a significant risk to the quality and safety of care provided by The Children's Trust. Staff must be vigilant and proactive in reporting any concerns, ensuring that incidents are captured comprehensively and accurately to facilitate effective responses and learning.

When reporting incidents using the IRAR system the following severity grading tool is used. Note: This severity rating dictates the urgency of escalation but does not dictate the choice of learning response. Appendix 2

Grade of incident	National Patient Safety Definition
No harm (including prevented safety incidents/near miss)	Incident prevented that had potential to cause harm but was prevented and no harm caused. Incident was not prevented and occurred, but no harm was caused. Near misses may also be caused by negligent acts or omissions.
Low harm	Any safety incident that required extra observation or minor treatment and caused minimal harm. Minor treatment is first aid, additional therapy, or additional medication. Harm may also be caused by negligent acts or omissions.
Moderate harm	Any safety incident that results in a moderate increase in treatment and / or caused significant but not permanent harm. Harm may also be caused by negligent acts or omissions. Moderate increase in treatment is transfer to hospital as in an inpatient or outpatient or prolonged episode of additional care
Severe, significant harm or death	Any safety incident that directly results in death. Serious harm to one or more children, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm Significant harm caused by negligent acts or omissions. A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure, allegations of abuse, adverse media coverage or public concern about the organisation One of the core sets of 'Never Events' outlined by the NPSA

In the context of incident severity grading, our policy outlines a structured notification process.

- For all incident forms completed a notification is sent to the relevant managers and clinical professionals
- Near misses and low harm incidents are addressed as part of the weekly safety huddle meeting.
- For incidents graded as 'Moderate' on the IRAR system, the Head of Nursing and Care or appropriate deputy, is to be immediately notified, ensuring the Duty of Candour is applied appropriately.
- For incidents thought to be 'severe, significant harm or death', immediate notification extends to the Director of Nursing and Quality, Head of Nursing and Care, Medical Director, and Director of Therapy. Again, ensuring the Duty of Candour is applied appropriately.

This ensures a comprehensive and timely response, aligning with our commitment to transparency, accountability, and the highest standards of patient care and safety.

Notifiable Incidents

The following TCT relevant notifications are required by law to be reported to the Care Quality Commission/Ofsted via the Registered Manager,

- Death of a child/young person – that occurred whilst services were being provided. In The Children's Trust School, all deaths must be reported to the minister of education.
- Any abuse or allegation of abuse – abuse in relation to the child/young person means sexual abuse, physical or psychological ill treatment; theft, misuse or misappropriation of money or property; or neglect and acts of omission which cause harm or place at risk of harm. (The Children's Trust Safeguarding Policy)
- Events that stop or may stop the service from running safely and properly – a level of staff absence or vacancy, or damage to the service's premises that mean that people's assessed needs cannot be met; the failure of a utility for more than 24 hours; the failure of fire alarms, call systems or other safety-related equipment for more than 24 hours; and other circumstances or events that mean the service cannot, or may not be able to meet service user assessed needs safely.
- Serious injuries to people who use the service which include injuries that lead to or are likely to lead to permanent damage or damage that lasts or is likely to last more than 28 days: injuries or events leading to psychological harm.
- Where there is any incident relating to a child which the Registered Manager considers to be serious.

Local Authority Social Workers

The child's local authority social worker will be informed of incidents under the Duty of Candour policy for moderate/severe harm. We will report to the Local Authority Designated Officer (LADO) where there is a suspicion of harm caused to a child by any actions/inactions of staff.

Commissioners

The child's commissioner will receive anonymised investigation reports of incidents under the Duty of Candour Policy of moderate or severe harm as above.

External reporting

Incidents are reported to external and internal stakeholders to enable identification of risks for patient safety and potential opportunities for learning and improvement both locally within The Childrens Trust and nationally.

