University Hospitals of Leicester NHS Trust

UHL Patient Safety Incident Response Policy

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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) under the NHS Patient Safety Strategy[i] and sets out University Hospitals of Leicester (UHL) NHS Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds a 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.

This policy should be read in conjunction with our current patient safety incident response plan[ii], which is a separate document setting out how this policy will be implemented. Specific objectives have been set out within our PSIR Plan to ensure we meet the four keys aims of PSIRF.

This policy format is set nationally in line with the national PSIRF planning resources.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust. Any response that seeks to find liability, accountability or causality is beyond the scope of this policy.

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

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. Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes as those listed below and are therefore outside of the scope this policy:

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

For clarity, the Trust considers these processes as separate from any patient safety investigation. Information from a patient safety response process can be used to support learning and improvement with those leading other types of responses, providing their application complies with any wider requirements, but other processes should not influence the remit of a patient safety incident response.

Our patient safety culture

UHL is committed to creating a positive safety culture in line with the NHS Patient Safety Strategy and the CQC quality statement "We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices."

A positive safety culture is defined as one where the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all.
- The UHL Safety Culture Steering Group will work to ensure the organisation promotes a positive safety culture through a focus on the workstreams noted below:
- Just & Restorative Learning Culture
- Psychological Safety and support for staff when an incident has occurred
- Civility (to include promoting diverse and inclusive behaviours)

PSIRF will enhance our Safety Culture work at UHL by creating much stronger links between a patient safety incident and learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at such learning and improvement within the culture we hope to foster. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoidability or cause of death.

We will utilise findings from our annual NHS National Staff Survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture. We will also look to undertake quarterly UHL pulse checks of the same metrics set within the National NHS National Staff Survey in addition to analysis of our incident reporting trends for all patient safety incidents including prevented patient safety incidents.

Patient safety partners

The NHS Patient Safety Strategy 2019 sets out of the NHS Framework for Involving Patients in Patient Safety where there is a requirement for patients and the public to be involved in the patient safety governance and management processes of an NHS organisation.

At UHL as part of our commitment to working with patients and the public we are actively working to achieve this through the recruitment, training and development of a minimum of 3 Patient Safety Partners (PSPs) for University Hospitals of Leicester (UHL). The post holders have a 2-year tenure to ensure the role remains aligned to the patient safety agenda.

The PSPs will support effective safety governance at all levels within our organisation by working as 'knowledge brokers' working in partnership with the patients, public and staff to provide their lived experience as a patient, carer, family member or a member of the local community to support and advise us on patient safety, resulting in a patient-centred approach to provide safer healthcare. Our PSPs will be involved in supporting us to design and maintain a safer healthcare system at all levels of our organisation through a variety of areas such as:

- working alongside our staff, patients, and volunteers,
- active membership in the Trust's safety oversight committees and groups,
- participation in investigation oversight groups.
- co-designing information material for patients and the public.
- encouraging Patients, Families and Carers to play an active role in their safety.
- contributing to safety recommendations following investigation, particularly around actions that address the needs of patients.
- contributing to staff patient safety training as required.

The PSPs will be supported in their role by a Patient Safety Specialist who will provide guidance and expectations of the role in addition to regular support meetings. Training needs will be agreed based on the individual knowledge and experience of each PSP.

Addressing health inequalities

UHL recognises it has a key role to play in tackling health inequalities in partnership with our local partner agencies and services by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

We are committed to delivering on statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.

Through implementation of PSIRF, we will seek to utilise data and learning from investigations to identify which actual and potential health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our processes.

We will also address apparent health inequalities as part of our safety improvement work. In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy. We consider this as an integral part of the future development process. Our current PSIRP has two local priorities related to tackling health inequalities.

Engagement of patient, families and staff following a patient safety incident will recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues will be identified through the review process and engagement with patients and families, for example, during the duty of candour / being open process. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

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

We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers and our staff to prevent recurrence.

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.

Patients & Families

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers. We also recognise from experience that patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents, and / or may have different questions or needs to that of our organisation.

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

As well as meeting our regulatory and professional requirements for Duty of Candour (Trust Reference: B42/2010), we want to be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident. All patient safety incidents will be reported utilising the Trust incident reporting and management system. Patients, and families as appropriate, will be provided with full details of the patient safety incident and offered support initially by the clinical team involved in their care.

