Patient Safety Incident Response Framework Policy

STNH649

Policy Information

Author	Michael Pollington/Sharon Basson
Role	Corporate Governance Manager/Director of Care
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Sharon Basson	12.03.25	2	Updates in line with PSIRF Plan

Equality & Diversity

This document has been assessed for equality impact. This policy is applicable to every member of staff within the organisation, irrespective of their age, caring responsibilities, disability, ethnic origin, gender, gender expression, gender identity, gender re-assignment, marital or civil partnership status, maternity or pregnancy status, race, religion or belief and sexual preference.

Contents

1 Introduction

The NHS Patient Safety Incident Response Framework (PSIRF) was launched in 2022, to be fully implemented in hospices as early as possible. It is a contractual requirement for the hospice and replaces the Serious Incident Framework, 2015

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out St Nicholas Hospice's (Hospice) approach to developing and maintaining effective and proportionate 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.

2 Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Hospice.

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. Out of scope processes include:

- claims handling
- management of individual performance
- human resources investigations into employment concerns
- professional standards investigations
- coronial inquests
- criminal investigations

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

3 Definitions

AAR – After Action Review

CGA – Care Gap Analysis

CQC – Care Quality Commission

CQGG – Clinical Quality and Governance Group

CREWS News – Caring, Responsive, Effective, Well-led, Safe clinical newsletter.

DO – Daily Oversight

ICB – Integrated Care Board

LeDeR - Learning Disabilities Mortality Reviews

MDT – Multidisciplinary Team

PSII – Patient Safety Incident Investigation

PSIRF – Patient Safety Incident Response Framework

SEIPS – Systems Engineering Initiative Patient Safety model

SNEE ICB – Suffolk and North East Essex Integrated Care Board

4 Roles & Responsibilities

4.1 PSIRF Executive Lead and Senior Response Officer (Director of Care)

- Ensure the organisation meets national patient safety incident response standards
- Ensure PSIRF is central to overarching safety governance arrangements
- Quality assure learning response outputs

4.2 Investigator

- Follow the standard process for all patient safety incidents
- Recognise when an incident is notifiable to external and statutory agencies
- Carry out investigations in a timely manner
- Be open, honest, and communicate with key stakeholders such as family, patients and carers, promptly, including the completion of Statutory Duty of Candour, when required.
- Consider and ascertain any psychological impact of incident on patient, family and staff involved in the incident.
- Provide learning outcomes and share with the organisation
- Ensure review of learning outcomes are represented at the Clinical Quality and Governance Group meetings
- Ensure reporting at Quarterly Clinical Committee meetings.

4.3 All staff

Report all incidents and near misses on the Radar compliance system as soon as practically possible from the incident.

5 Patient Safety Culture

The hospice is open and honest when things go wrong with care delivery. In this regard, the hospice will follow the requirements for Statutory Duty of Candour which applies to notifiable patient safety incidents. A notifiable patient safety incident is an incident which is unintended or unexpected and in the reasonable opinion of a healthcare professional, already has, or might result in death, or severe or moderate harm to the person receiving care. The requirements for Statutory Duty of Candour include a verbal and written apology, providing an update on enquiries. For the other incidents the hospice will ensure it is open with patients and families about what has happened, irrespective of the seriousness of the incident.

There is a strong culture to report all concerns and incidents, including near misses. We benchmark incidents with other hospices and report concerns as needed to the Trustees, Accountable Officer for controlled drugs, the CQC, and commissioners for transparency and learning.

The Clinical, Quality and Governance Group meet quarterly.

To prepare for PSIRF, the NHS England Preparation Guide has been used which covers:

- PSIRF Orientation
    - Create an implementation team
    - Allocate time for reading and reflection
    - Identify knowledge and support needs for getting started
    - Create a stakeholder list and plan
    - Agree structures and processes for programme management
    - Set ambition for PSIRF implementation
- Diagnostic and discovery – asking:
    - What is being done to support open and transparent reporting?
    - How do you engage and involve those affected by patient safety incidents?
    - What is being done to support the development of a just culture?
    - What is your incident response capacity and what are your training needs?
    - How do you use learning from incident responses to inform improvement?
    - What do you need to do next?
- Governance and quality monitoring
    - Develop processes for incident response decision-making
    - Define how system effectiveness will be monitored
    - Develop processes for reporting cross-system issues
    - Define how PSIRF implementation will be monitored
- Patient safety incident response planning
    - Map your services
    - Examine patient safety incident records and safety data
    - Describe the safety issues revealed by the data
    - Identify work underway to address contributory factors
    - Agree how you intend to respond to issues listed in your patient safety incident profile
- Curation and agreement of policy and plan
    - Populate the policy and plan templates and share these with stakeholders
    - Respond to stakeholder feedback on the draft policy and plan
    - Agree how to manage transition
    - Ensure commitment to delivering required improvement
    - Seek policy and plan approval/sign-off and agree 'transition date'
- Transition
    - applying new response methods (with fidelity to national guidance)
    - using the groups established to support patient safety incident response processes (eg patient safety response review groups/decision-making groups)
    - reflecting on your agreed plan with internal and external stakeholders and considering adaptations that may be needed
    - continuing to develop work identified in phase 2: Diagnostic and discovery to ensure that your organisation, ICB, and region have the foundations for successful delivery
    - collating insight: developing safety actions and safety improvement plans
    - collecting data to support quality monitoring
    - supporting and collaborating with others

The hospice will utilise the organisational values to treat staff involved in a patient safety incident in a consistent constructive and fair way. The hospice values are:

- Compassion
- Accountability
- Respect
- Equity

We support a culture of fairness, openness and learning by supporting staff to feel confident to speak up when things go wrong, rather than fearing blame.

Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

All staff must be aware of the Whistleblowing Policy and how to use it and when.

6 Co-production

The NHS Patient Safety Strategy (July 2019) recognises the importance of involving patients, their families and carers and other lay people in improving the safety of NHS care, as well as the role that patients and carers can have as partners in their own safety. We will work with stakeholders to ensure an approach of co-production.

To ensure that patient safety is maintained and improved, the hospice will continue to review and discuss patient safety incidents and undertake thematic analysis and reviews at:

- Quarterly Clinical Quality & Governance Group Meetings
- Quarterly Medicines Management Group Meetings
- Quarterly Safeguarding Group Meeting
- Monthly Infection Prevention and Control Group Meeting
- Weekly Quality Group (Huddle) Meetings
- Quarterly Clinical Sub-committee Meetings.

Learning from incidents will be presented across the organisation in the form of Learning from RADAR documents and CREWS News newsletters, published each Quarter. Action plans will be prepared and logged in RADAR for review.

An MDT approach will support teams to learn from patient safety incidents which have occurred.

7 Addressing Health Inequalities

The Hospice use Equality Impact Assessments to ensure the governance process minimises impact and addresses the need to improve access. Looks at practice and policy.

The Hospice recognises that we have a role to play in helping to reduce inequalities in health in palliative care by improving access to services around the need of our local population in an inclusive way. Under the Equality Act (2010) we will assess for any disproportionate patient safety risks across the range of protected characteristics to ensure nobody is disadvantaged.

A reasonable adjustments approach will be used for individuals for example, if a person with learning disabilities can't read or see safety signs, this will outline what we will put in place to ensure this person is aware and remains safe.

We will have access to representatives at LeDeR panel meetings (Learning Disabilities Mortality Reviews) via our West Suffolk Die Well Domain Group.

8 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.

The hospice engage across the organisation as much as possible with the Staff Consultative Group and Have Your Say Group, who represent the interests of stakeholders.

There are many opportunities for staff and volunteers to share views and any concerns across the hospice, including staff surveys, 1:1 and team meetings, and having availability of the senior managers and Directors.

9 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.

The Hospice will take a proportionate approach in its response to patient safety incidents to ensure that the focus is on maximising improvement from learning. The details will be expanded on in our PSIRF plan.

For better understanding of issues and causal factors, we will engage with patients, families and carers using a system based approach.

Examples of patient safety incidents which may be investigated are:

- Any incident involving a patient which results in moderate, severe or catastrophic harm, which may include:
    - Pressure ulcers
    - Medication incidents
    - Falls
    - A near miss incident which has potential to cause moderate or severe injury or damage

Where necessary, some incidents may require review or referral to another body or team, for example, Learning Disability Mortality Review Programme (LeDeR), Safeguarding.

