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Patient safety incident response standards

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Introduction

Organisations should uphold the patient safety incident response standards to ensure they meet the minimum expectations of the Patient Safety Incident Response Framework (PSIRF).

The standards cover the following aspects of PSIRF:

- policy, planning and oversight
- competence and capacity
- engagement and involvement of those affected by patient safety incidents
- proportionate responses.

This document provides the complete list of patient safety incident response standards, and where relevant refers to specific PSIRF documentation.

Policy, planning and oversight

1. Patient safety incident response policy standards

Providers are required to create a patient safety incident response policy that describes the systems and processes they have in place to learn and improve following a patient safety incident. Creating the right foundations for effective incident response is critical.

Where patient safety incident response standards are not met at the time the policy is approved, an achievable roadmap for meeting these must be set out.

As part of the design and development of their patient safety incident response policy organisations should uphold the following standards:

- 1.1. There are links and alignment between patient safety and quality improvement systems and processes, and related clinical governance systems and processes, including complaints.
- 1.2. Insight is shared between patient safety and quality improvement teams, and teams benefit from collective expertise.
- 1.3. The patient safety incident response policy and **all** other relevant policies promote a just culture (eg they do not include automatic suspension or removal of business-as-usual activities from staff involved in patient safety incidents).
- 1.4. Information governance agreements allow information sharing within and between relevant bodies to support effective communication during both incident response and improvement endeavours.
- 1.5. Governance/reporting structures are clear to staff, patients, and the public, and encourage openness and transparency.
- 1.6. The organisation's patient safety incident response policy is published on its website.

2. Patient safety incident response plan standards

Providers are required to create a patient safety incident response plan that describes how they intend to respond to patient safety incidents, including the methods to be applied and rationale. Organisations should ensure their plan:

- 2.1. Demonstrates a thorough analysis of relevant organisational data.
- 2.2. Demonstrates a collaborative stakeholder engagement process (informed by thorough service and stakeholder mapping activities to ensure all areas are involved and represented appropriately).
- 2.3. Provides a clear rationale for the response to each identified patient safety incident type.
- 2.4. Is updated as required and in accordance with emerging intelligence and improvement efforts.
- 2.5. Is published on their external facing website.

3. Oversight

Oversight under PSIRF focuses on engagement and empowerment rather than more traditional command and control. When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight “in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures”.¹

Organisations should uphold the following standards:

- 3.1. Roles and responsibilities in relation to patient safety incident response are clearly described and understood by staff.
- 3.2. Oversight processes are underpinned by the ‘oversight mindset’ principles described in the Oversight roles and responsibilities specification (eg focus on improvement, are collaborative).
- 3.3. Oversight approaches consider the recommendations in the [Oversight roles and responsibilities specification](#) (eg a variety of data is used, is not ‘one size fits all’).

¹ <https://reader.health.org.uk/framework-measuring-monitoring-safety/introduction>

Competence and capacity

Learning response leads, those leading engagement and involvement and those in PSIRF oversight roles require specific knowledge and experience.

Organisations may differ in how they approach engagement and involvement – this activity may be led by the person leading a learning response, or by a family/staff liaison officer or similar. The patient safety incident response standards distinguish between the training requirements and competencies for these two roles but recognise they might be fulfilled by the same individual.

A tabular overview of training requirements is detailed in the Appendix.

4. Patient safety incident response resources

- 4.1. Learning responses are **not** led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.
- 4.2. Learning response leads should have an appropriate level of seniority and influence within an organisation – this may depend on the nature and complexity of the incident and response required, but it is recommended that learning responses are led by staff at Band 8a and above.
- 4.3. Learning responses are **not** undertaken by staff working in isolation. A learning response team should be established to support learning responses wherever possible.
- 4.4. Staff affected by patient safety incidents are given time and are supported to participate in learning responses.
- 4.5. Learning response leads have dedicated paid time to conduct learning responses. If necessary, their normal roles are backfilled.
- 4.6. Subject matter experts with relevant knowledge and skills are involved, where necessary, throughout the learning response process to provide expertise (eg clinical or human factors review), advice and proofreading.
- 4.7. There is dedicated staff resource to support engagement and involvement of those affected.

5. Training provider requirements

- 5.1. Training is conducted by those who have attended courses in learning from safety incidents amounting to more than 30 days, are up to date in learning response best practice and have both conducted and reviewed learning responses. Accreditation with a recognised organisation is preferred.

6. Learning response training

- 6.1. Learning responses are led by those with at least two days' formal training and skills development in learning from patient safety incidents and experience of patient safety incident response.
- 6.2. Learning response leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the [patient safety syllabus](#).
- 6.3. Learning response leads undertake continuous professional development in incident response skills and knowledge, and network with other leads at least annually to build and maintain their expertise.
- 6.4. Learning response leads contribute to a minimum of two learning responses per year.