Core external stakeholders (but not limited to)

- Child Death Overview Panel (CDOP)
- Integrated care board (ICB)
- Learning from Patient Safety Events (LFPSE) - system that has replaced the National Reporting Learning System (NRLS) and Strategic Executive Information System (StEIS).
- OFSTED Care
- Care Quality Commissioners

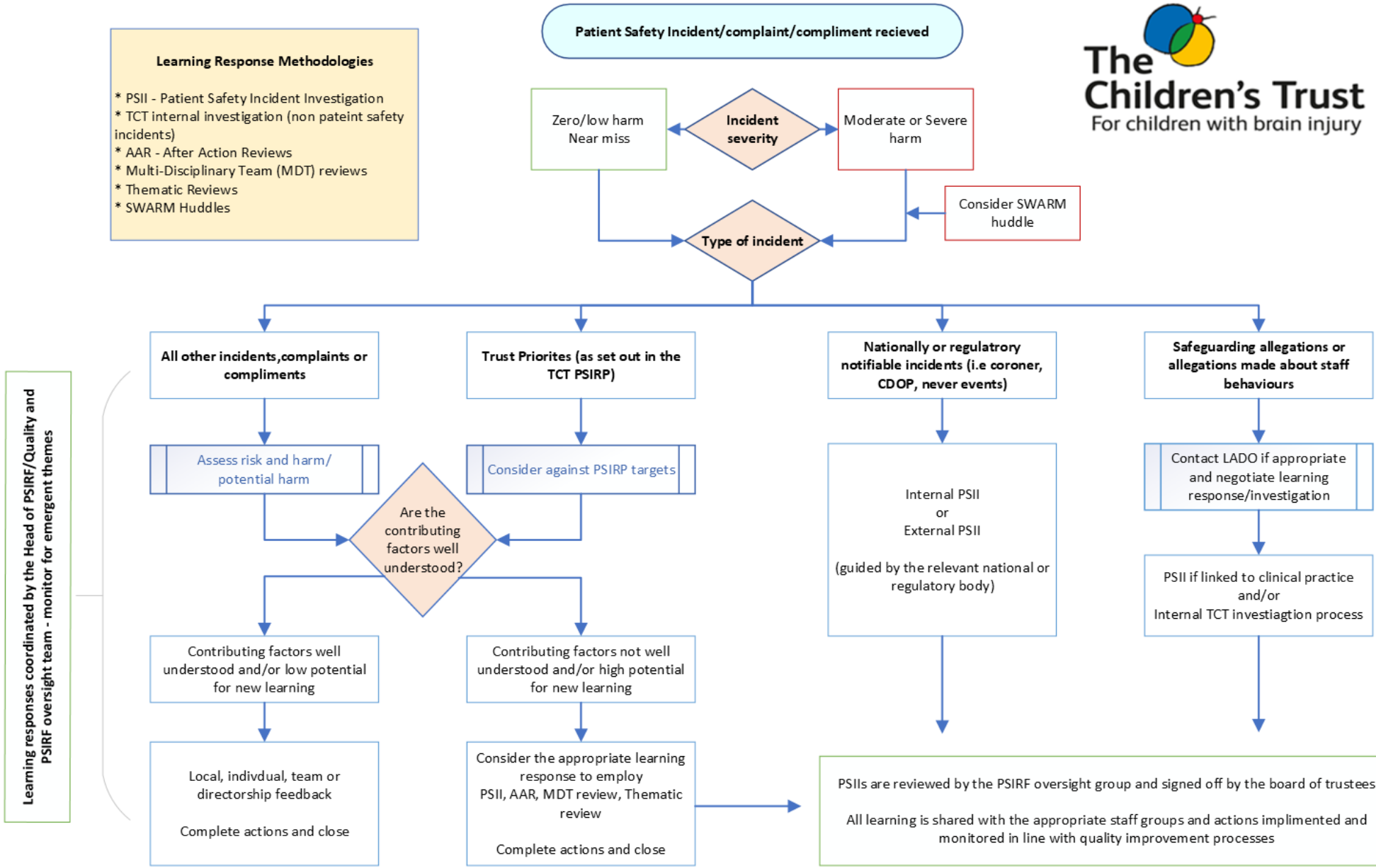
- Health and Safety Executive (HSE) for patients involved in Reporting of Injuries, Diseases, Dangerous occurrence Regulations (RIDDOR) incidents.

Compliments and good practice

At The Children's Trust, our learning extends beyond errors and incidents and we also deeply value insights from positive feedback and compliments. This approach allows us to identify and reinforce good practices, ensuring that excellence in care is recognized and replicated. By celebrating successes alongside analysing challenges, we cultivate a balanced perspective that drives holistic improvement and fosters a positive, learning-oriented culture.

