

Incident Reporting, Learning and Response Policy



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Review Date

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Date Updated:

May 2026

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Review Date

June 2026

Approved by:

Quality and Patient Safety Sign Off Meeting

Review Date

June 2026

Published Date:

September 2026

Next Review Date

September 2029

Is this policy a **mandatory read**? (tick as appropriate)

Yes ☐ No ☐ If "Yes", select the relevant audience below:

All Staff ☐

Nursing & Care ☐

Doctors ☐

Therapy ☐

Finance ☐

Estates & H&S ☐

People Team ☐

Risk & Governance ☐

Fundraising, Retail & Comms ☐

Policy Publication

The Loop ☒

Main TCT website ☒

School website ☐

1. Purpose and Objectives

The Children's Trust is committed to maintaining an open, transparent and learning-focused culture that promotes patient¹ safety and continuous improvement.

This policy explains how The Children's Trust:

- Identifies, reports and manages incidents, near misses and safety concerns.
- Meets the requirements of the NHS Patient Safety Incident Response Framework (PSIRF).
- Complies with the statutory Duty of Candour.
- Learns from incidents to improve care and reduce the risk of recurrence.
- Supports children and young people, families and staff involved in incidents with compassion.

The policy promotes a systems-based approach focused on learning and improvement and also considers other statutory requirements and processes.

2. Scope

This policy applies to:

- All employees, bank staff, agency workers, volunteers and contractors working for The Children's Trust.
- All incidents, near misses and safety events across all Trust services.

This policy does not replace:

- Human resources related investigations
- Safeguarding investigations (see Safeguarding policy)
- Investigations following deaths: Morbidity & Mortality reviews, Structured Judgement Reviews, Coroner's investigations, Child Death panels (see Child Death Policy)
- Criminal investigations
- Claims management processes
- Complaints processes (see Complaints policy)
- Professional standards processes
- Health and Safety Executive processes
- Freedom to Speak Up process

However, learning from incidents may be conducted alongside and contribute to these processes where appropriate.

¹ Patient refers to all children and young people in our care.

3. Definitions

Acronym or phrase	Definition
Child or Young Person	A child or young person receiving services from The Children's Trust. References to patient means the Child or Young person in our care
Patient Safety Incident	Any unintended or unexpected event that could have, or did, result in harm to a patient.
Near Miss	An event that could have caused harm but did not, either by chance or timely intervention.
Duty of Candour	The legal requirement to be open and honest with patients and families when moderate or severe harm or death has occurred.
PSIRF	The NHS Patient Safety Incident Response Framework which guides how organisations learn from patient safety incidents.
PSII	A Patient Safety Incident Investigation carried out where there is significant potential for learning or system 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.
Human Factors	An approach that incorporates human factors principles into healthcare practices and system designs to improve safety, performance, and satisfaction.
After Action Review	A reflective discussion, conducted anytime post-incident, allowing participants to evaluate what happened, successes, areas for improvement, and lessons learned.
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
Never Event	Incidents that are wholly preventable, with national guidelines and safety recommendations in place to establish strong systemic safeguards.
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

4. Policy Statement

The Children's Trust is committed to:

A Just and Learning Culture

We encourage staff to report incidents and concerns without fear of unfair blame or punishment.

Our approach focuses on understanding why incidents happened, identifying system issues, learning and improving, supporting staff and families, preventing recurrence.

Deliberate unsafe behaviour, gross negligence, capability or conduct issues or unlawful acts require separate management action and statutory pathways.

Transparency and Openness

We will be open and honest when things go wrong, communicate clearly with children and young people, families and staff, apologise where appropriate, share learning and improvements.

Continuous Improvement

Learning from incidents and good practice, complaints, compliments and near misses is used to improve care, reduce risk, develop staff training, improve systems and processes, strengthen safety culture. Data from incidents

will be triangulated with data from other sources, including complaints, compliments and audits to allow better understanding of system issues and focus quality assurance activities.

