NHS
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Incident Management Policy

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Associated Documentation:

- Risk Management Procedures
- Policy for Managing Compliments, Comments, Concerns and Complaints
- Safeguarding Policy
- Courts and Evidence Policy
- Disclosure Policy
- Claims Management Policy
- Freedom of Information Policy
- Supporting Staff Involved in an Incident, Complaint or Claim Policy
- Being Open (Duty of Candour) Policy
- Freedom to Speak Up (Raising Concerns) Policy
- Clinical Incident Review Policy
- Post-Incident Care Guidance
- Disciplinary Policy
- Criminal Incident Policy
- Patient Safety Incident Response Plan
- Patient Safety Incident Response Policy

Current published versions of the above can be found at the following link:
Library - Policies - PowerApps

Staff Summary

The Incident Management Policy is designed to provide structure and clarity around the process for receiving, investigating, responding to, reporting on and learning from incidents and Patient Safety Incident Investigations (PSII).
An incident can be defined as an adverse event that has caused harm to patients, staff or others, or has had a negative impact on the organisation. Incidents also include near misses where harm has not been realised, however, there was potential to do so. The Trust values near miss reporting to enable lessons to be learned at an early stage, before harm has occurred.
It is important that incidents are investigated in a timely manner to ensure that appropriate action is taken to resolve the incident and to ensure learning can take place and be applied across the Trust.
Proportionate learning responses for each incident will be decided upon by the regional governance teams responsible for monitoring of incidents in their respective areas.
Learning responses will look to perform a coordinated and data driven response to patient safety that prioritises compassionate engagement with those involved or affected.
Datix Cloud IQ (DCIQ) has been redesigned to include Patient Safety Incident Response Framework (PSIRF) learning response options with systems-based methodology in mind. Human interactions and factors should always be considered when reviewing Trust incidents.
Support will be available to all staff involved in a learning response. This may be via their line manager or alternative support services such as Occupational Health. Details of Trust support services can be found here: Occupational Health (sharepoint.com)
An After Action Review (AAR) or Multi-Disciplinary Team (MDT) approach should be adopted in most cases, which will be led by the investigator allocated to the case to ensure quality of information and understanding between all parties.
The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if systems and processes that support compassionate engagement and involvement of those affected by patient safety incidents (patients, families, and staff) are in place.
The Trust will be open with all persons involved in moderate and above incident as soon as practicable unless there is a specific reason to consider a different course of action, for example, relating to the health or wellbeing of the patient or carer. The decision to communicate with patients and/or carers should be made by the Executive Director of Quality and Chief Paramedic, with advice and input from other specialist experts across the Trust.
The Trust monitors learning on a case-by-case basis as outlined above and theme and trend analysis is conducted within Patient Safety Learning Group (PSLG) to amalgamate themes and trends identified through other routes, for example, complaints and claims.
The Trust will provide 'Systems Engineering in Patient Safety' (SEIPS) techniques and Investigation Skills training for managers across the Trust. This training is aimed at investigation leads who will undertake learning responses (for example, team leader colleagues).

1.0 Introduction

1.1. Yorkshire Ambulance Service (YAS) NHS Trust is committed to making safety a priority and taking reasonable and proportionate steps to prevent any harm coming to patients, staff and others.

1.2. The management of incidents and Patient Safety Incident Investigations (PSIIs) is a vital process for the Trust to learn when things have gone wrong and to identify areas of improvement to prevent recurrence. It is a critical component of the Trust's approach to

risk management and the Trust has clear processes in place for managing adverse events.

1.3. The Trust will undertake investigations under the following circumstances:

- an incident has occurred requiring a proportionate response
- a reoccurrence has been identified with associated trust learning
- A thematic analysis has identified a need for more detailed review of a particular incident.

1.4 The level of investigation will be proportionate to the incident.

1.5 The Trust will comply with the principles of Duty of Candour and will operate in an open and transparent way with all those involved, encompassing the principles of 'Just Culture' (See appendix A).

2.0 Purpose/Scope

2.1 The Incident Management Policy is designed to provide structure and clarity around the process for receiving, investigating, responding, reporting and learning from incidents and learning responses.

2.2. The policy is part of the organisation's internal control system and provides assurance to the Board that robust processes are in place to mitigate the risks associated with the management of incidents and PSIIs under the Patient Safety Incident Response Framework (PSIRF).

2.3. The policy is aimed at all staff across the Trust and should be read in conjunction with the current Patient Safety Incident Response Plan (PSIRP) available here: Policies and Procedures | Yorkshire Ambulance Service (yas.nhs.uk) and other relevant policies outlined at the start of this document.

3.0 Process – Incident Management

3.1 Incident Management Investigation

3.1.1 An investigation can be initiated following, but not limited to:

- Receipt of a complaint or concern from a patient and/or another person.
- Record of an incident reported by a staff member.
- A concern being raised by a staff member.
- Receipt of a claim being made against the Trust.
- Request for information to inform a coronial investigation or other legal process.
- A concern raised as part of an external process within the Safeguarding arena.
- A concern raised by external parties such as another healthcare provider, commissioners, and regulators.
- Through audit or management processes.

3.2 Reporting and Recording an Incident

3.2.1 An incident can be defined as an adverse event that has caused harm to patients, staff or others or has had a negative impact on the organisation. Incidents also include near misses where harm has not been realised, however, there was potential to do so. The

Trust values near miss reporting to enable lessons to be learned at an early stage, before harm has occurred.

3.2.2 PSIRF adds to this: *'Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.'*

3.2.3 The Trust aims to take all opportunities to gain experience from where things have gone well using the principles of system2/initiative-taking thinking.

3.2.4 The Trust uses the Datix Cloud IQ (DCIQ) incident management system to record all incidents and near misses. Staff can report an incident by:

- Calling the 24/7 Datix phone line on 0300 678 4070
- Submitting an incident form using the Datix Cloud IQ application on the Trust's intranet site here: Pulse - Home (sharepoint.com)

3.2.5 Appendix B outlines the process for reporting an incident (*Appendix J refers to Datix process*).

3.2.6 All incidents and near misses should be reported as soon as possible (within 24 hours) using one of the above outlined methods.

3.2.7 If an incident is reported via the Datix phone line, this will be handled by a member of the Quality and Safety Administration team within office hours (07:00-18:00, Monday to Friday) or by Health Desk colleagues within EOC out of hours.

3.2.8 Following the reporting of an incident, the record will undergo a quality check by a member of the Quality and Safety administration team within two working days to ensure that information has been entered correctly.

3.2.9 As part of the quality check process, the incident will be graded in accordance with the Trust Risk Matrix (Appendix C) based on the consequence of the event that has occurred and will be assigned to an appropriate investigator. Investigators will be determined based on the geographical area, responsibility, and incident type. The allocation of an investigator is dependent on the incident category and the severity; this matrix is held by the Quality and Professional Standards directorate and is regularly reviewed and updated.

3.3 Timescales

3.3.1 It is important that incidents are investigated in a timely manner to ensure appropriate action is taken to resolve the incident, and to ensure learning can take place and be applied across the Trust.

3.3.2 The quality check will take place within two working days of the incident being reported and, during this process, will be assigned to a locality team review lead.

3.3.3 As standard, all incidents will be investigated within a further 15 working days and will receive a final approval check within a further 15 working days. In exceptional circumstances this timescale may vary, based on the grading of the incident, if a more in-depth investigation is required.

3.3.4 The timescales outlined in this policy may vary. For example, when relying on external stakeholders to deliver necessary information, to support the identification of a

conclusion, pending for example investigations by a Police force or through Court processes/directions from HM Coroner. Any delays must be detailed in the 'Progress Notes' field within DCIQ to ensure transparency.

3.4 Allocation of Investigations

3.4.1 The allocation of investigations is specific to the investigation type, or learning response, and to the area of the Trust e.g. it is unlikely that PTS will undertake a CBD or CCR. For patient safety incident investigations (PSIIs), the investigation lead will be fully trained (see appendix D) in system-based investigation techniques. For other learning responses including After Action Review (AAR), Swarm huddle, Multi-Disciplinary Team (MDT) meeting, or Case Based Discussion/Clinical Case Review (CBD/CCR), it is compulsory that the investigation lead is fully appraised of any available training for facilitating the specific response. However, support will be available from a member of the patient safety team should this be required.

3.4.2 Where one of the above learning responses is not conducted, a basic review will be undertaken including a review of the information contained within the DCIQ record, and appropriate information gathering from those involved.

3.4.3 For specific guidance on how investigations are allocated, reference should be made to the associated policies and procedures held within those investigation areas, for example the Policy for Managing Compliments, Comments, Concerns and Complaints. Planned revision of these policies in the future will ensure alignment.

3.5 Learning Response 'Responsibilities'

3.5.1 Proportionate learning responses for each incident will be decided upon by the regional governance teams responsible for monitoring of incidents in their respective areas.