8.2 Patient safety incident response decision-making

The flow diagram on the next page has been created to guide the decision-making process for patient safety incidents at The Children's Trust.


Learning Response Methodologies
* PSII - Patient Safety Incident Investigation
* TCT internal investigation (non pateint safety incidents)
* AAR - After Action Reviews
* Multi-Disciplinary Team (MDT) reviews
* Thematic Reviews
* SWARM Huddles
Patient Safety Incident/complaint/compliment recieved
Zero/low harm
Near miss
Incident severity
Moderate or Severe harm
Consider SWARM huddle
Type of incident
All other incidents,complaints or compliments
Trust Priorites (as set out in the TCT PSIRP)
Nationally or regulatrory notifiable incidents (i.e coroner, CDOP, never events)
Safeguarding allegations or allegations made about staff behaviours
Assess risk and harm/ potential harm
Consider against PSIRP targets
Are the contributing factors well understood?
Internal PSII
or
External PSII
(guided by the relevant national or regulatory body)
Contact LADO if appropriate and negotiate learning response/investigation
PSII if linked to clinical practice
and/or
Internal TCT investiagtion process
Contributing factors well understood and/or low potential for new learning
Contributing factors not well understood and/or high potential for new learning
Local, indivdual, team or directorship feedback
Complete actions and close
Consider the appropriate learning response to employ
PSII, AAR, MDT review, Thematic review
Complete actions and close
PSIIs are reviewed by the PSIRF oversight group and signed off by the board of trustees
All learning is shared with the appropriate staff groups and actions implimented and monitored in line with quality improvement processes
Learning responses coordinated by the Head of PSIRF/Quality and PSIRF oversight team - monitor for emergent themes
The Children's Trust
For children with brain injury

Our protocol serves as the definitive guide for making informed decisions regarding patient safety incident investigations (PSIIs) at The Children's Trust. It underscores that a PSII may be initiated for any incident deemed appropriate by the PSIRF Oversight Team, emphasising the discretionary power to ensure comprehensive safety management.

At The Children's Trust, our approach to patient safety and incident investigations is deeply rooted in systems thinking, utilising methodologies that leverage the SEIPS systems analysis model to understand and improve the interactions between people, processes, and technology within healthcare systems. Our choice of methodology is not driven solely by the severity of an incident but by the potential for organisational learning and improvement. We will employ the templates and guides provided within the PSIRF guidance to ensure our investigations are thorough, consistent, and aligned with best practices. We will adapt our current internal investigation process for safeguarding incidents to incorporate the philosophy and systems thinking from PSIRF. This approach ensures that our patient safety initiatives are comprehensive, focusing on system-wide improvements to enhance the quality of care and patient safety.

Oversight of this process is provided by the Head of PSIRF/Quality alongside the Director of Clinical Services and the PSIRF Oversight Group (PSOG), ensuring each decision aligns with our highest standards of care and safety. As we navigate the implementation of this new process, we anticipate learning and refining our approach to enhance effectiveness and efficiency.

This governance framework is adaptable, acknowledging that adjustments will be necessary as we fully integrate the PSIRF process into our operations.

8.3 Responding to cross-system incidents/issues.

Learning responses will be managed as locally as possible to facilitate the involvement of those affected by and those responsible for delivery of the service in which the incident or issue relates to.

However, where a response involving multiple providers and/or services across a care pathway is too complex for a single provider to manage, ICBs will support the co-ordination of cross-system response.

Where there is insufficient capacity and/or capability, The TCT must engage early with the ICB, which can identify the right person to support the co-ordination of a cross-system learning response.

The ICB lead will liaise with TCT and relevant providers (and other ICBs if necessary) to agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

8.4 Infection Prevention and Control (IPC)

In line with NHS England guidance and our existing Infection Prevention and Control (IPC) procedures and policies The Children's Trust will carry out IPC Reviews under PSIRF where they meet the considerations for wider learning, impact on patient well-being and likelihood of occurrence.

This does not change the current methods of mandatory reporting through HCAI Data Capture System of key alert infections such as MRSA, E. coli, MSSA bacteraemia's and C. difficile.