A PSII (Patient Safety Incident Investigation) is required where an incident meets a national priority. These include incidents, such as Never Events and deaths thought more than likely than not due to problems in care (that is, those meeting the Learning from Deaths criteria for investigation), which require a PSII in order to learn and improve. A PSII is required to be logged on the Radar compliance system. The ICB will be notified when a PSII is commissioned.

Incidents which do not involve patients or cause no harm/low harm will be subject to thematic review to ensure that learning is achieved and further potential events prevented.

10 Resources and training to support patient safety incident response

The SRO will be the hospice contact if an incident is to be shared with the SNEE ICB.

The Director of Care will advise, monitor and delegate the investigation of incidents and complaints as needed, delegating to an appointed deputy during periods of absence.

They will have the following training;

- Patient, family and staff involvement in learning from patient safety incidents
- A Systems Approach to Learning from Patient Safety Incidents - Oversight Training
- Systems approach to Patient Safety Incident Investigations

It is essential to upskill staff who will be required to carry out investigations.

11 SEIPS – SWARM

The Systems Engineering Initiative for Patient Safety (SEIPS) model describes how a 'work system' (or 'socio-technical system) can influence processes, which in turn shapes outcomes (system performance and human well-being). The work system comprises six broad elements: external environment, organisation, internal environment, tools and technology, tasks and person(s). SEIPS is a useful problem-solving tool to support learning when from patient safety incidents and everyday work.

The SEIPS-SWARM is designed to be initiated as soon as possible after a patient safety incident occurs. SWARM- based huddles have been used by healthcare organisations in the United States (Li et al., 2015) and United Kingdom (Motuel et al., 2017) to identify learning from patient safety incidents. SWARMS are based on the concept of swarm intelligence: like bees, staff swarm to the site to quickly analyse what happened, why it happened, and decide what needs to be done to prevent it from happening in the future. SWARMs, which involve a multi-disciplinary team discussion, are carried out without unnecessary delay after the incident which prompted the SWARM to be initiated. SWARMS generate prompt learning following an incident, they are also known as hot de-brief's. They enable insights and reflections to be sought quickly and this can help prevent:

- Those affected forgetting key information because there is a time delay before their perspective on what happened is sought
- Fear, gossip and blame; by providing an opportunity to remind those involved that our aim is learning and improvement
- Information about what happened and 'work as done' being lost because those affected leave the organisation where the incident occurred.

The tool integrates the SEIPS model and SWARM approach to create a post-incident huddle to explore what happened and why in the context of how care was being delivered in the real-world (i.e., work as done). You may, if possible, include patients, their families and/or carers in a SEIPS-SWARM to ensure their perspective on what happened is reflected into the learning.

An effective SEIPS-SWARM includes the following six steps:

1. Introduce all participants so everyone knows each other, and their roles in the SEIPS-SWARM

2. Create a safe and a brave space by reassuring participants that the purpose of the SEIPS SWARM is to identify what happened and why by exploring the systems and contexts in which patient care was being delivered (i.e. work as done)
3. Replay the events that led to the SEIPS-SWARM to be initiated
4. Explore what happened and why, through the lens of the SEIPS model
5. Identify where else in the organisation the learning from the SEIPS-SWARM may be relevant
6. Identify safety actions, and where feasible, assign leads with specific deliverables and completion dates

APPENDIX A summarises the six steps to carrying out a SEIPS-SWARM.
APPENDIX B provides some top tips for carrying out a SEIPS-SWARM, linked to each of the six steps.
APPENDIX C shows the SEIPS-SWARM Work System Prompts which help to frame the discussion in Step 4 of the SWARM.

12 Our patient safety incident response plan

Our plan sets out how the Hospice intends to respond to patient safety incidents over a period of 12 to 18 months. 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. We will share draft plans with system partners as needed and the ICB.

13 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. We will review the plan 12 months after launch, in the first instance, 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 months.

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

A review and planning exercise will be undertaken annually to ensure efforts continue to be balanced between learning and improvement. This will be published in our annual Quality Account and will include mapping of our services, a review of organisational activity data, patient safety outcomes, and wider stakeholder engagement.

Our PSIRF Plan will be published on our website.

15 Patient safety incident reporting arrangements

A PSII is required when an incident meets the national criteria or for any local priorities where the agreed response is a PSII as set out in the incident response plan. A PSII may also be commissioned for any unexpected incidents of significant harm. The Director of Care will inform the ICB, Head of Patient Safety/Patient Safety Specialist. The incident will be managed through Radar, the Hospice compliance system.