3.5.2 These teams are currently arranged in the following groupings:

- Emergency Operations Centre (EOC)
- Integrated Urgent Care (IUC)
- Patient Transport Service (PTS)
- A&E Operations (West Yorks Integrated Care Board - WY ICB)
- A&E Operations (Humber and North Yorks Integrated Care Board - HNY ICB)
- A&E Operations (South Yorks Integrated Care Board - SY ICB)

3.5.3 A weekly locality led 'Local Incident Review Group' (LIRG) meeting will take place for each area to discuss cases and assign proportionate learning responses.

3.5.4 The Trust's central Patient Safety team takes responsibility for the following:

- *Patient Safety Incident Investigations (PSIIs) for all areas**
- Duty of Candour/family liaison for all areas
- Investigation reports required by His Majesty's Coroner (HMC) where the level of complexity is such that it cannot be dealt with by way of subject matter expert statements e.g. detailed evidence required from multiple departments
- Delivering training and support for PSIRF-related processes
- Coordination of learning responses with other organisations
- *Thematic analysis and update of the PSIRP at regular intervals**
- Laison with external bodies regarding PSIRF

***NB** - fully trained individuals (see appendix D) within regional teams may be asked to support with delivery of learning responses based on capacity and demand discussions.*

3.6 Proportionate Learning Responses - Principles

3.6.1 Learning responses will look to perform a coordinated and data-driven response to patient safety that prioritises compassionate engagement with those involved or affected.

3.6.2 DCIQ has been redesigned to include PSIRF learning response options with systems-based methodology in mind. Human interactions and factors should always be considered when reviewing Trust incidents.

3.6.3 Learning responses should be carried out with an independent view, with the main aim to identify learning. The Trust operates within the principles of 'Just Culture' with a focus on learning, restorative practice and redirection of individual blame to systems and process factors.

3.7 Fact Finding/Audit/Review

3.7.1 Incidents of a clinical nature may require a Clinical Case Review (CCR) or a clinical based discussion (CBD) to inform the investigation and this will be conducted by a suitably qualified colleague in accordance with the relevant policy.

3.7.2 The learning response may require input from another organisation. These will be managed on a case-by-case basis with support provided by the central Patient Safety team.

3.7.3 On occasion, it may be necessary for a review to be conducted by an external independent investigator or for specialist expertise to be provided independently of the Trust. This will be determined on a case-by-case basis however approval must be sought from the Executive Director of Quality and Chief Paramedic before taking such action.

3.7.4 Support will be available to all staff and volunteers involved in a learning response. This may be via their line manager (including the Post Incident Care process) or alternative support services such as Occupational Health. Details of Trust support services can be found here: Occupational Health (sharepoint.com)

3.7.5 Information from staff/volunteers will be required at an early stage of an incident being reported to understand as much about the adverse event as possible. This can be initially detailed in a 'version of events' from the individual(s). If the investigation escalates to a higher severity, such as when there is a requirement to comply with legal processes or HR investigation, a formal statement will then be required from the individual(s) which will be held on record along with other documents relating to the incident being reviewed. Documentation (including statements) relating to incident investigation may be disclosable under a request for records made to the Trust from individuals or for external legal processes. Therefore, staff/volunteers should be made aware that statements are a formal and legal record of events which may be used as evidence.

3.7.6 A case review may be necessary if there are elements of an investigation where concerns are raised. This may be related to adherence to timescales, for example, or the impartiality of an investigating manager. Case reviews should be requested via the Head of Investigations and Learning and will be reviewed on a case-by-case basis.

3.8 Proportionate Learning Responses – Options

3.8.1 The aim of any learning response is to:

- Identify and perform a **proportionate** response *('Proportionate' refers to a response that meets the needs of an individual circumstance, therefore will be decided upon on a case-by-case basis)*
- Understand what happened and establish the facts
- Analyse the information and subsequently identify recommendations and learning that will help reduce the risk of recurrence

3.8.2 It is not the aim of any learning response to apportion blame onto any individual or determine liability in any way. If at any point during the investigation process it is apparent that there has been any misconduct by a staff member this may instigate disciplinary proceedings; the current 'Disciplinary Policy, Procedure & Guidance' should be referred to.

3.8.3 Learning response options include any of the following:

- Patient Safety Incident Investigation (PSII)
- After Action Review (AAR)
- Multi-Disciplinary Team Meeting (MDT)
- Swarm Huddle
- **Local Option** - Clinical Case Review / Clinical Based Discussion (CCR or CBD)

3.8.4 If none of the above are appropriate:

- **Basic Investigation** (This includes a review of the DCIQ record undertaken by local management teams (usually involving discussion at LIRG) to ascertain any learning).

3.8.5 A toolkit relating to the advantages and disadvantages of each response can be found at Appendix E.

3.8.6 External training specific to facilitating some of the learning responses can be found here via the HSSIB online booking portal: https://www.hssib.org.uk/education/nhs-courses/#patient-safety-incident-response-framework-training-courses
(Availability may vary across the year, early booking is recommended).

3.8.7 An After-Action-Review (AAR) or MDT approach is likely to be adopted in **most** cases for incidents graded moderate or above and will be led by the investigator allocated to the case to ensure quality of information and understanding between all parties.

3.8.8 Engagement will be essential to review the timeline and to develop appropriate learning points; this will take the form of either direct or remote meetings.

3.8.9 Suggested roles required to participate with a Trust AAR are as follows:

- Patient Safety Incident Response Lead or Senior Leader
- Safety Governance Manager
- Colleagues noted to have been in the timeline for the incident***
- Relevant Head of Department
- Relevant Audit/Compliance Leads

- Clinical Governance Manager
- Relevant Locality or Directorate Management Leads
- Patient Safety Specialist
- Patient Safety Partner (Or Partners)

3.8.10 Patients, their relatives or next of kin may ask to be involved in the review of an incident and the AAR is an opportunity for this involvement. Psychological safety of participants should be considered when looking to invite members of the public to these sessions. It can be immensely beneficial and should be considered on a case-by-case basis.

3.8.11 During periods of high demand / REAP 4 protocols, where arrangements for standdown are more challenging, it may be necessary to substitute management representatives to attend meetings and discuss the case rather than colleagues who have been involved. Colleagues involved in the timeline should be involved by cascade and sharing of all documentation/notes created in all cases.

3.8.12 Swarms, CCRs and CBDs should be used where opportunities for learning are limited to an individual or small number of individuals.

3.8.13 Where a patient-related incident is graded as / or is suspected to have caused moderate or above harm (also referred to as a notifiable safety incident) the statutory Duty of Candour applies. Duty of Candour is the statutory requirement upon the Trust under CQC Regulation 20: Duty of candour - Care Quality Commission (cqc.org.uk) to be open and transparent with patients and/or carers and relatives when something has gone wrong.

3.8.14 Reference should be made to the Trust's Being Open (Duty of Candour) policy for how this is applied, and contact made with the Patient Safety team to arrange. Training requirements for those conducting engagement with patients and families can found in Appendix D.

3.8.15 Patient Safety Specialists (PSS) are in post to support all learning directly involving patient care; these colleagues are a vital link between national methodology/steer and local implementation and should be accessed in all cases for specialist knowledge and expertise.

3.9 Final Approval of DCIQ records

3.9.1 It is important that a specialist manager approves investigations to ensure quality and consistency.

3.9.2 The Trust has determined a list of final approvers who are aligned to a specialist area and who will be able to apply their relevant knowledge, skills and experience to determine whether the investigation has covered all relevant areas.

3.9.3 It is the final approver's responsibility to ensure the investigation has been carried out adequately, to go back to the investigator if more information is required and have assurance that lessons have been learned and actions identified prior to approving. Appendix F outlines the process for final approval of incidents.

3.9.4 In some cases, it will be appropriate to carry out the final approval of incidents via a batch update process. This would be for low level incidents which feed into a wider theme or trend work stream and these incident categories will be determined by the

relevant specialist lead, with approval from a manager within the Quality and Safety Team.

3.10 Feedback

3.10.1 The Trust acknowledges that feedback to the reporter following investigation is vital in ensuring engagement with staff and for learning to be shared.

3.10.2 All individuals reporting an incident will receive feedback following the investigation via the auto-feedback function on DCIQ. This is an automated email that is generated by the system once the incident has been approved. The incident investigator is required to write a summary feedback message in the 'Feedback' field that is checked by the final approver and sent to the reporter.

3.10.3 Additional feedback may also be given via telephone or face to face if this is necessary or the preferred option.

3.11 Learning from Incidents/Investigations

3.11.1 Appropriate restorative learning places emphasis on alignment with the NHS 'Just Culture' guide (Appendix A). Learning will be identified from each investigation and consideration given as to whether the learning should be on an individual, team or organisational basis as follows.

3.11.2 Local actions will be taken where necessary, following conclusion of an investigation and managed on an individual basis. Learning and actions at this level will be recorded on DCIQ.