8.5 Timeframes for learning responses

Patient Safety Incident Investigations

Where a PSII is required, the investigation will start as soon as possible after the patient safety incident is identified.

No specific timeframe is defined but PSIIs, but we will always endeavour to complete them as quickly as possible. Generally, we will aim to complete them within three months of their start date at the latest.

Ideally no PSII will take longer than six months. A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety.

Where the processes of external bodies delay access to information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

Other Investigations

For all other incidents responses, the PSIRF oversight team will set learning response timelines, dependent on the methodology and approach being utilised.

The LADO plays a crucial role in managing safeguarding investigations related to any potential harm caused to children by staff actions or inactions, determining the type of investigation to be used and the setting of timelines to ensure child safety.

Given the urgency, these processes often have tighter timelines, critical for safeguarding child welfare and minimising the impact of potential action such as suspensions. While The Children's Trust may conduct a more detailed learning response beyond this, it's imperative that the statutory and legal obligations of safeguarding investigations are maintained and adhered to.

9 Safety action development and monitoring improvement

In developing and monitoring safety actions, The Children's Trust emphasises the role of the Head of PSIRF/Quality and the Patient Safety Oversight Group (PSOG) in overseeing these activities. This ensures that all safety actions are aligned with the organisation's broader quality objectives.

We will be utilising the SEIPS model and the human factors intervention matrix (HFIX) to ensure actions are systems focused. We will adopt the SMART framework for setting safety actions, making them Specific, Measurable, Achievable, Relevant, and Time-bound.

It is also important that a proportionate number of actions are proposed following a learning response to ensure they are realistic in scale and achievability. To many actions may dilute the impact of improvement initiatives and reduce the organisation's ability to achieve the desired changes to practice

This approach facilitates clear, actionable goals and allows for effective monitoring and evaluation of the impact of these actions, reinforcing our commitment to ongoing improvement in patient safety and care quality.

We will undertake regular reviews of all patient safety and quality improvement actions to ensure they are systems focused and likely to lead to change. The iFACES tool can be used to evaluate the actions created.

Further guidance on this can be found in NHSE Guidance at https://www.england.nhs.uk/wpcontent/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

10. Safety improvement plans

Safety improvement plans bring together findings from patient safety incidents and issues.

The Childrens Trust will:

- Set out its patient safety incident response plan over a period of 12 to 18 months which intends to learn and improve from safety incidents and inform improvement plans.
- Review the output from learning responses as part of the PSOG and quality meetings.
- Create safety improvement plans as required to tackle broad areas for improvement.
- Monitor and adapt the impact of the safety improvement plans at Quality meetings.
- There are no thresholds for when a safety improvement plan must be developed; for example, after completing a certain number of learning responses. The decision to do so must be based on knowledge gained through the learning response process and other relevant data.
- Safety improvement plans will be disseminated through team meetings, service reviews and via a new quarterly TCT "Shared learning from incidents" newsletter.

TCT patient safety governance and learning sharing structure.

The table below outlines our structured meeting framework, ensuring effective management of incidents, investigations, and the authorisation process for Patient Safety Incident Investigations (PSIIs). This structured approach guarantees that critical decisions regarding PSIIs are made in a collaborative and informed manner, with a clear pathway for sharing learnings across the organization. See appendix 4 for our governance structure outlining how learning is shared both internally and externally

Meeting Title	How often?	Purpose of the meeting	Who is involved?
Patient safety huddle	Weekly	All incidents from the previous week are reviewed and appropriate, investigations, actions and responses are proposed and assigned in accordance with the decision-making flow chart	• Head of Nursing/Registered manager • Head of PSIRF/Quality • Head of Clinical Support and Education • Safeguarding team • Clinical quality and compliance manager • Health and Safety Lead
Patient Safety Oversight Group (PSOG) meeting	Every 2 months	To review the progress of all current Patient Safety investigations to ensure they are being conducted using PSIRF methodologies in a timely manner. To review the action logs Final sign off on all investigations except for PSII which are signed off by the senior leadership team and board of trustees	PSIRF oversight team • Director of Nursing and Care • Registered manager • Medical team lead • Head of Quality/PSIRF • Director of Therapy • + Risk and governance team • +/- Senior leadership team
Quality Meeting	Monthly	To review all ongoing quality improvement projects and actions To review the implementation of any learning and actions recommended following investigations.	• All clinical service leads. • Clinical Education • Audit and compliance team
Clinical Governance Meeting	Every 6 weeks	As part of the wider meeting there is a standing agenda item for sharing key learning from incidents complaints, and compliments	• All clinical/service leads, clinical education and key clinical staff
Clinical Governance and Safeguarding Committee	Every 6-8 weeks	Serious incidents and PSII reviewed and signed off here before board ratification	• Directors, service leads and clinical trustees
Board	Quarterly	Final sign off for all PSII	• Board of trustees