16 Patient safety incident response decision-making

Where a significant incident is reported, for example, either a near miss which could have caused lasting harm or an incident of moderate or greater harm, this will be reviewed internally for a decision on the most proportionate response, following the Hospice Incident Response Plan. The

Director of Care will discuss any significant incidents with the ICB for sharing, support and advice regarding the most proportionate investigation response.

17 Responding to cross-system incidents / issues

On occasions, The Hospice may be required to meet with other partners to discuss and learn from an incident which may not necessarily be our incident investigation to lead on. However, the hospice may have played a part in that patient's journey and so we will be willing to have a cross system approach in order to achieve the best, co-ordinated learning outcome.

On occasion, the Hospice may be required to engage in discussions or investigations being completed by partner organisations, due to having some involvement with the patient journey or when asked to provide third party support. Peer review is welcomed across organisations to support learning and quality.

18 Timeframes for learning responses

If a PSII is required, we will aim to complete this within 3 months, sooner if possible. The Director of Care will liaise with the patient or their representative on a regular basis and will communicate any potential changes to the timeframes of an investigation.

19 Safety action development and monitoring improvement

All learning from incidents will be shared across the organisation via official learning outcomes as noted above, to include discussion at team meetings the publication of a Quarterly Learning from RADAR or CREWS News update. Action Plans noted in RADAR and clinical audits will monitor improvement and completion of actions. Radar, the Hospice compliance system will be used to monitor further incidents and trends.

These processes will be monitored by the Clinical Sub-committee members via the CQGG meetings and by the Head of Nursing and Quality.

20 Safety Improvement Plans

Actions from surveys, audits, complaints, incidents and other feedback are discussed and reviewed at the Clinical Quality Governance Group and any concerns, trends and reportable incidents are escalated if required to the Board via the Quarterly Clinical Sub-committee. There is a particular attention to trends, improvement and increases in patient harm.

In normal circumstances, the SRO will ensure concerns, trends and reportable incidents are managed appropriately. If there is a significant impact to the management of the Hospice or safety of patients, this will be presented by the SRO, by exception, to the CEO and Chair of Clinical Committee before being shared with the Board of Trustees.

21 Non-Compliance of Policy

The potential consequences of not following this policy could be:

- Patient harm or death
- Initiation of the Disciplinary Policy and process
- Organisation warnings or fines
- Organisation reputation damage
- Prosecution of the employee, directors or CEO
- Removal from governing bodies or councils

22 Policy Supporting Documents & Laws

https://www.england.nhs.uk/patient-safety/incident-response-framework/	Complaints and Feedback Policy
Incidents Policy	Whistleblowing (freedom to Speak Up) Policy
Clinical Governance Policy	Duty of Candour Policy
Adverse Medical and Drug Alerts	Statutory Notifications to CQC and ICS

23 Policy Communication

The policy has been shared with key stakeholders for review and comment.

Once completed the policy is sent to governance@stnh.org.uk for uploading to the Radar portal and final approval.

Once approved a notification will be sent to all staff and it is expected staff agree they have read, understood and comply with the policy.

24 Policy Training

Investigator training available from NHS England.

If incidents or new issues are presented a specific training plan may be arranged to ensure staff understand their obligations under this policy.

Depending on the outcome of any issues, further guidance and support may be provided.

25 Policy Audit

The policy will be checked on Radar to ensure staff have read and understood. Anyone not responding will be targeted to ensure they read and understand the policy.