3.11.3 The Patient Safety Learning Group (PSLG) will coordinate learning relating to patient safety matters, to ensure the effective management and cascade of learning and improvement.

3.11.4 Analysis of investigations and learning will be conducted at team levels but triangulated through the Head of Investigations and Learning to inform PSLG. Opportunities to learn include:

- Integrated Performance Report (IPR)
- Lessons learned and trend analysis reported quarterly to the Clinical Quality Development Forum (CQDF) and Clinical Governance Group (CGG) and the Health & Safety Committee.
- Significant Events and Lessons Learned reports to the Trust Management Group, Trust Board and Quality Committee.
- Local learning reports sent to operational business areas.
- Central Incident Review Group (CIRG).
- Local Incident Review Group (LIRG).
- Learning From Deaths Group (LFD).
- Low and No Harm Group (LnHg).

3.11.5 Ad hoc reports may also be requested for certain groups or operational areas throughout the course of the year.

3.11.6 Data analysis will be conducted primarily using DCIQ , with additional qualitative data analysis carried out within the Quality and Professional Standards directorate in alliance with the Business Intelligence team.

3.11.7 All learning will be recorded on DCIQ and monitoring of achievement against the PSIRP will take place via continued analysis of quantitative and qualitative data within the PSLG monthly workplan.

3.11.8 The key groups for responding to lessons learned and implementing the actions are the Clinical Quality Development Forum (CQDF) and Patient Safety Learning Group.

3.12 Media Involvement

3.12.1 The Trust's Corporate Communications team should be notified of any incidents where there is potential for media interest by the lead investigator. The Corporate Communications team will apply the appropriate level of media management depending on the level of interest, consulting with the Quality and Professional Standards directorate throughout.

4.0. Process – Patient Safety Incident Investigation (PSII)

4.1 Patient Safety Incident Investigation

4.1.1 The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

4.1.2 The PSIRF replaces the Serious Incident Framework (SIF 2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

4.1.3 The Safety Governance Manager will be alerted of a possible patient safety incident investigation (PSII) via several routes. This may be through the escalation of an adverse event via CIRG or, for example, through a complaint or coronial investigation.

4.1.4 An early fact-find will be done to establish facts at regional Local Incident Review Groups (LIRG) however escalation/approval of commencement of a PSII will be exclusively via the Executive Director of Quality and Chief Paramedic at CIRG. In their absence, the Deputy Director of Quality and Nursing or the Deputy Medical Director will have delegated responsibility.

4.1.5 External reporting will take place automatically in the future via the 'Learning from Patient Safety Events' (LFPSE) service however, an interim solution has been agreed for the Safety Governance Manager to use the Strategic Executive Information System (StEIS) to alert commissioners as soon as practicable after the CIRG decision.

4.1.6 A Significant Event Alert (SEA) form will be circulated by the Executive Director of Quality and Chief Paramedic to an identified distribution group within the Trust to notify internal parties.

4.1.7 A template will be provided to the lead investigator (See Appendix G) which must be completed in full with no amendments or omissions.

4.2 Timescales for completion

4.2.1 The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the incident, and the risk that for as long as findings are not described, action may not be taken to improve safety or further checks will be required to ensure the recommended actions remain relevant.

4.2.2 Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the local response leads should work with all the information they have to complete the response to the best of their ability; it may be revisited later, should new information indicate the need for further investigative activity.

4.2.3 Indicative local time limits are below for guidance:

- After Action Review (AAR): 14 working days
- Swarm Huddle: Within 72 hours of incident
- Multi-Disciplinary Team (MDT): As soon as practicable
- Clinical Case Review (CCR) / Clinical Based Discussion (CBD): within four weeks of incident (per CCR policy)
- Patient Safety Incident Investigation (PSII): 60 – 90 working days (max six months)

4.2.4 Based on the above, the Trust will complete investigation work as soon as is practicably possible and liaise closely with families and representatives to provide realistic and achievable timescales.

4.3 Family Engagement/Family Liaison

4.3.1 Learning and improvement following a patient safety incident can only be achieved if systems and processes that support compassionate engagement and involvement of those affected by patient safety incidents (patients, families, and staff) are in place.

4.3.2 Compassionate engagement and involvement means 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.

When a PSII or other learning response is undertaken, organisations should meaningfully involve those affected, where they wish to be involved.

Terms of reference should be established very early on in the process, and family's concerns taken into consideration when establishing the boundaries of the review.

4.3.3 Close liaison with the quality and safety coordinator with responsibility for Duty of Candour or patient relations coordinator should be maintained through the period of investigation and regular updates provided as to progress and any unforeseen delays; our aim is to achieve a minimum of monthly contact where resource allows.

4.4 Duty of Candour

4.4.1 From October 2014, following parliamentary approval, NHS providers are required to comply with the Duty of Candour, meaning providers must be open and transparent with service users about their care and treatment, including when it goes wrong. The Trust has a statutory Duty of Candour to be open and honest with patients and carers.

4.4.2 The Trust has a Being Open (Duty of Candour) Policy and this should be applied in the management of all adverse events. The Trust's Lead for the Duty of Candour is the Head of Investigations & Learning and the being open process must be managed via this official route.

4.4.3 Early contact should be made with the patient and/or next of kin to inform them of the investigation and to give them an opportunity to be involved if they wish to do so.

4.4.4. In accordance with national guidance, the Trust will be open with all persons involved in moderate and above incident as soon as practicable unless there is a specific reason to consider a different course of action, for example relating to the health or wellbeing of the patient or carer. The decision on communication with patients and/or carers should be made ultimately by the Executive Director of Quality & Chief Paramedic with advice and input from other specialist experts across the Trust.

4.5 Collaborating with other Providers

4.5.1 In some instances, it may be appropriate to involve other healthcare providers as part of a joint investigation if the care provided to that patient crosses over a number of care provisions.

4.5.2 The lead organisation should be established at the start of the investigation, and this should be primarily based on who can identify the greatest amount of learning. The organisations should work together to complete one investigation report that covers the incident from end to end.

4.6 Approval and Submission

4.6.1 Following the completion of a PSII, the Safety Governance Manager will undertake a quality check of the investigation and work with the investigator to produce a final version of the report.

4.6.2 The report will be presented to the Patient Safety Learning Group (PSLG) by the investigator following prior circulation to ensure the investigation is comprehensive and the group will approve the recommendations and learning, including allocation of actions.

4.6.3 In some circumstances, which may include workload or capacity of group members; a subsection of the PSLG will be asked to review the completed report and provide commentary remotely, without a group discussion. If this is the case, the Executive Medical Director or Executive Director of Quality and Chief Paramedic must be present in the discussion to provide quoracy.

4.7 Closure and Monitoring

4.7.1 The Trust monitors learning from PSIIs via the Patient Safety Learning Group.

4.7.2 Overall responsibility is with the Trust Board for oversight and assurance. Integrated Commissioning Board (ICB) colleagues should be engaged with throughout the process however it is no longer a requirement to share completed work routinely following internal Trust approval.

4.7.3 As per the Trust's Records Management Policy, all records relating to Patient Safety Incident Investigation should remain confidentially stored for a period of no less than 20 years.

4.8 Learning from Learning Responses

4.8.1 The vital element of conducting a learning response is to ensure that appropriate learning takes place, and changes are made where necessary to avoid this happening again.

4.8.2 The Trust monitors learning on a case-by-case basis as outlined above and theme and trend analysis is conducted within PSLG to amalgamate themes and trends identified through other routes, for example complaints and claims.

4.8.3 Triangulation of learning enables the best action to be taken to improve safety across the Trust and it is vital that learning is shared across all levels of the investigation.

4.8.4 Learning is shared across the Trust via a number of forums, including key scrutiny committees and groups such as the Clinical Quality Development Forum (CQDF), the Clinical Governance Group (CGG), Patient Safety Learning Group (PSLG), Trust Board and Quality Committee as well as local governance meetings.

4.9 Feedback

4.9.1 In line with the principles outlined within the incident section of this policy, feedback will be provided to all staff involved following the conclusion of an investigation.

4.9.2 For PSIIs, this should be done face-to-face by the investigating manager and, where appropriate, a review meeting should be considered for all persons involved to collectively review the findings and receive feedback.

5.0. Training expectations for staff

5.1 The Trust will provide 'Systems Engineering in Patient Safety' (SEIPs) techniques and Investigation Skills training for colleagues across the Trust. This training is aimed at investigation leads who will undertake learning responses (For example – Team Leader grades).

5.2 Specialised training will be sought for colleagues directly involved in Patient Safety Incident Investigation (PSII) or for whom it is their primary function.

5.3 Statutory/Mandatory eLearning from the national patient safety syllabus at Levels 1 and 2 is available via the Trust ESR function in relation to investigation principles and practice. Level 1 (and Board Level 1).

5.4 In cases where training cannot be provided internally, or for colleagues within the quality function who require specialist skills, external sources will be sought from the NHS Patient Safety - Training Procurement Framework.