Additional meetings relevant to patient safety			
Standing item on all clinical team day agendas	All clinical team away days	To discuss key incidents and learning from across site and to focus on an individual team incidents and learning	• Clinical Staff
Children/young people and family patient safety partners forum	Quarterly	Invitation to discuss patient safety and key lessons learnt with our patients and families	• Head of PSIRF/Quality • Children/Young people and families
Staff patient safety forum	Quarterly	To discuss patient safety initiative with clinical staff and to hear their opinions and ideas	• Head of PSIRF/Quality • Any staff

Test of effectiveness and sustainability

To ensure the sustainability of learning and positive change following patient safety incidents, The Children's Trust is committed to embedding these insights into our daily operations and culture. By integrating lessons learned into policies, practices, and training, we aim to prevent recurrence and promote continuous improvement. Regular review mechanisms and feedback loops will help us monitor the effectiveness of implemented changes, ensuring they are enduring and adapt over time. Through active engagement with staff, patients, and families, we'll foster a collective commitment to a safer, learning-focused environment.

To test the effectiveness of actions and improvement plans from PSIRF investigations, we will use a multi-faceted approach:

- **Ensure Actions are Smart:** This means evaluating whether interventions and actions are designed in a way that success can be measured to demonstrate meaningful change and improvements.
- **Outcome Measurements:** Utilize specific, measurable outcomes related to each action plan, comparing pre- and post-implementation data.
- **Stakeholder Feedback:** Gather insights from patients, families, and staff affected by the changes to gauge satisfaction and impact.
- **Audit and Review:** Conduct regular audits of practice changes against established benchmarks to ensure compliance and effectiveness.
- **Continuous Monitoring:** Implement ongoing monitoring systems for key indicators of success, allowing for real-time adjustments.
- **Learning and Adaptation:** Facilitate forums for sharing learnings and challenges across the organization to foster a culture of continuous improvement.
- **Undertake a yearly review:** Breakdown incident, investigation, actions and feedback data prior to updating our PSIRP.

Each of these strategies can provide valuable insights into the effectiveness of implemented changes, ensuring that improvements are meaningful and sustainable.

11.1 Oversight roles and responsibilities

"When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures".

To achieve this, organisations must look carefully not only at what they need to improve but also what they need to stop doing (e.g. panels to declare or review Serious Incident investigations). Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control."

NHSE, PSIRF Guidance: 'Oversight roles and responsibilities specification and Patient safety incident response standards' (p2)

All Staff

All staff at The Children's Trust play a crucial role in ensuring the safety and well-being of patients. It is everyone's responsibility to be vigilant, promptly report any patient safety incidents, near misses, or unsafe conditions through the organisation's reporting systems, and actively participate in PSIRF processes as required. Staff are encouraged to contribute to a culture of transparency, learning, and continuous improvement, applying principles of care, compassion, and systems thinking to enhance patient safety and care quality across all areas of our service provision.

The Children's Trust Board of Trustees or its Committees:

- **Executive Lead:** Allocating a member of the board to act as executive lead for PSIRF.
- **Accountability**: Hold overall accountability for patient safety and quality within the organization.

Delegated to the clinical trustees as part of the Clinical Governance and Safeguarding Committee

- **Oversight:** Approval and oversight of the PSIRF implementation and updates.
- **Resources:** Ensuring resources and support are allocated for effective PSIRF execution.
- **PSII sign off**: Complete the final sign off of all patient safety incident investigations (PSII only)
- **Ensuring Strategic Alignment:** Confirm that PSIRF initiatives are in harmony with the organisation's broader safety and quality goals.