4.1 Roles and Responsibilities

Board of Trustees is responsible for:

- Supporting and role modelling a positive patient safety culture
- Ensuring appropriate governance arrangements
- Receiving assurance regarding patient safety and learning
- Approving PSIRF arrangements

Chief Executive is responsible for ensuring this policy is implemented organisation-wide

Director of Nursing and Quality is responsible for:

- Overall leadership of patient safety and governance
- Oversight of PSIRF implementation
- Ensuring learning and improvement actions are completed
- External engagement with regulators and commissioners

Directors and Senior Managers are responsible for:

- Ensuring staff understand and follow this policy
- Supporting staff involved in incidents
- Ensuring learning is embedded within services
- Promoting a just culture

Clinical Governance Team (CGT) is responsible for:

- Daily oversight of incidents (Monday – Friday)
- Triaging incidents, allocating Learning Response Leads / Investigators and guiding appropriate pathway / learning response
- Supporting learning responses and investigations
- Monitoring actions and timescales
- Reporting themes and trends
- Supporting external reporting requirements

Learning Response Leads / Investigators are responsible for:

- Conducting learning responses fairly and promptly
- Engaging staff and families appropriately
- Maintaining accurate records
- Completing reports and actions within agreed timescales

All Staff must:

- Report incidents, near misses and concerns promptly
- Participate in learning responses when required
- Complete required training
- Support a positive and open safety culture

5. Reporting Incidents

All incidents, near misses and safety concerns must be reported using the Trust incident reporting system (Vantage). Staff response:

1. Ensure immediate safety.
2. Provide care or treatment required.

3. Inform or escalate to appropriate manager and / or senior on duty.
4. Inform parents/families where appropriate.
5. Record relevant information in clinical/care records.
6. Complete an incident report as soon as possible. Care/clinical incidents should normally be reported before the end of the shift.

6. Incident Severity Levels

A severity grading of harm is used for reporting, escalation and monitoring but does not necessarily dictate the choice of learning response. See appendix for full definitions.

No Harm / Near Miss: An incident that either did not reach the affected person or reached the person but caused no harm.

Low Harm: An incident causing minor temporary harm requiring minimal treatment or observation.

Moderate Harm: An incident causing significant but temporary harm or requiring additional treatment or hospital care.

Severe Harm: An incident resulting in: Permanent harm, Life-saving intervention, Major treatment, Significant psychological harm

Death

7. Duty of Candour

The Children's Trust will comply with the statutory Duty of Candour (CQC Regulation 20²). Statutory Duty of Candour applies where incidents of moderate harm, severe harm or death have occurred. An apology is not an admission of liability.

We will:

1. Inform the family as soon as possible.
2. Offer a sincere apology.
3. Explain what is known at the time.
4. Explain what investigation or learning response will occur.
5. Provide written follow-up.
6. Offer ongoing support.

For low harm or no harm incidents, staff should still follow the principles of openness and honesty in line with professional duty of candour (guidance from NMC³ and GMC⁴). See appendix for further details.

Any Duty of Candour activity needs to be recorded on the Incident System (Vantage) overseen by the Clinical Governance Team (CGT).

8. Learning Responses and Investigations

² <https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/health-social-care-act/regulation-20>

³ <https://www.rcn.org.uk/Get-Help/RCN-advice/duty-of-candour>

⁴ <https://www.gmc-uk.org/professional-standards/the-professional-standards/candour---openness-and-honesty-when-things-go-wrong/the-professional-duty-of-candour>

The Children's Trust uses a range of learning response methods depending on statutory requirements, potential for learning, complexity, risk, impact on patients or services. The response selected is not based solely on the level of harm and should be proportionate

The CGT will triage the reported incident and recommend a learning response based on the above (see appendix for flow chart). This is only a guide and those allocated to review / investigate can decide on the most appropriate learning response when they consider and review the initial information. SWARM huddles may have already taken place, and this should be considered by the investigator as part of their decision making as to next steps to ensure a proportionate and learning focussed approach.

Should new information come to light during an investigation or learning response, the type of investigation can be changed appropriately (see appendix for decision making). During an investigation, should an investigator find information that may require specialist advice (e.g. from Safeguarding team, People team, H&S team, Data Protection Officer) then they must contact them directly and gain advice on next steps.

Other types of investigations

There are some events and incidents that require investigations, external engagement and referrals outside of the Learning response / PSIRF pathway. These include HR / disciplinary, safeguarding, criminal, complaints, misconduct/capability issues, (professional standards), death⁵ and will follow different regulatory requirements.