6.0. Implementation Plan

6.1 The following stakeholders have been consulted in the development, consultation and review of this policy:

Clinical Quality Development Forum (CQDF)	Clinical Governance Group (CGG)	Legal Services Manager
Patient Relations Manager	Information Governance Manager	Information Systems Manager

Safety Governance Manager	Area Clinical Governance Leads	Learning Response Leads from Operational Areas
Policy Development Group (PDG)		

6.2 The policy has been agreed by members of the Clinical Governance Group.

6.3 The latest approved version of this policy will be posted on the Trust intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust induction.

6.4 Archived documents will be stored electronically within the Document Library archive. A copy of previous versions of the policy will be additionally held by the policy author.

7.0 Monitoring compliance with this Policy

7.1 Regulatory compliance reports will be presented by the Head of Investigations and Learning throughout the year to a range of executive committees and groups. The committees review the reports, note any deficiencies and remedial actions in their minutes. Progress against relevant action plans associated with this policy will be monitored as part of routine business and will be subject to the Trust's performance management process.

7.2 The effectiveness of this policy is monitored against adherence to national frameworks and requirements, each of which will be specified within the individual investigation area policies. Key Performance Indicators (KPIs) based on national and local standards have been agreed and performance against these KPIs is monitored through reports to executive committees and through dashboards.

8.0 References

8.1 The following sources of information have been used in the creation of this document.

NHS Improvement 'A just culture guide'
NHS England » A just culture guide

CQC Regulation 20: Duty of Candour
Regulation 20: Duty of candour | Care Quality Commission (cqc.org.uk)

Serious Incident Framework (2015).
https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

Training Procurement Framework (2022)
Training & Development Services - East of England Collaborative Procurement Hub (eoecph.nhs.uk)

NHS England (2024) Patient Safety Incident Response Framework (PSIRF)
NHS England » Patient safety incident response framework and supporting guidance

NHS England (2024) Guide to Responding Proportionately to Patient Safety Incidents
b1465-3.-guide-to-responding-proportionately-to-patient-safety-incidents-v1.2.pdf (england.nhs.uk)

NHS England (2024) Oversight roles and responsibilities specification
B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk)

NHS England (2024) Patient Safety: Incident Response Standards
NHS England » Patient safety incident response standards

NHS England: Learning From Patient Safety Events service (LFPSE)
NHS England » Learn from patient safety events (LFPSE) service

NHS Improvement: National Reporting and Learning System (NRLS)
NHS England » Report a patient safety incident

Learn Together (2023) Investigator Guidance
PSIRF_Learn-together_Investigator_Guidance_web.pdf

9.0 Appendices

9.1 The following appendices are included within the document:

- Appendix A – Just Culture Guide
- Appendix B – Incident Flowchart
- Appendix C – Risk Matrix
- Appendix D – Training Requirements
- Appendix E – Learning Response Toolkit
- Appendix F – Final Approval Guide
- Appendix G – Patient Safety Incident Investigation Template (Nov 2023)
- Appendix H – Definitions
- Appendix I – Roles and responsibilities
- Appendix J – Managing the PSIRF process in Datix guide

Appendix A – Just Culture Guide

NHS

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

→ **Yes** — **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. — END HERE

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

→ **Yes** — **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. — END HERE

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

→ **Yes** — **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. — END HERE

if No to all go to next question - Q3. foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

→ **if No to any** — **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. — END HERE

if Yes to all go to next question - Q4. substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

→ **if Yes to any** — **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. — END HERE

if No to all go to next question - Q5. mitigating circumstances

5a. Were there any significant mitigating circumstances?

→ **Yes** — **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. — END HERE

if No

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. — END HERE

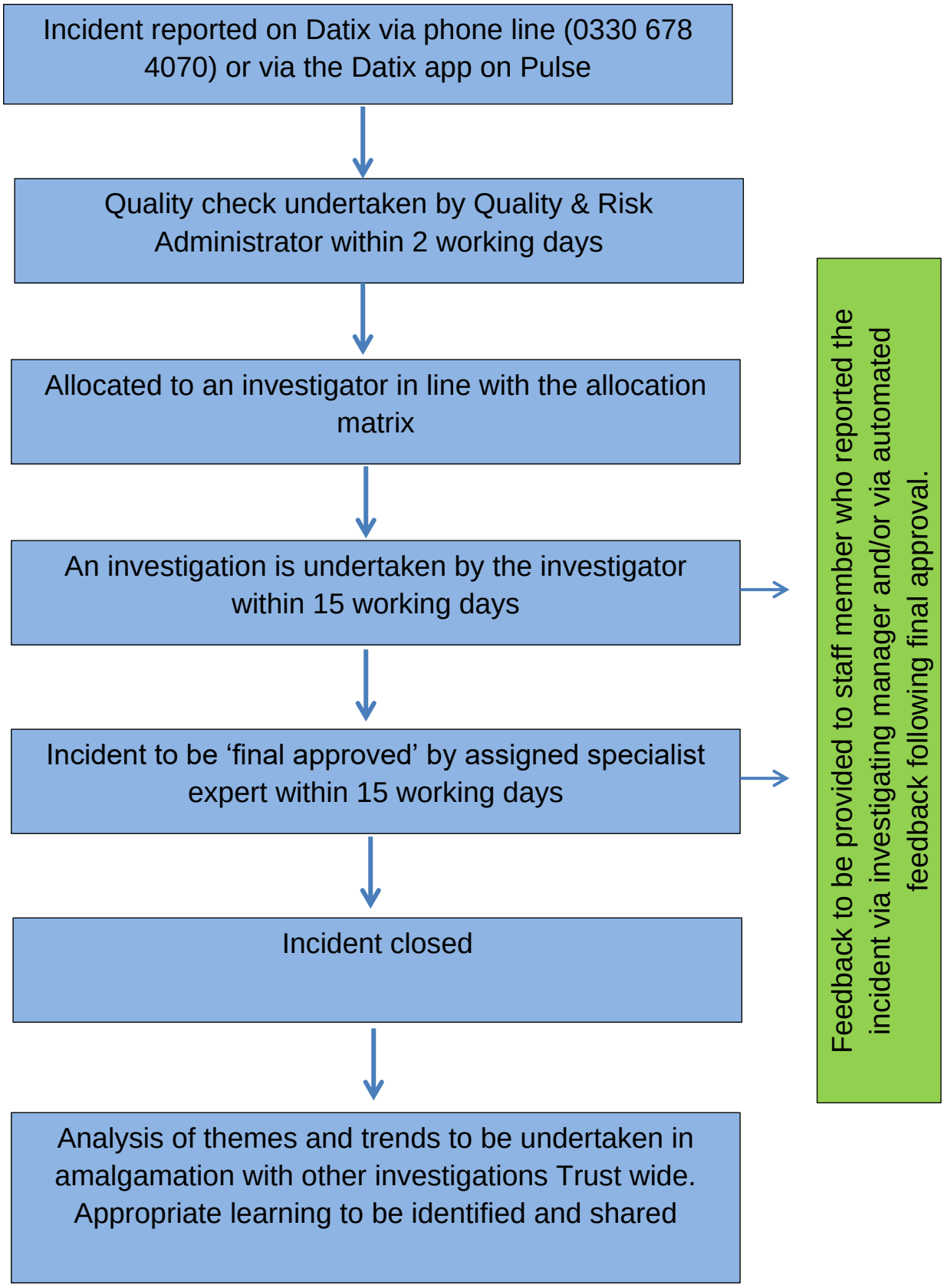
improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

NHS England and NHS Improvement

Appendix B – Incident Flowchart



Appendix C – Risk Matrix

Risk Matrix

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

Key to managing risk scores:		
Risk score of 1 - 6	Low	Managed at a local team/departmental level. Local management to determine and develop risk treatment plans or to manage through routine procedures; and consider including on the risk register. This level of risk may be short-lived or aggregated into a higher risk.
Risk score of 8 – 12	Moderate	**Consider implications for Risk Register.** Managed at local team/departmental level, unless escalated to Directorate or Trust/Subject specific group. Where there is a severity score of 4 or 5 alone, this may be considered for escalation to the Risk & Assurance Group regardless of the likelihood score.
Risk score of 15 – 25	High	**Consider implications for Risk Register.** Managed at local team/departmental level and/or Directorate or Trust/Subject specific group depending on management control, treatment plan, or wider strategic implications for the Trust. Risk Leads consider escalation and review at Risk and Assurance Group (RAG) where consideration is given to escalating the risk into the Corporate Risk Report and/or Board Assurance Framework (BAF).