- **Monitoring and Reporting:** Regularly review progress reports on PSIRF implementation, incident investigations, and action plans, ensuring issues are escalated appropriately.
- **Resource Allocation:** Oversee the distribution of necessary resources to support effective PSIRF execution and continuous improvement efforts.
- **Quality Assurance:** Ensure that learning from PSIRF activities is accurately captured, leading to meaningful improvements in patient safety.

Head of PSIRF/Quality

- **Policy and Plan Development**: Craft and implement comprehensive PSIRF policies and plans.
- **Learning Response Coordination**: Manage the coordination of responses to learning from incidents.
- **Support for Response Leads**: Offer robust support to individuals leading learning responses.
- **Stakeholder Engagement**: Facilitate interaction with the Integrated Care Board (ICB) and external stakeholders, ensuring collaborative efforts.
- **Quality Assurance**: Oversee the quality assurance of reports generated from incident investigations.
- **Staff Support**: Provide support to staff involved in incidents, fostering a culture of care and improvement.
- **PSOG Leadership**: Lead the Patient Safety Oversight Group (PSOG) meetings, driving strategic decisions.
- **Action Coordination**: Ensure that actions derived from learning are effectively implemented and followed up.
- **Reporting and Feedback**: Compile and communicate reports and feedback to Senior Leadership Teams (SLT) and the board.

Patient Safety Oversight Group (PSOG)

- **Strategic Oversight**: Providing strategic direction for patient safety and incident response initiatives.
- **Family Engagement**: Actively involve families in the incident response process, ensuring their needs and concerns are addressed.
- **Allocate resources**: Review incidents and allocate learning response resources to ensure timely reporting and maximise learning form incidents.
- **Review and Approval**: Reviewing learning response quality, conclusions, and actions.
- **Monitoring and Evaluation**: Overseeing the progress of patient safety actions and evaluating their effectiveness in improving safety outcomes.
- **Facilitating Learning**: Encouraging a culture of continuous learning and improvement across the organization. Offer support to learning response leads.
- **Stakeholder Communication**: Ensuring effective communication between all stakeholders involved in patient safety processes.

Learning Response Leads

- **Leading Investigations**: Coordinating and conducting thorough investigations into patient safety incidents.
- **Systems approach**: Conduct learning response investigations using systems thinking approaches such as the SEIPs model.
- **Facilitating Learning**: Extracting and disseminating key learnings from incidents across the organization.
- **Collaboration**: Working closely with clinical teams and support staff to ensure comprehensive incident analysis.
- **Support and Guidance**: Providing support to staff involved in incidents, guiding them through the response process.
- **Action Plan Development**: Creating system focused action plans based on investigation findings to prevent recurrence.

Senior Leadership Team/Clinical Directors

- **Leadership in Patient Safety**: Demonstrating a commitment to patient safety as a core leadership responsibility, setting a positive example for all staff members.
- **Active Investigation Participation**: Collaborating closely with Learning Response Leads during investigations to ensure thorough and comprehensive analysis.
- **Implementation Commitment**: Pledging to adopt and integrate learnings and action items from investigations into everyday practices, enhancing patient safety.
- **Compassionate Support**: Providing empathetic and compassionate support to children, young people, families, and staff affected by incidents, emphasizing the organization's care and concern.
- **Systems Thinking Application**: Utilizing systems thinking in the deployment of actions and quality improvement initiatives, aiming for holistic improvements.
- **Cultivating PSIRF Awareness**: Ensuring that their teams recognize the value and benefits of PSIRF, fostering a culture of safety and continuous improvement across the organization.

12.1 Complaints and appeals.

The Children's Trust is committed to providing consistently high standards of service. All complaints must be handled thoroughly without delay and with the aim of satisfying the complainant, learning from the issues raised whilst being fair and open with those involved.

There is a need to view complaints positively as a valuable contribution to improving services. The Children's Trust is committed to identifying lessons learnt so services can be improved.

The Children's Trust will seek to distinguish between requests for assistance in resolving a problem quickly to the satisfaction of family and those complaints that require further exploration in order to identify learning from the issues raised.