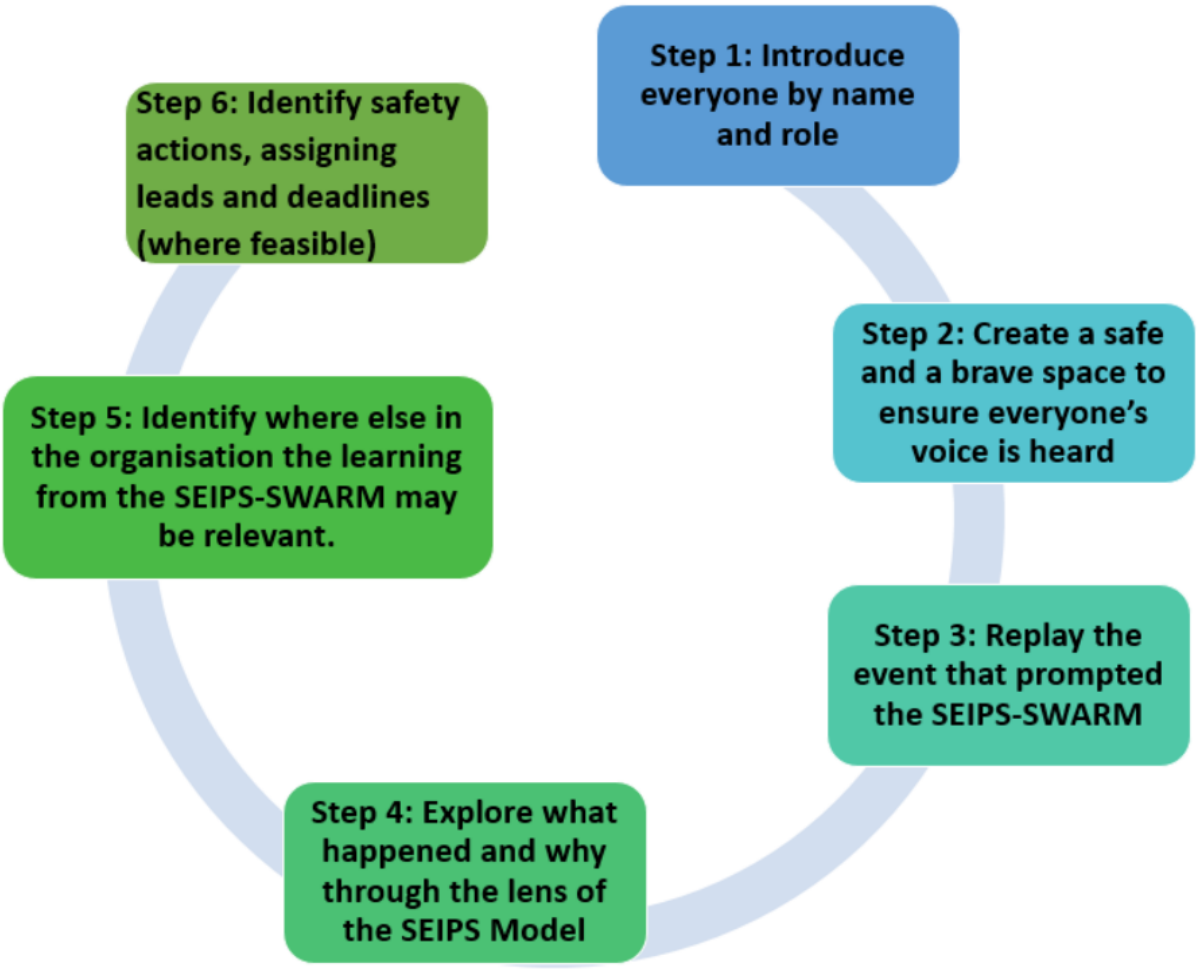
As part of auditing the success of the policy, incidents will be checked regularly for any related trends that could be due to a non-understanding of policy. If this is the case the policy will be reviewed.