Risk scoring = Consequence x Likelihood (CxL)

	Likelihood score				
Severity score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Consequence Score (C) Guidance

Choose the most appropriate risk descriptor for the identified risk from the left-hand side of the table, then work along the columns in the same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Risk Consequence score and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Risk Descriptors	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Safety **Harm to patients/staff and/or public (including physical and/or psychological harm)**	Minor injury not requiring first aid or no apparent injury	Minor injury or illness, requiring minor intervention 1-2 people affected No long term consequences.	Moderate injury which impacts on an individual or a small number of people Some degree of harm up to a year. RIDDOR/MHRA/agency reportable incident	Major injury leading to long-term incapacity/disability Serious mis-management of care with long-term effects 16-50 people affected	Death /life threatening harm Multiple permanent injuries or irreversible health effects More than 50 people affected
Staff **Competence and training, poor staff attendance for mandatory/key training**	Insignificant effect on delivery of service objectives due to failure to maintain professional development or status	Minor error due to a lack of appropriate skills, knowledge and competence to undertake duties.	Moderate error due to limited skills, knowledge & competence to undertake duties	Major effect on delivery of service objectives due to failure to maintain professional development or status	Significant effect on delivery of service objectives due to failure to maintain professional development or status

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Critical report	Multiple breeches in statutory duty Prosecution Severely critical report, zero performance rating
Service/business interruption	Loss of ability to provide services (interruption of >1 hour)	Loss of ability to provide services (interruption of >8 hours)	Loss of ability to to provide services (interruption of >1 day)	Loss of ability to provide services (interruption of >1 week)	Permanent loss of service or facility
Business programmes/ projects	Temporary defects causing minor short term consequences to time and quality	Poor project performance shortfall in area(s) of minor importance	Poor project performance shortfall in area(s) of secondary importance	Poor performance in area(s) of critical or primary purpose	Significant failure of the project to meet its critical or primary purpose
Financial loss/Contracting	Small loss of budget (£0 - £5,000)	Medium financial loss (£5,000 - £10,000)	High financial loss (£10,000 - £50,000)	Major financial loss (£50,000 - £100,000) Purchasers failing to pay on time	Huge financial loss (£100,000 +), loss of contract / payment by results Unrecoverable financial loss by end of financial year
Information governance risks	Minimal or no loss of records containing person identifiable data. Only a single individual affected.	Loss/compromised security of one record *(electronic or paper)* containing person identifiable data.	Loss/ compromised security of 2-100 records *(electronic or paper)* containing confidential/ person identifiable data.	Loss/ compromised security of 101+ records *(electronic or paper)* containing person identifiable data.	Serious breach with potential for ID theft compromised security of an application / system / facility holding person identifiable data *(electronic or paper).*
Adverse publicity/ reputation/Public confidence	Rumours No public/political concern	Local media area interest – short-term reduction in public confidence	Extended local/regional media interest. Regional public/political concern.	Regional/national media interest with less than 1 day service well below reasonable public expectation	National media interest with more than 1 day service well below reasonable public expectation.
Litigation	Likely repudiation at pre-action stage.	Damages valued at less than £10,000 Minor concerns relating to care highlighted, no systemic issues identified Allegations not substantiated and claim likely to be successfully defended and discontinued at pre-action stage.	Civil action / Criminal prosecution / Prohibition notice- proceedings issued Likelihood of success at trial >50% Damages) valued between £10,000 and £100,000 Concerns relating to treatment/care/systemic issues identified which are not likely to have impacted on the outcome Low level risk of reputational damage.	Civil action / Criminal prosecution/Prohibition notice – proceedings issued Likelihood of success at trial <50% Damages between £100,000 and £1 million Major concerns as to treatment/care/systemic issues which are likely to have impacted on the outcome Reputational damage (local level) Raises individual employee failings and or Trust policy concerns	Civil action/Criminal prosecution/Prohibition notice – indefensible Damages >£1 million Catastrophic / significant systemic issues/concerns which have significantly contributed to the outcome Damage due to never event Reputational damage (national level)
Coroner's requests / inquests	No issues or concerns identified No identified risk of criminal or civil litigation No identified risk of reputational damage	Minor concerns identified unrelated to management of patient No identified risk of criminal or civil litigation No identified risk of reputational damage	Concerns relating to treatment/care/systemic issues which are not likely to have impacted on the outcome Does not raise significant individual or Trust policy failings	Significant concerns to treatment/care/systemic issues which are likely to have impacted on the outcome Areas of concern not addressed receiving a Coroner's Prevention of Future Death report (PFD).	Catastrophic / significant issues/concerns which are likely to have significantly contributed to the outcome High likelihood of a Coroner's Prevention of Future Death

	Witness statements admitted under Rule 23 YAS not an Interested Person	YAS not an Interested Person.	Low level risk of civil litigation claim Low level risk of reputational damage Family and/or other Interested Persons legally represented	Consideration given to legal representation at Inquest YAS has Interested Person Status Concerns raised by Coroner/other Interested Persons Potential for for Prevention of Future Deaths report- issues addressed pre- inquest Notification of civil claim- contemplated or actual Reputational damage (local level) Jury/Article 2 inquest Family and/or other Interested Persons legally represented	report- issues not addressed pre-inquest YAS has interested person status. Raises issues of national importance Potential to result in public national enquiry (i.e. London Bombings, Mid Staffordshire enquiry) Potential for criminal prosecution or civil claim proceedings issued Reputational damage (national level) Jury/Article 2 inquest Family and/or other Interested Persons legally represented.
Complaint	Minor injury not requiring first aid or no apparent injury Misunderstanding of an element of the service which can be corrected Local rapid resolution anticipated with no service change requirements	Minor injury or illness, requiring minor intervention Single failure to meet internal standards with no consequence Local resolution anticipated, local service change may be required	Moderate injury which impacts on a small number of people Single failing resulting in loss of appointment or care Resolution service wide with possible escalation of actions	Major injury leading to long-term incapacity/disability Repeated failure to meet internal standards within organisation Resolution service wide with possible escalation of actions	Death /life threatening harm Unacceptable level or quality of treatment/service . Grossly substandard care Resolution expected to be protracted, major trust wide service change may be required
Safeguarding children & Adults at Risk ***Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery***	No issues or concerns identified clinically or with reputation Progression to strategy meeting or multi-agency review unlikely No media interest Response to query responded to within 2 working days No, or minimal impact or breech of guidance/statutory duty	Minor concerns over patient care CDOP/Form B with uncomplicated information gathering Minor delay in response to external agency request (more than 5 working days) No allegations against Trust or employees Short term service impact from brief investigation involving discussions Police, Social care and HR	Moderate concerns about patient care, response times, clinical interventions CDOP requiring moderately complex information gathering and analysis Referral to LADO and Police. Disciplinary process commenced, suspension from front line duties Possible media interest anticipated	Major concerns with patient care that could have affected outcome Major injury leading to incapacity or disability Repeated failure to reach internal standards Regional media statement requested Abuse enquiry becomes public enquiry	Incident leading to death or permanent disability Healthcare did not take appropriate action/intervention to safeguard against abuse occurring Abuse that resulted in (or was identified through) a SCR, DHR, LLR Inquest requiring safeguarding information Staff/ex-staff member is found guilty of abuse and convicted Media interest highly likely

Likelihood Score (L) Guidance

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to determine the frequency.

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Probability	< 5% 1 in 100,000 chance	6-20% 1 in 10,000 chance	21-50% 1 in 1000 chance	50-80% 1 in 100 chance	>81% 1 in 10 chance
	This will probably never happen/recur Will only occur in exceptional circumstances	Unlikely to occur Do not expect it to happen/recur but it is possible it may do so	Reasonable chance of occurring Might happen or recur occasionally	Likely to occur Will probably happen/recur but it is not a persisting issue	More likely to occur than not Will undoubtedly happen/recur, possibly frequently

Appendix D – Training Requirements
To be read in conjunction with
NHS England (2024) Patient Safety: Incident Response Standards
https://www.england.nhs.uk/long-read/patient-safety-incident-response-standards/

Learning responses must be conducted/facilitated by suitably trained individuals, who meet the following minimum requirements:

- 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.
- Learning response leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus (available via ESR).
- 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.
- Learning response leads contribute to a minimum of two learning responses per year.

All staff leading learning responses should be able to:

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

All staff leading on engagement with families and staff should:

- Have at least six hours of training in involving those affected by patient safety incidents in the learning process.
- Have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
- 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.
- Contribute to a minimum of two learning responses per year.

Appendix E – Learning Response Toolkit

SWARM Huddle

NHS Yorkshire Ambulance Service NHS Trust

What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research and evidence available to confirm its efficacy?	Who is involved?
"A novel rapid approach to RCAs [root cause analysis] to establish a consistent approach to investigate adverse or other undesirable event" (Jing Li et al 2015)	After any event where patient safety was at risk	**No more than 30 minutes**	Normally chaired by a senior lead who generates a short report.	There is some research literature on its use in healthcare. Link	People directly involved in the incident

Strengths?

- Immediate learning occurs with early actions identified.
- Connecting immediately after event may reduce social isolation/ruminating/stress for staff.
- Evidence shows it can increase the reporting of incident.
- Quick and responsive.
- Quick and easy to undertake so increases likelihood of being done.
- Reduces key information being lost by its immediacy.