Staff

Involvement of staff and colleagues (including our partner agencies) is of paramount importance when responding to a patient safety incident to ensure a holistic and inclusive approach from the outset. This reinforces existing guidance[iii] of using a Just Culture approach where restorative learning and reflection is encouraged.

It is recognised that this new approach will represent a culture shift for the organisation which needs to provide support and guidance utilising the principles of good change management, so staff feel ‘part of’ rather than ‘done to’. We will therefore ensure regular communication and involvement through our Safety Culture group which is a collaborative work between People Services and Patient Safety team.

We will continue to promote, support and encourage our colleagues and partners to report any incident, near-misses or examples of good care. It is also recognised that staff and colleagues

need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame. We will continue to closely monitor incident reporting levels and continue promote an open and just culture to support this.

Support for Staff following a Patient Safety Incident will initially be through line manager support and access to but access to the Trust wellbeing support, Occupational Health and AMICA staff counselling services will all be available. We are strengthening our support for staff following an incident with our Trauma Risk Management (TRiM) support system which is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event.

All staff who feel unfairly treated following a Patient Safety Incident will be encouraged to liaise with the Patient Safety Team or the Trust Freedom to Speak Up service.

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, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

UHL welcomes this approach as it allows for proportionate responses to patient safety incidents allowing us to focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and maximising improvement for patient safety.

It is also recognised that our planning needs to account for other sources of feedback and intelligence such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. PSIRF guidance specifies the following standards that our plans should reflect:

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

Our Patient Safety Incident Response Plan (PSIRP) reflects these standards and how they will be achieved alongside how the Trust will meet both national and local focus for patient safety incident responses.

Our PSIRP will also be:

- Updated as required and in accordance with emerging intelligence and improvement efforts
- Published on our external facing website

Resources and training to support patient safety incident response

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. It is therefore essential that as an organisation we evaluate our capacity and resources to deliver our plan. Our PSIRP details more specifically which incidents will require a comprehensive investigation, led by the Patient Safety Team, with an indication of how many of these we expect to complete in a year. The PSIRP also provides more specific details in relation to the number of comprehensive investigations that may be required for single or small groups of incidents that do not fall into one of the broader improvements workstreams/priorities.

UHL has four designated Patient Safety Specialists. Currently the support to facilitate the PSIRF framework is from within the corporate Patient Safety Team and the Womens and Childrens Patient Safety Team.

There are trained learning response leads across the organisation who lead incident responses for their areas such as in Safeguarding, Radiation Protection, Radiotherapy, Falls and Blood Transfusion. The Patient Safety Team are also providing further training to incident response leads identified within each Clinical Management Group (CMG). It is therefore expected that CMG

leads will involve all relevant staff in more routine / low risk incident reviews, though further advice and guidance can always be provided by the Patient Safety Team if required.

The national requirement is for all staff to undertake the Level 1 NHS patient safety syllabus e-learning on Essentials of Patient Safety. On 1 August 2023 this was added to our e-learning HELM system as Essential to Role for all staff.

It is important that the organisation seeks regular feedback from colleagues with regard to investigating and learning from incidents and considers whether any additional or bespoke training is required, either more widely or targeted at specific staff groups or individuals.

UHL's Patient Safety Incident Response Plan (PSIR Plan)

Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 18 months from 1st April 2024 to 1st October 2025. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Our PSIR Plan is based on a comprehensive analysis of our patient safety risk profile across all services within UHL over the past three years with collaboration with our stakeholders.

The five local priorities identified in our PSIR Plan will be regularly reviewed against patient safety data reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

Reviewing our patient safety incident response policy and plan

Our PSIR Plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 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 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.

Responding to patient safety incidents

PSIRF guidance[iv] states:

"Where an incident type is well understood – for example, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness – resources may be better directed at improvement rather than repeat investigation (or other type of learning response)."

Patient safety incident reporting arrangements

Patient safety incident reporting will remain in line with the existing Trust policy on reporting, management, review and learning from incidents (Trust Reference: A10/2002). It is recognised that staff must continue to feel supported and able to report any incidents, or concerns in relation to patient safety, to promote a system of continuous improvement and a just and open culture.

All staff are responsible for reporting any potential or actual patient safety incident on the Trust incident reporting system (Datix) and will record the level of harm they know has been experienced by the person affected.

CMGs will have regular review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where Duty of Candour applies (Trust Reference: B42/2010). Most incidents will only require local review within the service, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated within the CMG and through the reporting mechanisms within the Trust's PSIRF Governance Process outlined in Appendix 1.