7. Competencies for learning response leads

All staff leading learning responses should be able to:

- 7.1. Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
- 7.2. Summarise and present complex information in a clear and logical manner and in report form.
- 7.3. Manage conflicting information from different internal and external sources.
- 7.4. Communicate highly complex matters and in difficult situations.

8. Engagement and involvement training

- 8.1. Engagement and involvement with those affected is led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process.
- 8.2. Engagement leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
- 8.3. Engagement leads undertake continuous professional development in engagement and communication skills and knowledge, and network with other leads at least annually to build and maintain their expertise.
- 8.4. Engagement leads contribute to a minimum of two learning responses per year.

9. Competencies and behaviours for engagement leads

- 9.1. Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
- 9.2. Listen and hear the distress of others in a measured and supportive way.
- 9.3. Maintain clear records of information gathered and contact with those affected.
- 9.4. Identify key risks and issues that may affect the involvement of patients, families, and staff.
- 9.5. Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

10. Oversight training

- 10.1. All patient safety incident response oversight is led/conducted by those with at least two days' formal training and skills development in learning from patient safety incidents **and** one day training in oversight of learning from patient safety incidents.

- 10.2. Those in an oversight role within an integrated care system (ICS) have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
- 10.3. Those with an oversight role on a provider board or leadership team (eg an executive lead) have completed level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the patient safety syllabus.
- 10.4. All individuals in oversight roles in relation to PSIRF undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

11. Competencies for individuals in oversight roles

All staff with oversight roles can:

- 11.1. Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
- 11.2. Apply human factors and systems thinking principles.
- 11.3. Obtain (eg through conversations) and assess both qualitative and quantitative information from a wide range of sources.
- 11.4. Constructively challenge the strength and feasibility of safety actions to improve underlying system issues.
- 11.5. Recognise when safety actions following a patient safety incident response do not take a system-based approach (eg inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
- 11.6. Summarise and present complex information in a clear and logical manner and in report form.

Engagement and involvement of those affected by patient safety incidents

'Those affected' includes staff, patients, and families in the broadest sense; that is, the person or patient (the individual) to whom the patient safety incident occurred, their family and close relationships. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have/had a direct and close relationship with the individual to whom the incident occurred.

12. Compassionate engagement with those affected

All organisations are required to ensure:

- 12.1. Obligations relevant to the Duty of Candour are upheld.

Those affected by patient safety incidents should be:

- 12.2. Fully informed about what happened
- 12.3. Given the opportunity to provide their perspective on what happened.
- 12.4. Communicated with in a way that takes account of their needs.
- 12.5. Given an opportunity to raise questions about what happened and to have these answered openly and honestly.
- 12.6. Helped to access counselling or therapy where needed.
- 12.7. Given the opportunity to receive information from the outset on whether there will be a specific learning response and what to expect from the process.
- 12.8. Signposted to where they can obtain specialist advice and/or advocacy and/or support from independent organisations regarding learning response processes.

13. Meaningful involvement of those affected in a learning response

When a learning response takes place, those affected should be involved in a meaningful way. The following standards are endorsed for all learning responses but must be upheld where a patient safety incident investigation is undertaken.

Those affected should be:

- 13.1. Provided with a named main contact within the organisation with whom to liaise about any learning response and support.
- 13.2. Allowed to bring a friend, family member or advocate of their choice with them to any meeting that is part of the learning response process they are involved in.
- 13.3. Informed who will conduct any learning response and of any changes to that arrangement.
- 13.4. Given the opportunity to input to the terms of reference for the learning response, including being given the opportunity to request the addition of any questions especially important to them (note this does not mean that their requests must be met, but they must have any decision not to meet their request explained to them).
- 13.5. Given the opportunity to agree a realistic timeframe for any learning response.
- 13.6. Informed in a timely fashion of any delays with the learning response and the reasons for them.
- 13.7. Updated at specific milestones in the learning response should they wish to be.
- 13.8. Given the opportunity to review the learning response report with a member of the learning response team while it is still in draft and there is a realistic possibility that their suggestions may lead to amendments. Note this does not mean that their suggestions must be incorporated but any decision not to incorporate their suggestions must be explained to them.
- 13.9. Invited to contribute to the development of safety actions resulting from the learning response.

- 13.10. Given the opportunity to feedback on their experience of the learning response and report (eg timeliness, fairness, and transparency).

Proportionate responses

14. Timeframes

- 14.1. Patient safety learning responses start as soon as possible after the incident is identified.
- 14.2. Patient safety learning response timeframes are agreed in discussion with those affected, particularly the patient(s) and/or their carer(s), where they wish to be involved in such discussions.
- 14.3. Depending on discussions with those involved, learning responses are completed within one to three months and/or no longer than six months.