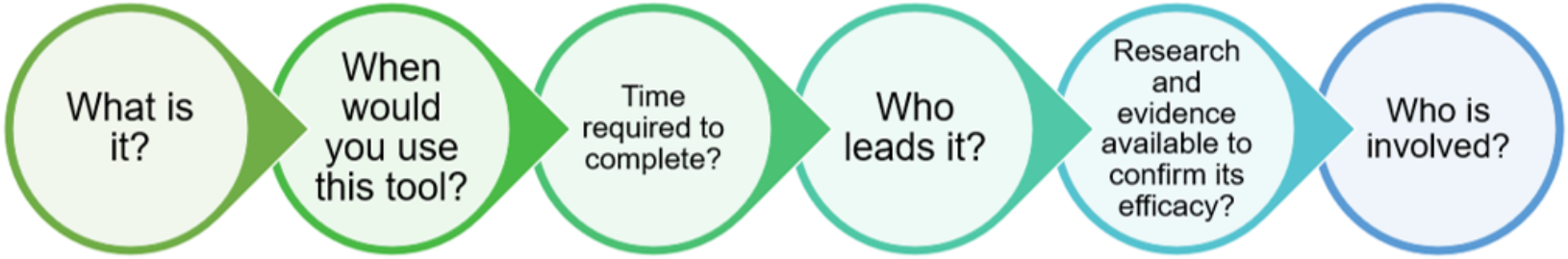
Weaknesses?

- Scope of learning narrowed by limits on who is participating.
- Learning is focused on a single event rather than the interactions in the system that come with wider participation.
- Psychological safety is assumed to be present so full participation may not be achieved.
- It seeks learning to reduce the risk of a single event reoccurring and not wider learning about behaviours, team interactions and system weaknesses.
- Weak governance arrangements for tracking actions and collating learning through many SWARMs.

PSIRF YAS Learning Response Toolkit V0.1 SD June 2023

Multi-Disciplinary Team (MDT) Review

NHS Yorkshire Ambulance Service NHS Trust



What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research and evidence available to confirm its efficacy?	Who is involved?
An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process.	After several similar events have occurred, when it's more difficult to collate staff recollections of events, either because of the passage of time or staff availability	No defined time allocated. Likely to include a workshop lasting 2 to 3 hours.	Likely to be led by a patient safety facilitator who will use the MDT review as one source of data for learning about a series of events or a theme	No specific research on the structures, processes and outcome of MDT reviews has been carried out	Those directly involved in these events from the MDT, plus patient safety experts, other senior clinicians

Strengths?

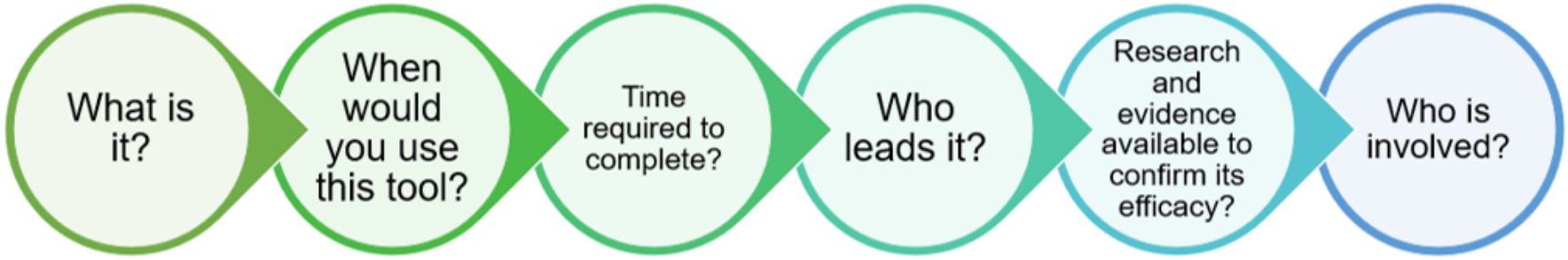
- The participation of many members of the MDT without the spotlight on a single adverse event enables a broad and deep discussion to take place and a system view to be gathered.
- Can be adapted to incorporate the systems engineering initiative for patient safety (SEIPS) framework to structure the review.

Weaknesses?

- Responsibility for learning and acting on the learning primarily rests with the person/s who set up the MDT review reducing the sphere of influence.
- Whilst participants will contribute and learn, it is not the specific purpose of the activity.
- It is a planned event, and it may take many weeks to set up and ensure full MDT representation is available.
- Resource intensive to undertake.

After Action Review (AAR)

NHS Yorkshire Ambulance Service NHS Trust



What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research and evidence available to confirm its efficacy?	Who is involved?
A structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT.	After any event, where patient care or service was not as effective or safe as expected, or when events turned out better than expected.	Likely to take 45 minutes to 90 mins depending on complexity of the issue and the numbers participating.	Led by a facilitator trained in AAR techniques.	Extensive research evidence base available on the structures, processes and outcomes demonstrating its effectiveness in improving team performance and patient safety.	Those directly involved in the event and others connected to them or the patient pathway. YAS also includes a PSP on every AAR where practicable.

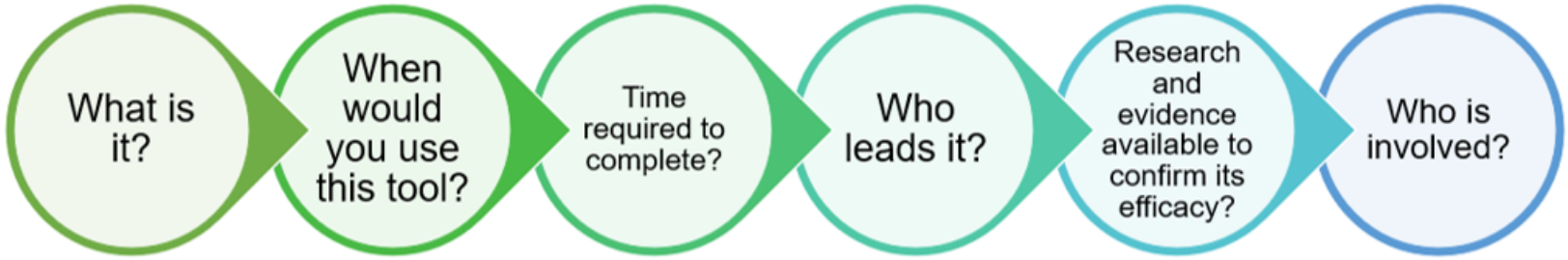
Strengths?

- The individuals learn for themselves what was happening and identify similarities and differences between themselves and others.
- Learning during the AAR is the focus, not the report, with those participating positioned as the agents of change and improvement.
- It's a group learning process, so the interactions between members of the team are available to learn from and improve. This has a strong effect on team performance and patient safety.
- It is highly adaptable, suitable for a wide range of events.
- Psychological safety is actively created and maintained throughout.
- Provides a safe reflective environment which staff experience as supportive, reducing isolation and rumination after events.

Weaknesses?

- Whilst lessons learned and actions arising are shared outwards and upwards, primary responsibility for change rests with those involved reducing central authority.
- There are limited ways to track if individuals have changed their behaviour or completed actions because of the AAR.
- Governance processes for tracking AAR activity and outputs are not established in many providers. This means the value of collated learning may not be available.

Patient Safety Incident Investigation (PSII)



What is it?	When would you use this tool?	Time required to complete?	Who leads it?	Research and evidence available to confirm its efficacy?	Who is involved?
An in-depth review of a single patient safety incident or cluster of events to understand what happened and how.	When there has been serious harm to a patient or patients	Approximately 20 to 80 hours, over several weeks	Undertaken by a trained patient safety investigator who collates data, conducts interviews, undertakes analysis and writes the recommendations report	Extensive research has been undertaken into the structures processes and outcomes of PSII across the world.	People directly involved in the incident, senior clinicians, the patient, or family members of the involved patients.

Strengths?

- It is a well-established approach which is widely recognised and valued by patients and their families.
- PSIIs provide a thorough analysis of an event where harm happened and ensure specific causes are identified.
- Responsibility for the investigation and the completion of the actions arising is clearly articulated in the governance arrangements.

Weaknesses?

- Investigations take a long time to complete and actions arising in the PSII report can take many more months to be completed.
- Outcomes are less system focused than other tools.
- The quality of PSIIs varied before PSIRF mandated training for investigators.
- Staff are only involved when they are interviewed, and this can feel very stressful.