Please follow the TCT Complaints Policy and Procedures

If a complainant is still not satisfied for complaints related to health, contact can be made with:

• The responsible commissioner funding the child/young person's placement,
• The child's local Social Services Department – details from www.direct.gov.uk
• For children on NHS commissioned placements – www.ombudsman.org.uk

If the complainant is still not satisfied about an issue which effects the whole of The Children's Trust School, rather than an individual child a complaint may be made to Ofsted: Tel no: 0300 123 1231 https://contact.ofsted.gov.uk/onlinecomplaints

Staff

In the first instance if a staff member wishes to make a complaint or raise a concern, they can discuss with their line manager. If they would prefer, they can speak directly to the human resources team or whistle blowing champions. Refer to the following polices as appropriate:

- Grievance Policy,
- Bullying Intimidation & Harassment at Work Policy
- Whistleblowing policy.

List of all other relevant policies

- Bruising in children and young people
- Infection prevention and control policy
- Incidents reporting and investigations including duty of candour
- Child protection and safeguarding policy
- End of life policy
- Frequency of monitoring policy
- Managing safeguarding allegations against people who work or volunteer with children
- Medicines management and administration policy
- Medical device and equipment management policy
- Disciplinary policy

Document Change Control

Version	Status	Description (of changes)	Reviewed by	Reviewed/ Issued Date
0.1	Draft	Initial Draft	CGSC	March 2024
1.0	Final	Approved	Board of Trustees	April 2024

1.1	Extended	Extended to Dec 2025 to review implementation of PSIRF within TCT following restructure in N&C including Governance.	QPS Meeting	July 2025

Appendix 1 - The Children's Trust PSIRF Training Matrix

Who	Required courses	Format
Board/Trustees	• Level 1: Essentials of patient safety for boards and senior leadership teams • Level 2: Access to practice 2 • Level 2: Patient safety in the acute sector • Human Factors / Ergonomics (Safety Science) for Patient Safety Level 1	E-learning
Senior Leadership	• Level 1: Essentials of patient safety for boards and senior leadership teams • Level 2: Access to practice 2 • Level 2: Patient safety in the acute sector • Human Factors / Ergonomics (Safety Science) for Patient Safety Level 1	E-learning
PSIRF Oversight	• Systems approach to learning from patient safety incidents – 2 days • Oversight learning from patient safety incidents – 6 hours • Involving those affected by a patient safety incident - 6 hours	Face to Face (or virtual)
Learning Response Leads - LRL (those undertaking investigations) *(On top of e-learning)*	• Systems approach to learning from patient safety incidents –2 days	Face to Face (or virtual)
People Team *(On top of e-learning)*	• Systems approach to learning from patient safety incidents –2 days	Face to Face (or virtual)
All staff – clinical	• Level 1: Essentials of patient safety • Level 2: Access to practice 2 • Level 2: Patient safety in the acute sector • Human Factors / Ergonomics (Safety Science) for Patient Safety Level 1	E-learning
All Staff – Non-clinical	• Level 1: Essentials of patient safety • Level 2: Access to practice 2 • Level 2: Patient safety in the acute sector • Human Factors / Ergonomics (Safety Science) for Patient Safety Level 1	E-learning
Future designated Engagement leads	• Involving those affected by a patient safety incident - 6 hours	Face to Face (or virtual)

Appendix 2 – The Children's Trust incident severity grading tool

(From the TCT Incident Reporting and Investigation including Duty of Candour policy

Grade of incident	National Patient Safety Definition	Actions
No harm (including prevented safety incident/near miss)	Incident prevented that had potential to cause harm but was prevented and no harm caused. Incident not prevented and occurred, but no harm was caused.	Children/parents are not usually contacted or involved in investigations and these types of incidents are outside the scope of Duty of Candour. It is decided locally whether 'no harm' events (including prevented patient safety incidents) are discussed with parents, their families, and carers, depending on local circumstances and what is in the best interest of the child.
Low harm	Any safety incident that required extra observation or minor treatment and caused minimal harm. Minor treatment is first aid, additional therapy, or additional medication.	Unless there are specific indications or the parent requests it, the communication, investigation and analysis of the event, and the implementation of changes will occur at local level with the participation of those directly involved in the event. Reporting to the Clinical Governance team will occur through standard incident reporting mechanisms and be analysed centrally to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. Communication will take the form of an open discussion between the staff. Low incidents are outside the scope of Duty of Candour, but staff should apply the principles of being open.
Moderate harm	Any safety incident that results in a moderate increase in treatment and / or caused significant but not permanent harm. Moderate harm may also be caused by negligent acts or omissions. Moderate increase in treatment is transfer to hospital as in an inpatient or outpatient or prolonged episode of additional care	A higher level of response is required in these circumstances. The Head of Nursing & Care must be notified immediately and be available to provide support and advice during the *Being Open* process. Once the level of harm is validated to be moderate or higher, the 'Being Open' process will be applied. **Apply the Duty of Candour process**
Severe, significant harm or death	Any safety incident that directly results in death.	A higher risk of response is required in these circumstances. The Head of Nursing & Care