15. Patient safety incident response methodology

- 15.1. Responses are conducted for the sole purpose of learning and identifying improvements that reduce risk and/or prevent or significantly reduce recurrence.
- 15.2. Responses are insulated from remits that seek to determine avoidability/preventability/predictability; legal liability; blame; professional conduct/competence/fitness to practise; criminality; or cause of death.
- 15.3. With reference to the [just culture guide](#), referral for individual management/performance review or disciplinary action only occurs for acts of wilful harm or wilful neglect.
- 15.4. Patient safety incident investigation reports are produced using the standardised national template.
- 15.5. Patient safety incident investigation reports are written in a clear and accessible way.
- 15.6. National tools (or similar system-based tools) are used and guides followed for learning response methods.

- 15.7. Learning and improvement work are adequately balanced – the organisation does not continue to conduct individual learning responses when sufficient learning exists to inform improvement.

16. Cross-system responses

- 16.1. ICSs provide necessary support to facilitate cross-system learning responses.
- 16.2. Where multiple organisations need to be involved in a single learning response, the response is led by the organisation best placed to investigate the concerns. This may depend on capability, capacity, or remit.
- 16.3. Organisations consider whether a learning response needs to examine the care provided throughout a specific care pathway as opposed to focussing solely on the part of the pathway most proximal to the incident.
- 16.4. Organisations actively engage partner organisations that provided care to the patient(s) involved where that care may have played a role in the incident being examined.
- 16.5. Organisations work together and co-operate with any learning response that crosses organisational boundaries.

17. Safety action and improvement

Organisations are required to develop safety actions to address areas for improvement identified in learning responses. Safety actions can relate to the local context or broader system issues. It is expected that:

- 17.1. Once systemic, interconnected contributory factors are robustly identified, the board/leadership team directs, champions and appropriately resources improvements, including by refocusing activity from individual responses to implementation and monitoring of required actions where appropriate.
- 17.2. All safety actions are developed with relevant stakeholders including those responsible for implementation.
- 17.3. The implementation and efficacy of all safety actions are **monitored**, and a named individual identified with responsibility for this.

Appendix: Training requirements

Specific knowledge and experience are required for those leading learning responses and those in oversight roles (see Table A1). This includes knowledge of systems thinking and system-based approaches to learning from patient safety incidents.

Those involved in the quality assurance of patient safety incident response (ie provider boards/executive leads) must have the knowledge to constructively challenge the strength and feasibility of safety actions to improve underlying system issues. They must be able to recognise when the proposed safety actions following a patient safety incident response do not take a system-based approach; for example, where they inappropriately focus on revising policies without understanding 'work as done', or involve self-reflection for certain individuals rather than reviewing wider system influences.

Those in system oversight roles (ie provider board PSIRF lead(s), ICB PSIRF leads, the Care Quality Commission (CQC) relationship managers and inspectors) must have knowledge of effective oversight and supporting processes, including effective use of data for assurance and patient safety incident response system development.

Staff in oversight roles must be appropriately trained to support the practical application of PSIRF oversight principles and standards.

Training procurement framework

The [NHS training and development framework](#) assists with identifying training providers for the following required PSIRF courses:

- systems approach to learning from patient safety incidents
- involving those affected by patient safety incidents in the learning response process
- oversight of learning from patient safety incidents.

Health Safety Investigation Branch (HSIB) training

HSIB offers an education programme to the NHS delivered by professional healthcare safety investigation experts. HSIB's level 2 (previously level 3 Bronze and Silver) investigation training meets the requirements for training in a 'systems approach to learning from patient safety incidents.'

Patient safety syllabus

As part of the NHS Patient Safety Strategy, work is underway to develop and deliver NHS-wide patient safety training. Health Education England published the national patient safety syllabus in May 2021 covering five levels of training. Level 1 (essentials for patient safety) and level 2 (access to practice) became available for all NHS staff via the eLearning for Health platform in October 2021.

Levels 3 to 5 will be developed and are expected to be released throughout 2022

Table A1: PSIRF training requirements

Topic	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
Systems approach to learning from patient safety Incidents	2 days/12 hours	<ul style="list-style-type: none"> • Introduction to complex systems, systems thinking and human factors • Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews • Safety action development, measurement, and monitoring 			
Oversight of learning from patient safety incidents	1 day/6 hours	<ul style="list-style-type: none"> • NHS PSIRF and associated documents • Effective oversight and supporting processes • Maintaining an open, transparent and improvement focused culture • PSII commissioning and planning 			
Involving those affected by patient safety incidents in the learning process	1 day/6 hours	<ul style="list-style-type: none"> • Duty of Candour • Just culture • Being open and apologising • Effective communication • Effective involvement • Sharing findings • Signposting and support 			

Patient safety syllabus level 1: Essentials for patient safety	eLearning	<ul style="list-style-type: none"> • Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety and is open to learning about risk and safety 			
Patient safety syllabus level 2: Access to practice	eLearning	<ul style="list-style-type: none"> • Introduction to systems thinking and risk expertise • Human factors • Safety culture 			
Continuing professional development (CPD)	At least annually	<ul style="list-style-type: none"> • To stay up to date with best practice (eg through conferences, webinars, etc) • Contribute to a minimum of two learning responses 			

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