26 Policy Maintenance

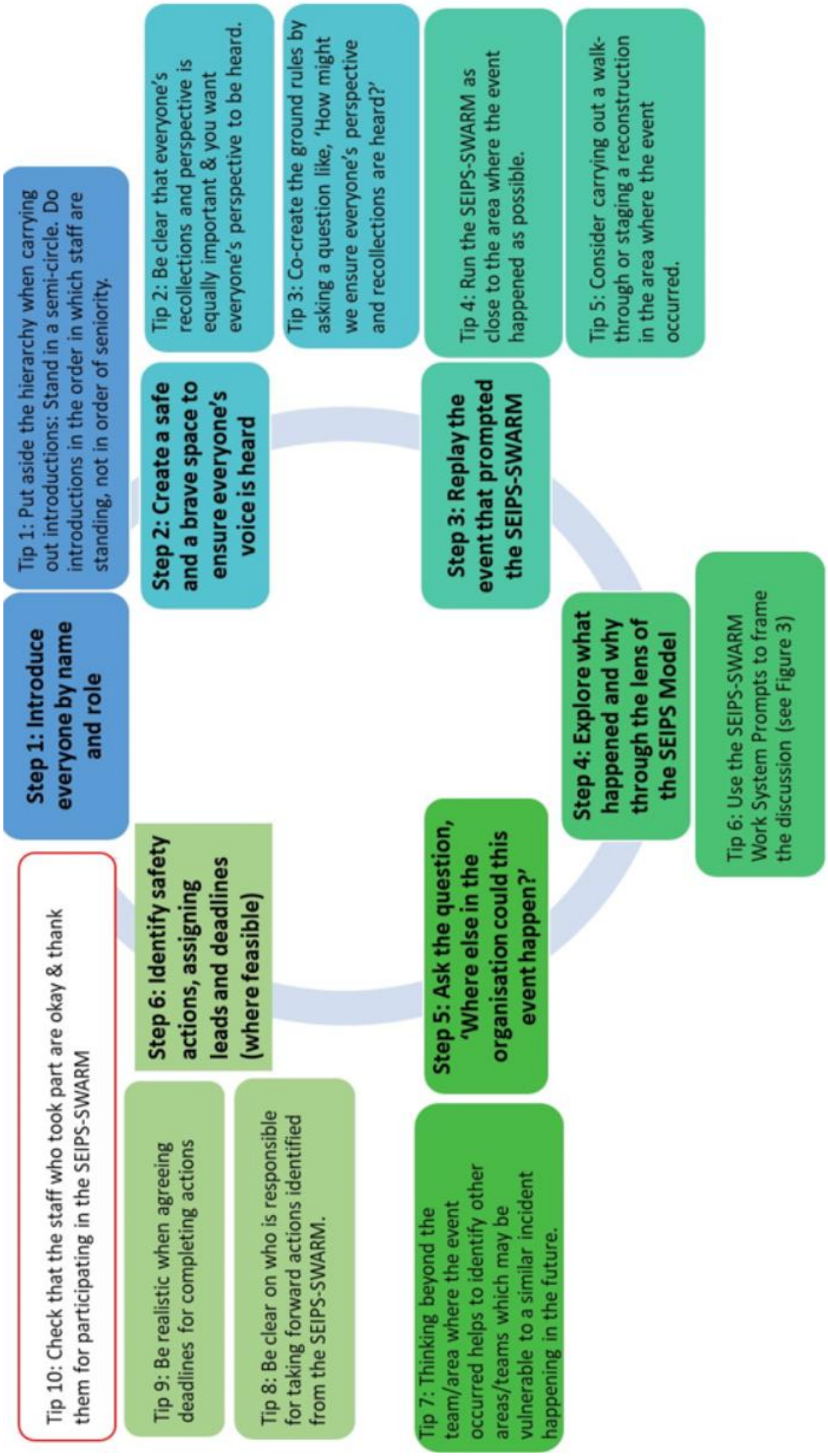
The policy will be kept in a central location, on the Radar system with a review date set.

The policy will be reviewed yearly to ensure law change is acting upon as soon as possible.