	Serious harm to one or more children, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm. A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure; allegations of abuse. adverse media coverage or public concern about the organisation One of the core sets of 'Never Events' outlined by the NPSA	and the Director of Nursing and Quality, Medical Director and Director of Therapies must be notified immediately and be available to provide support and advice during the *Being open* process if required. **Apply the Duty of Candour process**

Appendix 3 - Glossary of terms

TCT (The Children's Trust): Our organisation abbreviated**.**

PSIRF (Patient Safety Incident Review Framework): Defines NHS guidelines for establishing robust systems and processes to address patient safety incidents, focusing on learning, and enhancing patient safety.

PSIRP (Patient Safety Incident Response Plan): A mandate for all entities offering NHS-funded services, applicable to patient safety incidents within both NHS and private healthcare settings.

PSI (Patient Safety Incident): Any unforeseen event that has the potential to, or does, harm one or more patients in healthcare.

PSII (Patient Safety Incident Investigation): Inquiries conducted to unearth contributing factors to an incident, synthesizing findings to pinpoint recurring themes and learning opportunities, culminating in comprehensive improvement strategies.

PSR (Patient Safety Review): An examination of patient safety incidents to pinpoint issues, implement immediate corrective actions, identify enhancement areas, and address concerns from patients, families, or carers, aiming for service improvement.

PSOG (Patient Safety Oversight Group): Led by the head of PSIRF/Quality, this group are responsible for the oversight of all patient safety activities.

Swarm Huddle: An immediate, post-incident safety discussion led by a designated coordinator, involving all relevant participants, fostering open, blame-free dialogue to analyse the incident and assess PSII applicability.

AAR (After Action Review)/Cold Debrief: A reflective discussion, conducted anytime post-incident, allowing participants to evaluate what happened, successes, areas for improvement, and lessons learned.

Thematic Reviews: Comprehensive analyses focusing on patterns or themes across multiple incidents to identify systemic issues and opportunities for widespread organizational learning and improvement.

SEIPS (Systems Engineering Initiative for Patient Safety): A framework for analysing healthcare systems and processes to enhance patient safety by focusing on the interactions among system components.

HFIX (Human Factors Integration): An approach that incorporates human factors principles into healthcare practices and system designs to improve safety, performance, and satisfaction.

Never Event: Incidents that are wholly preventable, with national guidelines and safety recommendations in place to establish strong systemic safeguards.

Duty of Candour: The professional and legal obligation of healthcare providers to maintain openness and honesty with patients when adverse events occur.

LADO (Local Authority Designated Officer): The LADO is responsible for managing and overseeing investigations into allegations or incidents where a child may have been harmed or put at risk due to the actions or inactions of a staff member. Their role is pivotal in determining the necessity and scope of an investigation to ensure child safety and welfare.

ICB (Integrated Care Board): A statutory NHS body responsible for planning healthcare services, managing budgets, and ensuring service provision within a specific region.

SMART Goals: A criteria set for objective setting, ensuring goals are Specific, Measurable, Achievable, Relevant, and Time-bound, facilitating clear, actionable targets.

Appendix 4 – Learning response governance structure

The appendix diagram below illustrates The Children's Trust's comprehensive governance structure, designed to facilitate the flow of information, actions, and learning from patient safety incidents. This structure supports robust internal communication and external sharing, ensuring that insights gained are widely disseminated and integrated into our practices. Through clear reporting lines and designated committees, we ensure accountability and continuous improvement. Our governance framework emphasizes collaboration across all levels of the organization, fostering a culture where patient safety is a shared responsibility and where lessons learned lead to sustained positive changes in care delivery.