CMGs will highlight to the Patient Safety Team any incident which appears to meet the requirement for reporting externally. This may be to allow the Trust to work in a transparent and collaborative way with our ICB or regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

The Patient Safety team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

Certain incidents require external reporting to national bodies such as MSNI, HSE, RIDDOR and MHRA. Please refer to the Trusts Incident Reporting Policy for full details and guidance.

Patient safety incident response decision-making

Initial trigger for a further investigation will most commonly be made via the weekly Executive Team Incident Review Meeting (see Appendix 1), however this can also be initiated by any Executive Directors or their deputies, Head of Patient Safety or any CMG Triumvirate Member

The Patient Safety Team will provide regular reports to CMG Quality and Safety Boards including analysis on a monthly basis to identify and track emerging themes and trends outside of normal variation. This information will be reviewed regularly against our identified priorities in the PSIRP

to determine whether any shift in focus is required, which will be agreed by the Patient Safety Learning and Improvement Committee if required.

As outlined in the Trust's policy on reporting, management, review and learning from incidents (Trust Reference: A10/2002), the process for completion of a review will remain for those incidents that have caused moderate and above harm, may meet national or local priority criteria, or have the potential to cause harm in future in order to determine any further response. Working under PSIRF will provide a wider range of options for applying different types of learning tools. The PSIRF principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to the decision making under the Trust's PSIRP. This may often mean no further investigation is required, especially where the incident falls within one of the improvement themes identified in the PSIRP or other improvement programmes or where local actions have already been taken.

Responding to cross-system incidents/issues

All incidents recommended for external review, following initial managerial review, will be shared via the nominated Patient Safety Team lead. The sharing of incidents will always be coordinated between Patient Safety Team to patient safety team across organisations. The Trust will work closely with the system partners and local ICB teams to ensure clear lines of sharing information.

All concerns and incidents reported by partner organisations go through our 'Transferring Care Safely' concerns process and are all reported onto the Datix system. These are subject to triage and will be escalated to the Patient Safety Team if a concern meets the threshold for a harm incident, an incident with potential for future harm or an incident that meets the threshold for national or local priorities within our PSIR plan.

Managerial review and response will be completed by the relevant service team and any additional reviews will be triggered as with internally reported incidents. Themes from externally reported concerns and incidents are used in the triangulation for our quarterly patient safety thematic reviews.

Where incident investigation beyond managerial review demonstrates overlap with another local provider, a joint investigation will be completed. The recommendation for response type will be considered internally and then negotiated with the other organisation to agree a clear response route and Terms of Reference.

Timeframes for learning responses

Timescales for a PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within two to three months of their start date.

No local PSII should take longer than six months.

The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. There must be a balance 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 or require further checks to ensure they remain relevant.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between UHL and those affected.

Timescales for other forms of learning response

A learning response must be started as soon as possible after the patient safety incident is identified and the timeframes will be agreed with the patient and/or their family.

Safety action development and monitoring improvement

PSIRF moves away from the identification of 'recommendations' which may lead to premature attempts to devise a solution. UHL acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed. Safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from CMGs and the support of the Quality Improvement team with their improvement expertise.

The Trust will have systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm and areas for improvement. The Trust will generate safety actions in relation to each of these defined areas for improvement. Following this, the Trust will have measures to monitor any safety action and set out review steps.

Safety action development

UHL will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

- Agree areas for improvement – specify where improvement is needed, without defining solutions
- Define the context – this will allow agreement on the approach to be taken to safety action development.
- Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved.
- Prioritise safety actions to decide on testing for implementation
- Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics
- Safety actions will be clearly written and follow SMART principles and have a designated owner.

Safety action monitoring

Safety actions must continue to be monitored within the CMG governance arrangements to ensure that any actions put in place remain impactful and sustainable. CMG reporting on the progress with safety actions including the outcomes of any measurements will be made to the Patient Safety Learning and Improvement Committee (Appendix 1).

Safety improvement plans

As referred to throughout the policy, the Trust has developed a Patient Safety Incident Response Plan (PSIRP) that clarifies what our improvement priorities are. The PSIRP details how we will ensure patient safety incidents are investigated in a more holistic and inclusive way, to identify learning and safety actions which will reduce risk and improve safety and quality.