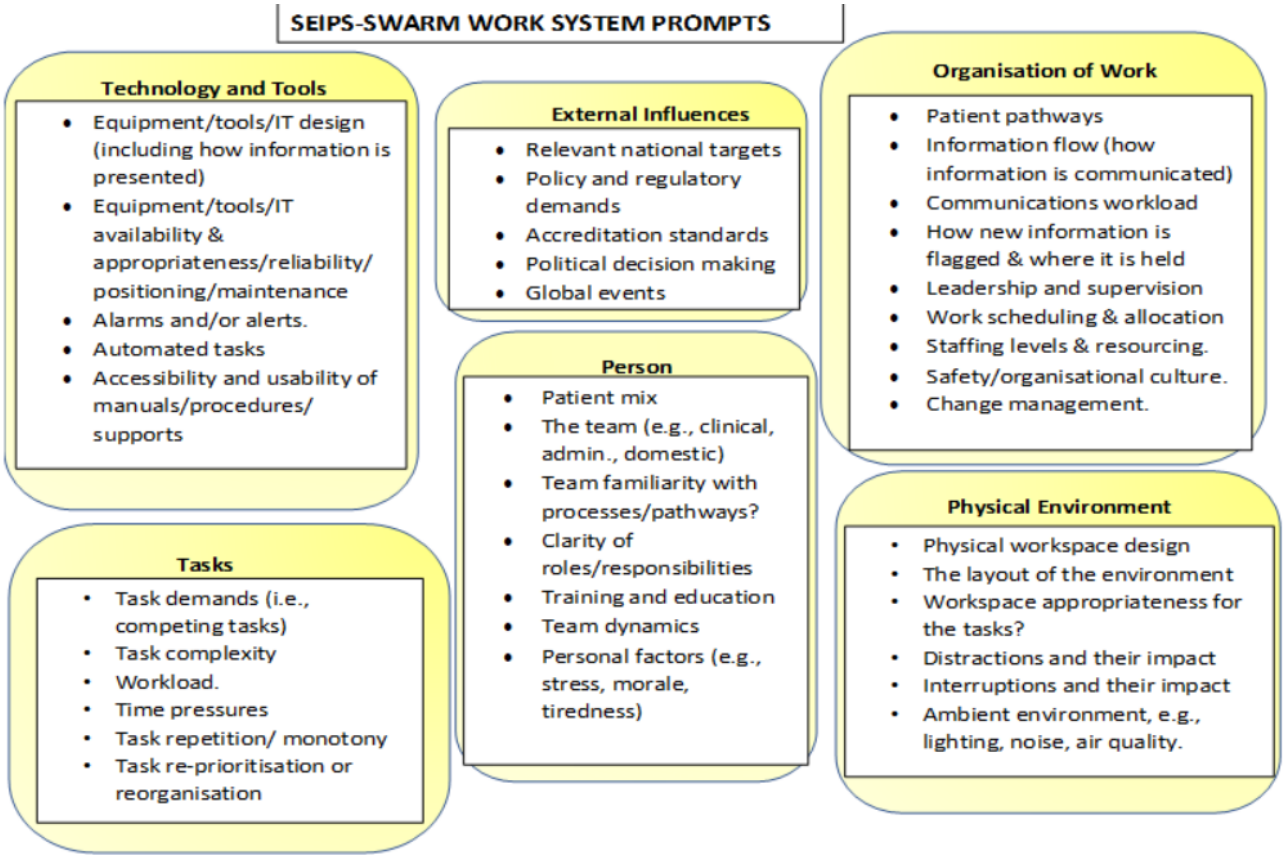
APPENDIX A: Six steps to carry out a SEIPS-SWARM



APPENDIX B: Ten tips for facilitating a SEIPS-SWARM



APPENDIX C: The SEIPS-SWARM Work System Prompts



APPENDIX D: Patient Safety Incident Response Plan

National Requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for PSII) require a locally led PSII.

Table 1 below sets out the local or national mandated responses.

	National priority	Response
1	Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led
3	Maternity and neonatal incidents meeting the Healthcare Safety Investigation Branch (HSIB) criteria	Refer to HSIB for independent PSII
4	Child Deaths	Refer for Child Death Overview Panel review. Locally led-PSII (or other response) may be required alongside the Panel review - organisations should liaise with the panel
5	Death of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR review
6	Safeguarding incidents in which: Babies, children and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism; modern slavery & human trafficking or domestic abuse/violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards
7	Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration or locally led learning response See : Guidance Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)
8	Deaths in custody (e.g. police custody, in prison , etc) where heath provision is delivered by the NHS	In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.
9	Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act	Locally led PSII by the provide in which the event occurred with STG/ESTH participation if required

	(2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	
10	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead and STG / ESTH participation
11	Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria from a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.

APPENDIX D: Local Focus

Patient Safety Incident Type	National Priority/SNHC Required Response	Anticipated Improvement Route
Incidents meeting a national priority due to their severity, such as Never Events & those meeting the Learning from Deaths criteria	**Daily Oversight** by Clinical Manager on Call. Swarm-based Huddle – SNHC refer to this as an **Immediate Debrief.** **Patient Safety Incident Investigation (PSII)** – as soon as possible after the patient safety incident is identified.	**Immediate Debrief** held as soon as possible post-incident. Led by most senior clinician on duty, and involving subsequent communication with wider teams who may not be present. May need to be repeated to ensure all necessary staff are able to access. Immediate patient safety actions or mitigations agreed. If event takes place during out of hours period, the Clinical On Call Manager to support. Duty of Candour considered. PSII led by Director of Care, Head of Nursing & Quality and/or Medical Consultants. Completed within 1 – 3 months, no longer. To be reviewed by CQGG and Clinical Sub-committee. ICB Head of Patient Safety and CQC to be informed of event and plan. Director of Care leads on presenting to team and meeting with patient/family, on completion of report.
Patient related incidents resulting in moderate or above harm (including near misses)	**Daily oversight** by Clinical Manager on Call. **Immediate debrief**. **Weekly Quality Meeting (Huddle)** – agree appropriate and proportionate response	Immediate Debrief, led by most senior clinician on duty. Should be proportionate to the level of incident. Any immediate patient safety actions agreed at Daily Safety Huddle (Sylvan Ward) or Community Huddle.