Appendix F – Final Approval

Category	Final Approval Lead
Trust Vehicle Related	Information Systems Manager
Care Pathway	Information Systems Manager
Violence and Aggression	Local Security Management Specialist
Moving and Handling	Moving and Handling Specialist
Response Related - EOC	Safety Governance Officer / EOC Clinical Response and Governance Manager
Slips, Trips & Falls	Health and Safety Manager
Response Related – IUC	IUC Governance Team
Security	Local Security Management Specialist/Violence Reduction Lead
Clinical Assessment	Information Systems Manager
Non-Medical Equipment	Health and Safety Manager
Medical Equipment	Medical Devices Team
Medication – Controlled Drug	Area Clinical Governance Lead (MOG)
Medication – Non-Controlled Drugs	Area Clinical Governance Lead (MOG)
Clinical Treatment	Information Systems Manager
Consent Related	Information Systems Manager
Exposure to Harmful Substances	Health and Safety Manager
IT Related	Service Delivery Manager
Information Governance	Information Governance Team
IP&C	Head of Safety / Senior Infection Control Practitioner
Fire	Information Systems Manager
Response Related - PTS	PTS Governance and Training Coordinator
Self-Harm	Information Systems Manager
Environment & Estates	Information Systems Manager
Training	Head of YAS Academy
Adverse Publicity	Information Systems Manager
Financial Loss	Information Systems Manager

NHS
Yorkshire
Ambulance Service
NHS Trust

Patient Safety Incident Investigation (PSII) Report

Distribution list

DCIQ Reference	
StEIS Reference	
Other Reference (CAD/Adastra/Cleric)	
Directorate/Location:	
Date Incident Occurred:	
Time Incident Occurred:	
Report Approved Date:	
Approved by:	

Name	Organisation	Date Shared

Version Control

Version	Date	Initials	Status (A/D)	Comments (Description of Change)

Status Key: A - Approved D - Draft

Notes on the PSII template

This national template is designed to improve the recording and standardisation of PSII reports and facilitate national collection of findings for learning purposes. This format will continue to be evaluated and developed by the National Patient Safety Team.

General writing tips

A PSII report must be accessible to a wide audience and make sense when read on its own. The report should:

- use clear and simple everyday English whenever possible
- explain or avoid technical language
- use lists where appropriate
- keep sentences short.

On completion of your final report, please ensure you have deleted all of the blue information boxes and green text.

About patient safety incident investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and staff.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Duty of Candour and the Engaging and involving patients, families and staff after a patient safety guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when staff may be referred to them.

PSIIs are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

A note of acknowledgement

Notes on writing a note of acknowledgement
In this brief section you should thank the patient whose experience is documented in the report along with contributions from their family and others (including carers, etc) who gave time and shared their thoughts.
You could consider referring to the patient by name or as 'the patient' according to their wishes.
Also thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements.

Executive summary

Notes on writing the executive summary
To be completed after the main report has been written.

Incident overview

Notes on writing the incident overview for the executive summary
Add a brief, plain English description of the incident here.

Summary of key findings

Notes on writing the summary of key findings for the executive summary
Add a brief overview of the main findings here (potentially in bullet point form).

Summary of areas for improvement and safety actions

Notes on writing about areas for improvement and safety actions for the executive summary
Add a bullet point list of the areas for improvement highlighted by the investigation and list any safety actions. Note whether the area for improvement will be addressed by development of a safety improvement plan.
Some actions to address identified areas for improvement may already have been designed in existing an organisational safety improvement plan. Note that here.
Areas for improvement and safety actions must be written to stand alone, in plain English and without abbreviations.
Refer to the Safety action development guide for further details on how to write safety actions.
NB: The term 'lesson learned' is no longer recommended for use in PSIIs.

Background and context

Notes on writing about background and context
The purpose of this section, where appropriate, is to provide a short, plain English explanation of the subject under investigation – in essence, essential pre-reading to assist understanding of the incident. It might be a description of a pulmonary embolism, aortic dissection, cognitive behavioural therapy, NEWS, etc.
It may also be worth using this section to summarise any key national standards or local policies/guidelines that are central to the investigation.

Description of the patient safety incident

Notes on writing a description of the event
The purpose of this section is to describe the patient safety incident. It should not include any analysis of the incident or findings – these come later.
Think about how best to structure the information – eg by day or by contact with different services on the care pathway.
It should be written in neutral language, eg 'XX asked YY' not 'YY did not listen to XX'. Avoid language such as 'failure', 'delay' and 'lapse' that can prompt blame.
If the patient or family/carer has agreed, you could personalise the title of this section to '[NAME]'s story/experience'.

Investigation approach

Investigation team

Role	Initials	Job title	Dept/directorate and organisation
Investigation commissioner/convenor:			
Lead Investigator / Learning Response Lead:			
Candour Lead:			

Summary of investigation process

Notes on writing about the investigation process

If useful, you should include a short paragraph outlining the investigation process:

- how the incident was reported (eg via trust reporting system)
- how agreement was reached to investigate (eg review of patient safety incident response plan, panel review, including titles of panel members)
- what happened when the investigation was complete (eg final report approved by whom)?
- how actions will be monitored.

Terms or reference

Notes on writing about scope

In this section you should describe any agreed boundaries (that is, what is in and out of scope) for the investigation. For example, you might want to note:

- the aspects of care to be covered by the investigation
- questions raised by the those affected that will be addressed by the investigation

If those affected by the patient safety incident (patients, families, carers and staff) agree, they should be involved in setting the terms of reference as described in the Engaging and involving patients, families and staff after a patient safety incident guidance.

A template is available in the learning response toolkit to help develop terms of reference.

Information gathering

Notes on writing about information gathering

The purpose of this section is to provide a short overview of your investigation approach. You should include a brief overview of your methods including:

- investigation framework and any analysis methods used. Remember to keep jargon to a minimum (eg the investigation considered how factors such as the environment, equipment, tasks and policies influenced the decisions and actions of staff)
- interviews with key participants (including the patient/family/carer)
- observations of work as done
- documentation reviews, eg medical records, staff rosters, guidelines, SOPs
- any other methods.

Recorded reflections, eg those used for learning portfolios, revalidation or continuing professional development purposes, are not suitable sources of evidence for a systems-focused PSII.

Statements are not recommended. Interviews and other information gathering approaches are preferred.

Findings

Notes on writing your findings

The purpose of this section is to summarise your analysis of the information you have gathered and to state the findings you have drawn from that analysis.

You may choose to include diagrams and/or tables to communicate your analytical reasoning and findings.

Do not re-tell the story in the description of the patient safety incident. This section is about the ‘how’ the incident happened, not the ‘what’ and ‘when’.

Start with an introductory paragraph that describes the purpose of the section and structure you are going to use.

For your findings to have impact you will need to communicate them in a clear and logical way. Before you start, think about how best to structure the section, then make a plan.

You may find sub-headings useful. The structure you choose will depend on your investigation, but you could organise the information as follows:

- by the themes you have identified during the investigation – in which case put your strongest theme first

- following the framework or the analytical method you used
- in chronological order corresponding to the care pathway described in the reference event, eg community care, ambulance service, acute care (taking care not to repeat the story of the reference event)
- in order of the main decision points during the incident.

Use clear, direct language, eg 'The investigation found…'

If the section is long and contains multiple sub-sections, consider adding a summary of key points at the end of each sub-section.

Technical terms should be kept to an absolute minimum. If they are required, you should explain them in the text (glossaries should be avoided).

Include your defined areas for improvement and safety actions (where appropriate) in the relevant places in this section.

Areas for improvement that describe broader systems issues related to the wider organisation context are best addressed in a safety improvement plan. You should describe what the next stages are with regards to developing a safety improvement plan that will include meaningful actions for system improvement.

Summary of findings, areas for improvement and safety actions

Notes on writing the final summary
The purpose of this section is to bring together the main findings of the investigation.
Areas for improvement and associated safety actions (if applicable) should be listed using the table provided (also available in Appendix B of the safety action development guide).
If no actions are identified the safety action summary table is not required. Instead you should describe how the areas for improvement will be addressed (eg refer to other ongoing improvement work, development of a safety improvement plan)

Safety action summary table

Area for improvement: [eg review of test results]								
	Safety action description (SMART)	Safety action owner (role, team directorate)	Target date for implementation	Date Implemented	Tool/measure	Measurement frequency (eg daily, monthly)	Responsibility for monitoring/ oversight (eg specific group/ individual, etc)	Planned review date (eg annually)
1.								
2.								
3								
4								
5								
…								

Area for Improvement: [eg nurse-to-nurse handover]								
	Safety action description (SMART)	Safety action owner (role, team directorate)	Target date for implementation	Date Implemented	Tool/measure	Measurement frequency (eg daily, monthly)	Responsibility for monitoring/ oversight (eg specific group/ individual, etc)	Planned review date (eg annually)
1.								
2								
3								
4								
5								
…								

Appendices

Notes on appendices
Include any necessary additional details such as explanatory text, tables, diagrams, etc (Delete this section if there are none).

References

Notes on references
Include references to national and local policy/procedure/guidance, and other data sources as required.