On these occasions a rapid review including appropriate senior staff will be coordinated by the CGT and decision on next steps made. There may be occasions where a learning response occurs in parallel with other types of investigations, but responsibilities and purpose will be clear from the outset.

Medication related incidents will usually fall under PSIRF learning response process, with the opportunity for system thinking and improvement and individual learning and support where required. Repeated medication errors by the same staff member will trigger a more structured support and improvement plan to ensure clinical competency and Children and Young Peoples safety. For further information refer to The Children's Trust Medicine and Administration Policy⁶

Freedom To Speak Up

Freedom to Speak Up (FTSU) is an independent process within The Children's Trust, however, is recognised there are opportunities for shared learning and data triangulation.

The FTSU guardian receives monthly incident reports that outline themes and trends which can provide further context to the issues and concerns they may have directly received. The FTSU guardian can also contact the Clinical Governance team and request bespoke reports (such as reports regarding a specific subject or location) for the purpose of understanding or triangulating data. The FTSU guardian and Head of Clinical Governance meet monthly to discuss any themes or trends and data is handled and shared appropriately according to Data Protection legislation, professional confidentiality and the principles of FTSU.

Types of Learning Response

Triage / Rapid review: immediate review of information to hand to ascertain level of risk, harm and decide appropriate investigations, communications and notifications. This is not a learning response but a decision-making step in the process.

a) Brief Review / No Further Action: For straightforward incidents where learning is already understood, actions actively being addressed, no new learning is likely, low / no risk.

⁵ For Child deaths refer to TCT Child Death Policy.

⁶ <https://theloop.thechildrenstrust.org.uk/page/10965>

- b) SWARM huddle (immediate):** A structured team discussion to identify learning immediately or shortly after the event. A SWARM is a quick gathering of staff involved in the incident triggered as soon as possible whilst memories are fresh; it considers immediate risks and system issues, captures evidence that maybe helpful and identifies if a more detailed learning response is required.
- c) After Action Review (AAR) (Shortly after):** An AAR is a more structured huddle that gathers staff shortly after an event and asks 4 key questions: what did we expect to happen, what actually happened, why was there a difference, what can we learn or do differently next time. It focusses on the gap between planned processes and systems and the reality of real-world work and includes multiple perspectives of different staff groups. AAR can also be used for complex but successful events to identify what went well and consider how to replicate it.
- d) Thematic Review:** Review of patterns or trends across multiple incidents to identify commonly repeated system issues.
- e) Multidisciplinary Team (MDT) Review:** A collaborative review involving relevant professionals; often used for complex case reviews over a longer time period or involving multiple staff groups.
- f) Patient Safety Incident Investigation (PSII):** A detailed systems-based investigation where there is significant potential for organisational learning. There is an investigation template to use and tools such as SWARM / AAR may be helpful to shape reflective conversations.

9. Investigation Principles

All learning responses should be fair and proportionate, focus on systems and processes, involve staff and families / parental responsible person appropriately, identify contributory factors, produce practical safety improvements and be completed within agreed timescales.

Investigators / Learning Response leads should be **train**ed and supported to conduct learning responses / investigations. This may include line managers providing time away from usual work activities, providing additional training and support. The CGT will provide templates, support and guidance throughout.

The Children's Trust uses systems-based approaches including reflective conversations, PSIRF tools, Human factors principles, SEIPS methodology, Quality improvement methods.

All investigation notes, documents, evidence and summary outcome and learning improvement / actions should be captured on the Incident System (Vantage).

10. Timescales

There are no hard deadlines for learning response investigations but below are some expected / best practice timescales. Investigations should be commenced as soon as possible and those involved and affected kept up to date with progress. Pathways and investigations outside of PSIRF / learning response process may have defined timelines to meet. Investigations taking longer than 3 months require approval through governance processes.

- **Brief Review / No Further Action / SWARM huddles:** normally completed within 7 days.
- **After Action Reviews / MDT review:** normally completed within 28 days.
- **Thematic Reviews and PSII:** normally completed within 3 months, ideally no longer than 6.