	which could include PSII or AAR	Investigation to be reviewed by CQGG.
Category 1 pressure ulcers	N/a	If reported via RADAR, immediate closure with no further action.
Pressure ulcers Category 2 (in our care)	**Daily oversight** by Clinical Manager on Call. Audit quarterly. Care Gap Analysis approach to be adopted to investigation.	Led by Ward Manager, delegated as appropriate. Completed within one month from reporting date. Themes to be identified by Pressure Ulcer Prevention Group and themes shared at CQGG meeting. Shared learning published Quarterly Learning from RADAR newsletter or C.R.E.W.S. News. Assurance provided to Clinical Sub-committee.
Pressure ulcers Category 3 and 4	**Daily oversight** by Clinical on Call Manager. **Immediate Debrief** **Weekly Quality Meeting (Huddle)** - agreement of proportionate response which could include PSII or AAR	Immediate Debrief, led by most senior clinician on duty. Response should be proportionate to the incident. Any immediate patient safety actions/mitigations agreed. PSII (if agreed approach) to be led by Head of Nursing and Quality. Completed no later than 3 months after event. External regulatory reporting to take place for Category 3 and 4 and SDTI's which develop into Category 3 and 4 pressure ulcers. Statutory Duty of Candour completed, as appropriate.
Medicines related incidents resulting severe harm (including near misses)	**Daily oversight** by Clinical Manager on Call.	Immediate Debrief, held as soon as possible post-incident. Led by Head of Nursing and Quality/Medical Consultant.

Hospital treatment or longer length of stay, but recoverable.	**After Action Review.** **PSII**	Incident reported to East of England CDAO by Director of Care, or Deputy. SEIPS led by Head of Nursing/Medical Consultant. Statutory Duty of Candour completed. Quarterly reporting to NHSE Local Intelligence Network. Reviewed by Quarterly Medicines Management Group. Reported at Clinical Sub-committee, including summary of safety actions taken and learning outcomes. Internal and external learning shared.
Medicines related incident with moderate harm level Minor amendment to treatment plans, no extended length of stay.	**Daily oversight** by Clinical Manager on Call. Care Gap Analysis. Audit quarterly – thematic analysis	Led by Ward Manager, in partnership with Medicines Management Lead. Completed within one month of reporting. Care Gap Analysis approach. Quarterly reporting of Controlled Drugs incidents to NHSE Local Intelligence Network.
Slips, trips, falls with no harm/low harm	**Daily oversight** by Clinical Manager on Call. Audit quarterly	Led by Ward Manager, delegated as appropriate. Care Gap Analysis approach. Reviewed by CQGG. Reported into Clinical Sub-committee, including learning and actions.
Multiple incidents with potential for harm identified as emerging need for further investigation ie. Multiple near miss falls/medication related incidents,	**Daily oversight** by Clinical Manager on Call. **After Action Review.**	Led by Head of Nursing and Quality. Agreed at Weekly Quality Group (Huddle). Completed within two months of identifying trend.

considered 'red flags'. Adoption of SEIPS approach.		May seek external support from ICB Quality Leads. Reviewed by CQGG. Reported at Clinical Sub-committee. Learning outcomes shared.
IT / Information Governance (IG) incident resulting in data breach	**After Action Review.**	Led by DPO (Data Protection Officer) Completed within 5 days of start. Reported to ICO when necessary. Duty of Candour considered. Reviewed by CQGG. Reported at Finance, Risk and Resources Sub-committee.
Theme with potential for harm or improvement identified by CQGG as requiring thematic analysis using SEIPS methodology.	**SEIPS**	Completed by Head of Nursing & Quality or Director of Care. May seek external support from ICB Quality Leads. Learning outcomes shared.