These themes, as detailed in the PSIRP, are based on an extensive analysis of historic data and information from a range of sources (eg: incident trends, complaints, mortality reviews, risk registers, legal claims and inquests) and feedback from staff and patients. Each theme will have its own improvement plan utilising QI methodology, where appropriate, to determine what the key drivers are to patient safety risks, how improvements can be made and how these can be monitored for completion and effectiveness. Whilst the PSIRP identifies the broad organisational priorities, it is recognised there may be more specific priorities and improvements identified at a CMG and service level, which although will not form part of the overarching plan, can still be approached utilising the more holistic and inclusive PSIRF approach. The Patient Safety Team will provide support and guidance, as required, to services and CMGs in this regard. The Quality Improvement (QI) team can also assist in these improvements and identify where there is overlap with existing and developing QI programmes across the Trust.

Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed. These will be identified through CMG governance processes and reporting to the Patient Safety Learning and Improvement Committee who may commission a safety improvement plan. Again, the CMGs will work collaboratively with the Patient Safety Team and the Quality Improvement teams and others to ensure there is an aligned approach to development of the plan and resultant improvement efforts. Monitoring of progress with regard to safety improvement plans will be overseen by reporting by the designated lead to the Patient Safety Learning and Improvement Committee on a scheduled basis.

The agreed governance processes in line with the PSIRF guidance so it is clear how the PSIRP improvement priorities will be overseen through CMG and Corporate governance structures and processes. CMG and service level improvements will be managed locally with assurance and reporting to CMG Boards and Corporate oversight and assurance committees to provide ‘ward to board’ assurance.

Oversight roles and responsibilities

Under PSIRF, oversight systems should focus on engagement and empowerment leading to improvement rather than the more traditional command and control compliance of centrally mandated measures.

UHL has developed a PSIRF governance structure (Appendix 1) to enable effective patient safety incident management oversight in addition to learning and safety action oversight to monitor completion and monitor effectiveness.

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission, we have specific organisational responsibilities with PSIRF.

In order to meet these responsibilities, the Trust has designated the Chief Nurse to support PSIRF as the executive lead.

Ensuring that the organisation meets the national patient safety standards

The Chief Nurse will oversee the development, review and approval of the Trust's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the restorative just working culture that the Trust aspires to.

To achieve the development of the plan and policy, the Trust will be supported by internal resources within the Patient Safety team led by the Head of Patient Safety who reports to the Chief Nurse.

To define its patient safety and safety improvement profile, the Trust will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders.

Ensuring that PSIRF is central to overarching safety governance arrangements

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms of the Quality Committee and Patient Safety Committee. Both committees will comprise oversight question responses to ensure that the Trust Board has a formative and continuous understanding of organisational safety.

The Patient Safety Committee will provide assurance to the Quality Committee that PSIRF and related workstreams have been implemented to the highest standards. CMGs will be expected to report on their patient safety incident learning responses and outcomes. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.

CMGs will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

The Trust will source necessary patient safety training across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

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

Quality assuring learning response outputs

The Trust will revise the current terms of reference of the Adverse Events Committee to align with the principles of PSIRF to create a Patient Safety Learning and Improvement Committee. This committee will ensure that PSIIs are conducted to the highest standards, support the executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed.

Complaints and appeals

Concerns and complaints are a valuable resource for monitoring and improving patient safety.

Any complaints relating to this guidance, or its implementation can be raised informally with the Trust's Head of Patient Safety, initially, who will aim to resolve any concerns as appropriate.

UHL recognises that there will be occasions when patients, residents, family members or advocates are dissatisfied with aspects of the care and services provided. Formal complaints from patients or families can be raised through the Trust's complaints procedure at https://www.leicestershospitals.nhs.uk/patients/patient-welfare/patient-advice-and-liaison-service-pals/

Process for monitoring compliance

The audit criteria for this policy and the process to be used for monitoring compliance are given in the Policy Monitoring table below:

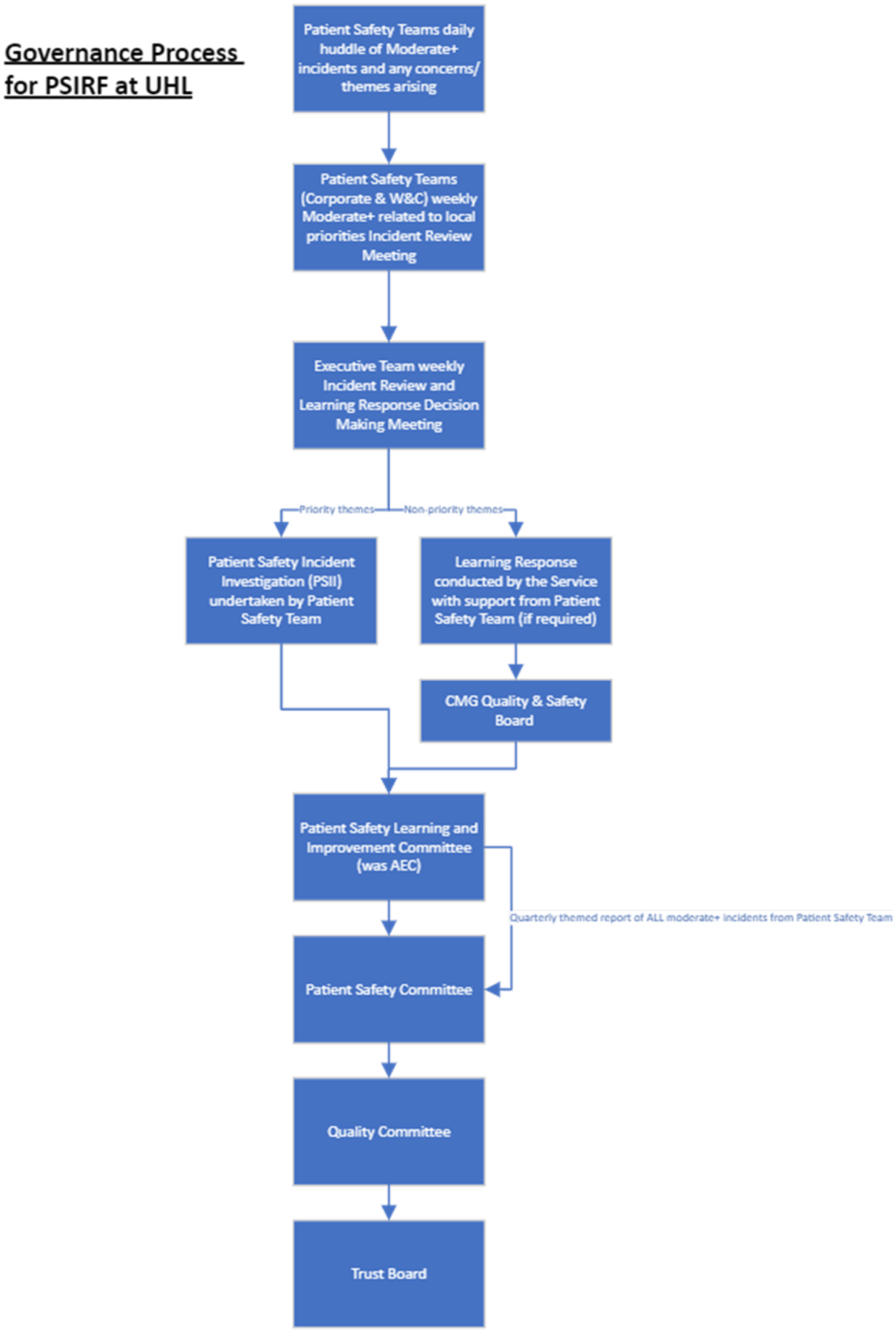
Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Consistent application of this policy	CMG/ Directorate Senior Leadership Teams	Feedback from CMG/Directorate representatives on patient safety incident responses	Weekly	Weekly Executive Patient Safety Incident Review Meeting
Ensuring resources and training support for patient safety incident response types	Corporate Patient Safety Team and W&C Patient Safety Team	Monitoring of PSIRF face to face training uptake and Essential to Role training 'Essentials of Patient Safety' via HELM	Quarterly	Patient Safety Learning and Improvement Committee/Patient Safety Committee
Monitoring learning and improvement outputs	CMG/ Directorate Senior Leadership Teams/Corporate Patient Safety Team	Datix – closed Patient Safety Incidents	Quarterly and annual reports	CMG Board Meetings/ Patient Safety Learning and Improvement Committee/Patient Safety Committee

Equality impact assessment

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Appendix 1: Governance process



Supporting references, evidence base and related policies

[i] NHS Patient Safety Strategy https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf
[ii] UHL PSIR Plan 2024 https://www.leicestershospitals.nhs.uk/aboutus/our-purpose-strategy-and-values/patient-safety/
[iii] NHS Patient Safety Just Culture Guide https://www.england.nhs.uk/patient-safety/a-just-culture-guide/
[iv] PSIRF supporting guidance, Guide to responding proportionately to patient safety incidents. NHSE 2022. https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1-FINAL.pdf