11. Engagement and support for CYP, Families and Staff

Children and Young People and their family⁷ involved in, or affected by, an incident will be treated with compassion and respect, receive clear communication and updates, and receive support and signposting for further information

⁷ For Looked After Children with a designated social worker, the SW should be informed and offered the same engagement

and support where required. At the outset of an investigation there will be consideration on the involvement of the child or young person and their family; its appropriateness, practical process and commitment to our duty of candour. Where a child or young person and their family raise concerns or questions relating to the incident these should be included in the investigation. For more serious or complex incidents, the CGT will allocate a named staff member to facilitate communication with the child or young person and their family.

Staff involved in incidents will be supported through a just culture approach, receive managerial and pastoral support, be treated fairly and respectfully and have access to training and guidance. The CGT will allocate PSII investigations to staff who have completed their full 2 day PSIRF training and provide support and guidance for all staff conducting or involved with Learning response and investigation.

12. External Reporting and Notifications

The Trust will report or notify incidents externally where required (see appendix for detail). This may include:

- Care Quality Commission (CQC)
- Ofsted
- Integrated Care Board (ICB)
- Learn from Patient Safety Events (LFPSE)
- Local Authority Designated Officer (LADO)
- Health and Safety Executive (HSE)⁸
- Medicines and Healthcare products Regulatory Agency (MHRA)⁹
- Child Death Overview Panel (CDOP)
- Police
- Charity Commission
- A child or young persons' Designated Social Worker
- Public health agency¹⁰
- Fundraising Regulator

The Children's Trusts Registered Manager should be informed where external notifications are required and oversee the notification process. Notifications / reference numbers and communications need to be added to the incident on the Incident System (Vantage).

13. Governance and Oversight

The Children's Trust maintains governance arrangements to ensure incidents are reviewed appropriately, learning responses are completed on time, actions are monitored, learning is shared, trends are identified, improvements are sustained.

Key Governance Meetings

Weekly Incident Review Meeting

- New incident themes and trends
- Immediate actions

⁸ Incidents that meet the definition under RIDDOR need reporting; please refer to Health and Safety policy

⁹ Medication / device incidents relating to suspect safety concerns, side effects and defects need reporting via Yellow Card scheme

¹⁰ Major infection outbreaks must be reported via local health protection teams. Refer to TCT Infection Control / Major Outbreak policy

- Identify Duty of Candour and notifications required
- Learning response allocation + escalations
- Key shared learning from closed incidents the previous week

Quality and Patient Safety Meeting

- Progress of investigations
- Themes and trends: reported incidents and closed incidents
- Organisational / system learning
- Compliance and assurance
- PSIRF implementation

Quality and Patient Safety Incident and Policy sign off meeting

- Quality of reports
- PSII, Thematic reviews, AAR, MDT review report sign off
- Action completion oversight

Board

- Receives any PSII reports

15. Learning and Improvement

Incident reports, investigation documents, learning and actions are logged, tracked and monitored centrally via the Trust's Incident System (Vantage).

The main purpose of investigations is to identify impactful learning and recommend improvement actions. Investigators will document recommendations on the Investigation System (Vantage) and actions leads will be allocated by the investigator or CGT as required.

Actions must be based on SMART principles: Be proportionate, focus on system improvement, be measurable and achievable, be monitored for effectiveness. Prompts to action leads will be automated via the Incident System (Vantage) and overseen by the CGT.

Any actions or improvements that are considered to be substantial system changes will need to have a Quality Impact Assessment (QIA) completed in advance of change.

Some change actions / improvements will need either auditing or include a Quality Improvement methodology (such as Plan, Do, Study, Act PDSA cycle) so impact and measure of success can be monitored and evaluated.

Summary assurance reports regarding key learning and improvements will be collated by the CGT for the Quality and Patient Safety Meetings.

Learning from incidents will be shared through: Team meetings, Training and education, Safety briefings / message of the week, Bulletins via the Loop, Quality improvement programmes

16. Equality and Inclusion

The Children's Trust is committed to reducing health inequalities and ensuring equitable care.

Learning responses and safety actions will consider individual needs, communication needs, equality and diversity impacts, barriers to safe care.

17. Training

The Trust will ensure staff receive training appropriate to their role. This may include incident reporting, Duty of Candour, PSIRF principles, Human factors, Learning response methodologies, patient safety approaches and quality improvement methodologies. See appendix for training detail.

18. Compliance Monitoring and Review

Compliance with this policy will be monitored through quarterly review and reporting on:

Incident trends, Investigation completeness, Timeliness of learning responses, Duty of Candour compliance, Statutory notifications compliance

This policy will normally be reviewed every three years or sooner if required by: changes in legislation, national guidance, organisational change, learning from incidents.

19. Related Policies

This policy should be read alongside:

- Safeguarding Policy
- Risk Management Policy
- Health and Safety Policy
- Complaints Policy
- Record Keeping Policy
- Infection Prevention and Control Policies
- Medicines Management Policies
- Human Resources Policies
- Sudden Death of a Child Policy
- Freedom to Speak Up Policy

20. References

- NHS Patient Safety Incident Response Framework (PSIRF)
- NHS England Patient Safety Guidance
- Health and Social Care Act 2008
- Duty of Candour Regulations
- Health and Safety at Work Act 1974
- Children Act 1989
- Care Quality Commission Guidance

Document Change Control

Version	Status	Description (of changes)	Reviewed by	Reviewed/ Issued Date
0.1	Draft			
0.2	Draft			
1.0	Final			

1.1	Draft			
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APPENDIX 1: Physical Harm Severity definitions¹¹

Grade of incident	National Patient Safety Definition (LFPSE)
No harm	No harm
Low physical harm	All of the following apply - minimal harm occurred – patient(s) required extra observation or minor treatment - did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit - did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication - did not or is unlikely to affect that patient's independence - did not or is unlikely to affect the success of treatment for existing health conditions.
Moderate physical harm	at least one of the following apply: - has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention - has limited or is likely to limit the patient's independence, but for less than 6 months - has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm
Severe physical harm	at least one of the following apply: - permanent harm/permanent alteration of the physiology - needed immediate life-saving clinical intervention - is likely to have reduced the patient's life expectancy - needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment - has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions - has limited or is likely to limit the patient's independence for 6 months or more.
Fatal	at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death,

¹¹ Ref: <https://www.england.nhs.uk/long-read/policy-guidance-on-recording-patient-safety-events-and-levels-of-harm>

APPENDIX 2: Psychological Harm Severity Definitions¹²

Grade of incident	National Patient Safety Definition (LFPSE)
No psychological harm	Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm
Low psychological harm	at least one of the following apply: • distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit • distress that did not or is unlikely to affect the patient's normal activities for more than a few days • distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition
Moderate psychological harm	at least one of the following apply: • distress that did or is likely to need a course of treatment that extends for less than six months • distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months
Severe psychological harm	at least one of the following apply: • distress that did or is likely to need a course of treatment that continues for more than six months • distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

¹² <https://www.england.nhs.uk/long-read/policy-guidance-on-recording-patient-safety-events-and-levels-of-harm>

APPENDIX 3: 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 of children under 18 must be reported to Department of Education and Ofsted, Local Authority and Child Death Review partners + CQC (Regulation 16&17).
- Any abuse or allegation of abuse in relation to the child/young person. Refer to TCT 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.
- Service management changes (CQC Regulation 14, 15 & 21)
- Serious Incidents and injuries to people who use the service (CQC Regulation 18)
- Where there is any incident relating to a child which the Registered Manager considers to be serious.

A full list of notifications required by the Care Quality Commission can be found here:

<https://www.cqc.org.uk/guidance-regulation/providers/registration/guidance>

Ofsted guidance on required notifications can be found here: <https://www.gov.uk/guidance/tell-ofsted-about-a-serious-incident-in-a-childrens-home-or-secure-childrens-home>

If someone has died or has been injured because of a work-related accident, this may have to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). Please Refer to Health and Safety policy for RIDDOR¹³ procedure and seek advice from the Head of Health and Safety.

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 (refer to Safeguarding policy)

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 Children's Trust and nationally.

Core external stakeholders (but not limited to)

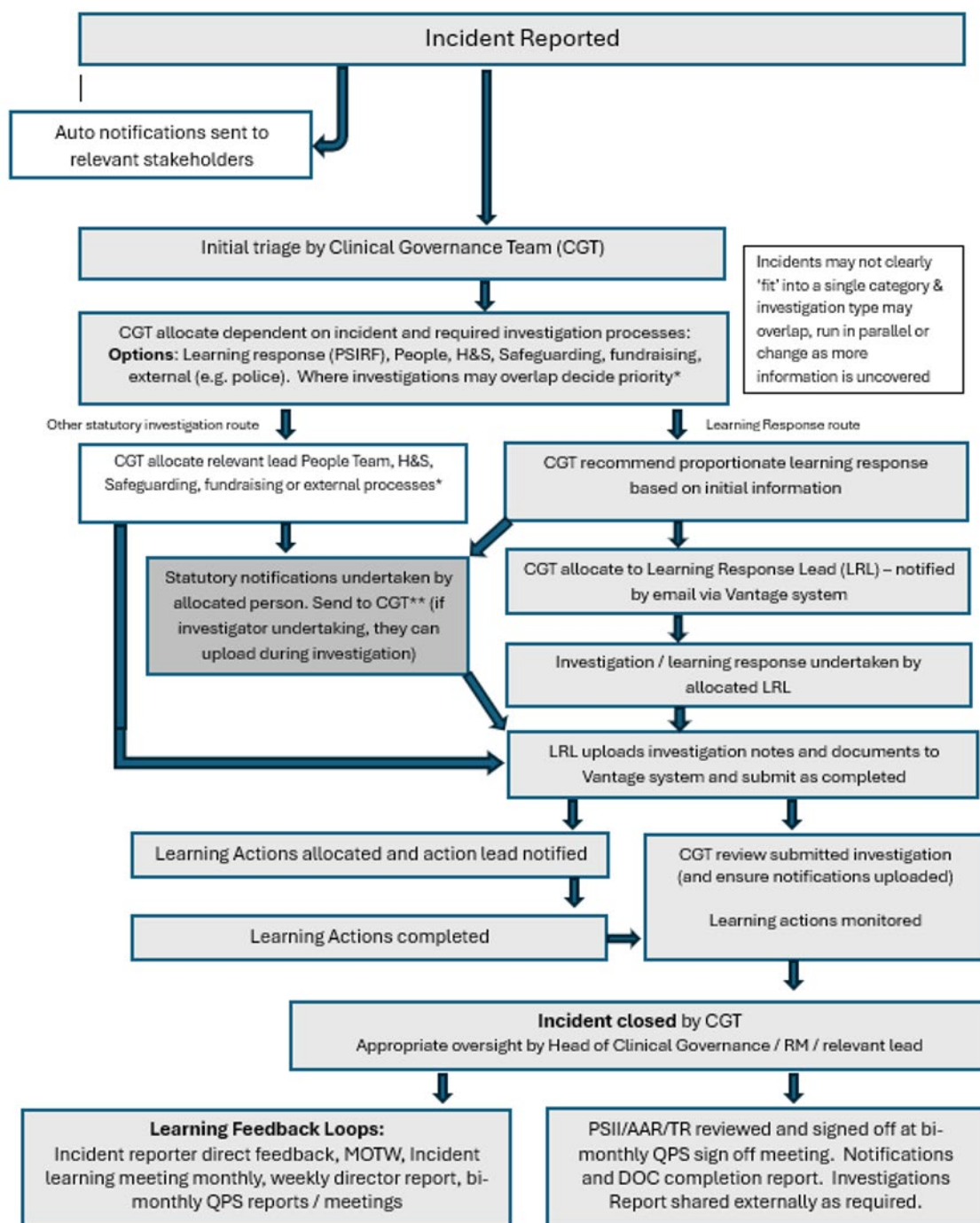
- Child Death Overview Panel (CDOP)
- Integrated care board (ICB)
- Learning from Patient Safety Events (LFPSE)
- OFSTED Care
- Local Authority
- Health and Safety Executive under RIDDOR incidents
- Care Quality Commission
- Information Commissioners Office
- Fundraising Regulator
- Charity Commission

¹³ <https://www.hse.gov.uk/riddor>

APPENDIX 4: PSIRF related

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)

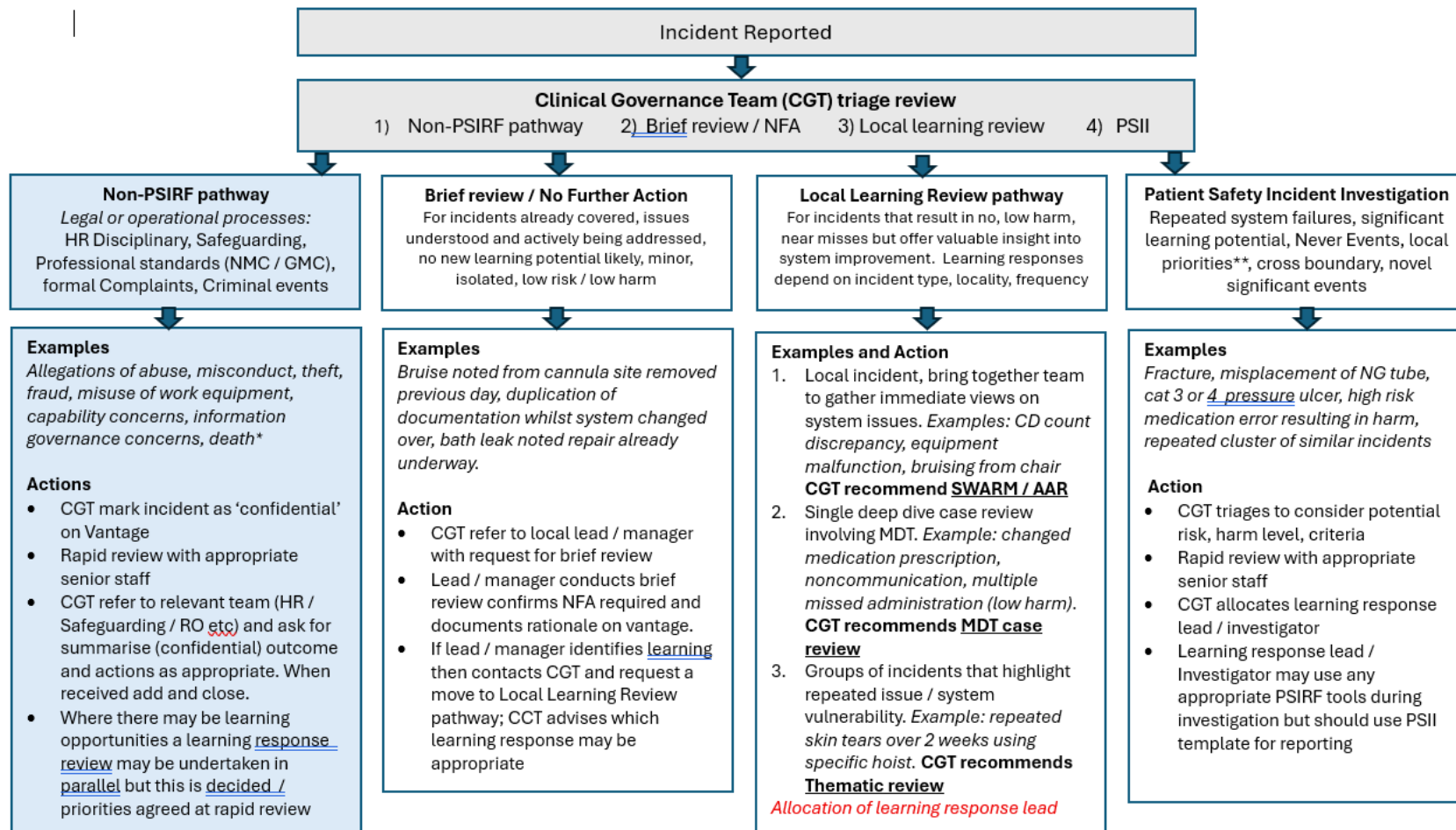
APPENDIX 5: Incident management flowchart



*relevant leads to decide appropriate investigator or referrer if external.

**send to clinical.governance@thechildrenstrust.org.uk

APPENDIX 6: Triage / decision on learning response



*Death of a child will trigger a number of statutory and regulatory processes including CDR processes, safeguarding practice review, LeDeR, SJR and notifications. A PSII may also be undertaken. A rapid review will identify the processes to be followed and priorities.

**local priorities may trigger PSII. This means incidents relating to the following may have a lower threshold for considering a PSII or other learning response: Medication safety, PEWS / ISBR, food and nutrition, Respiratory skills and knowledge, children wellbeing including bruising / injuries / behaviour