Appendix H - Definitions

Investigation	A systematic approach to establish the facts about a case in order to understand the reason as to why something has happened.
Incident	An adverse event that gave rise to actual loss, damage or harm. See Near Miss definition also.
Adverse event	An unplanned event which has given rise to actual or possible personal injury, patient dissatisfaction, property loss or damage, or damage to the financial standing or reputation of the Trust.
Serious Incident (SI)	A serious incident (SI) requiring investigation was defined by the NPSA in the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation as an incident that occurred in relation to NHS funded services and care resulting in a number of key factors. This has now been superseded by national guidance under PSIRF.
After Action Review	An after-action review (**AAR**) is a structured review or de-brief process for analysing ***what*** was expected to happen and ***what*** *has happened*, ***why*** it happened and if there is any difference from expectation, and ***how*** learning can be taken forward to reduce the risk of reoccurrence.
Severity	Outcome or impact of an event.
Datix Cloud IQ	The system used by the Trust to amongst others, record risks and adverse events.
Swarm Huddle	A swarm is designed to start as soon as possible after a patient safety incident occurs. Healthcare organisations in the US and UK have used swarm-based huddles to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. Swarms enable insights and reflections to be quickly sought and generate prompt learning
Root Cause Analysis (RCA)	A structured investigation that aims to identify the true causes(s) of a problem and the actions necessary to eliminate it.
Duty of Candour	Statutory duty meaning NHS providers must be open and transparent with service users about their care and treatment, including when it goes wrong.
Near Miss	An event that had potential to result in harm or injury but did not.
Never Events	An event defined nationally as something that should never occur in NHS healthcare provision. There is a list provided in the national Never Events Policy to outline that these are.
Patient Safety Incident Investigation (PSII)	A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

Learning Response	PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm. Organisations can explore patient safety incidents relevant to their context and the populations they serve rather than exploring only those that meet a certain nationally defined threshold. Some events in healthcare require a specific type of response as set out in policies or regulations. The PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Instead, organisations are now able to balance effort between learning through responding to incidents or exploring issues and improvement work.
Systems Engineering in Patient Safety (SEIPS)	The systems engineering initiative for patient safety (SEIPS) is a framework to help us understand outcomes within complex socio-technical systems, like healthcare. SEIPS has developed over a number of academic papers and offers a range of tools that can help an investigator to understand why things happen.

Appendix I – Roles & Responsibilities

Trust Board
The Trust Board is responsible for ensuring that effective systems are in place for the management of incidents and serious incidents. The Trust Board seeks assurance regarding the Trust's response to incidents and serious incidents through the Chief Executive Officer and the Executive Director of Quality & Chief Paramedic.

Quality Committee
The Quality Committee undertakes an objective scrutiny of the Trust's clinical governance and quality plans, compliance with external quality regulations and standards and key functions associated with this, including processes to ensure effective learning from incidents and serious incidents. The committee scrutinises bi-monthly reports provided by the Head of Investigations & Learning and supports the Board in gaining assurance on the effective management of incidents and serious incidents

Incident Review Group (CIRG)
The CIRG is a working group that meets weekly, and which is responsible for reviewing and instigating appropriate action to address issues identified in relation to incidents, complaints and concerns, claims, coroner's inquests, professional body referrals and safeguarding cases.

Local Incident Review Group (LIRG)
The LIRG is a working group comprising of directorate based senior colleagues with influence and experience of patient safety. The groups meet weekly to discuss incidents of note with the aim of deciding upon learning response actions, severity and escalation of matters to CIRG (where appropriate).

Chief Executive Officer (CEO)
The Chief Executive Officer is ultimately accountable for the implementation of the process for managing the Trust's response to incidents. As the Accountable Officer the Chief Executive provides the Trust Board with assurance regarding the Trust's processes for managing these.

Executive Director of Quality & Chief Paramedic
Has responsibility for ensuring that adequate arrangements are in place to effectively manage incidents, and for ensuring that an appropriate system is in place to identify and implement learning following investigations. The Director has responsibility for providing the Trust executive and Trust Board with updates on significant developments and assurance on the
incident management process.

Deputy Director of Quality & Nursing
The Deputy Director of Quality & Nursing has responsibility for ensuring practical processes are in place to adequately manage incidents and serious incidents and ensure that the appropriate learning is identified. The Deputy Director will take direct management of the Head of Investigations & Learning.

Head of Investigations & Learning
The Head of Investigations & Learning has responsibility for the management of the processes associated with investigations and learning including the management of incidents and serious incidents. They will lead on learning arising from these functions, in conjunction with learning from other inputs such as complaints and will ensure the identification of appropriate recommendations and actions to ensure quality and safety is maintained.

Learning from Death Process (LFD)
The purpose of the Learning from Deaths Group is to support the Trust in delivering its obligations to monitor patient outcomes and ensure clinically effective care is delivered. Senior clinical leaders undertake strategic mortality reviews with cross directorate support, feeding back the learning within this forum. This is to ensure that lessons and actions are identified that would not otherwise be commonly highlighted under other Trust processes for the purpose of reducing all avoidable deaths. The group operates as part of the Trust's wider integrated governance arrangements, with strategic links to both quality improvement and clinical care.

Patient Safety Specialist (PSS)
The requirement for NHS organisations in England to identify one or more person as their designated Patient Safety Specialist(s) is a key part of the NHS Patient Safety Strategy
These specialists will work full time as patient safety experts, providing dynamic, senior leadership, visibility and support. In addition, they will support the development of a patient safety culture, safety systems and improvement activity. Specialists will also work in networks with Patient Safety Specialists from other organisations to share good practice and learn from each other, making them fundamental to patient safety across the NHS in England.

Safety Governance Manager
The Safety Governance Manager manages the day-to-day processes related to the management of incidents and serious incidents and will support the investigators throughout the course of investigations, will ensure actions are tracked following completion of a serious incident and will identify the relevant themes and trends arising from serious incidents.

All Managers
All managers are required to co-operate with the Head of Investigations & Learning and the other responsible managers within the directorate, by responding in a timely manner to requests for any information or support required during the course of their business. Managers may also be asked to participate in investigations, and it is expected that they will apply due diligence to this process, provide support to affected staff, and facilitate effective organisational learning and improvement.

Staff
All Trust staff have a responsibility to co-operate with the Head of Investigations & Learning & the Risk Manager and the teams that sit within the Quality, Governance & Performance Assurance directorate by responding in a timely manner to requests for any information and by active participation in an investigation process.

Learning Response Lead
The Learning Response Lead will lead and undertake robust investigations by working with a range of internal and external stakeholders; to investigate, analyse, using recognised tools encompassing principles of human factors and ergonomics, systems engineering, psychology and investigation best practice. A high level of sensitive engagement with patients, families, staff and others affected by incidents is expected in this role.

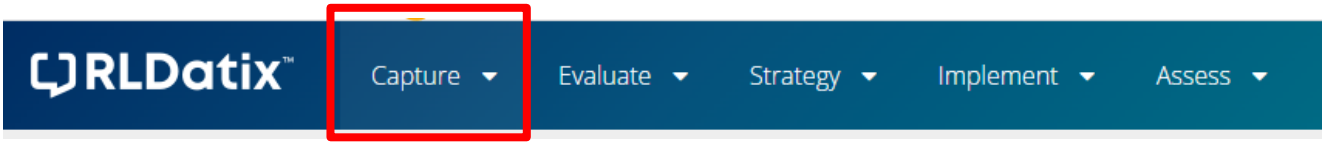
Appendix J – Managing the PSIRF process in Datix

With the launch of the PSIRF process altering how incidents are now managed this guide should hopefully help users work through the new process within the Datix system.

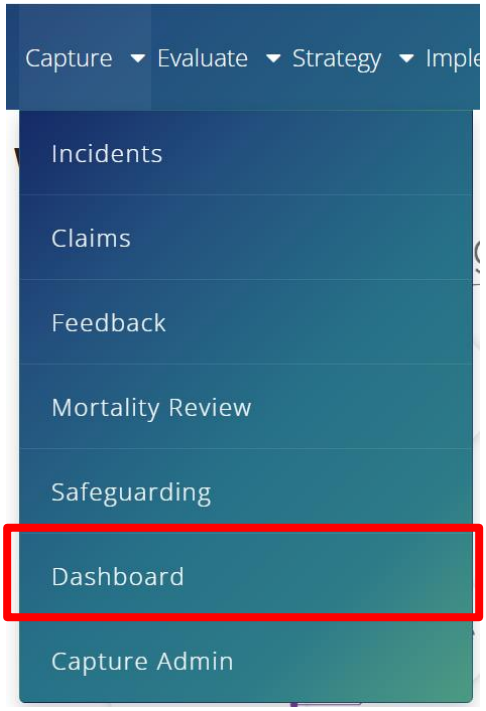
This guide is supported by the Quality Check guide and the Managers Guide.

Dashboards

The process is driven locally by the use of the dashboards within DCIQ, all users who need access to these dashboards should have been assigned already however if more users need adding please can you email Richard Harrington the name of the person who needs adding. To access the dashboards in DCIQ, you need to click Capture at the top:



And then in the drop down that appears select Dashboards:

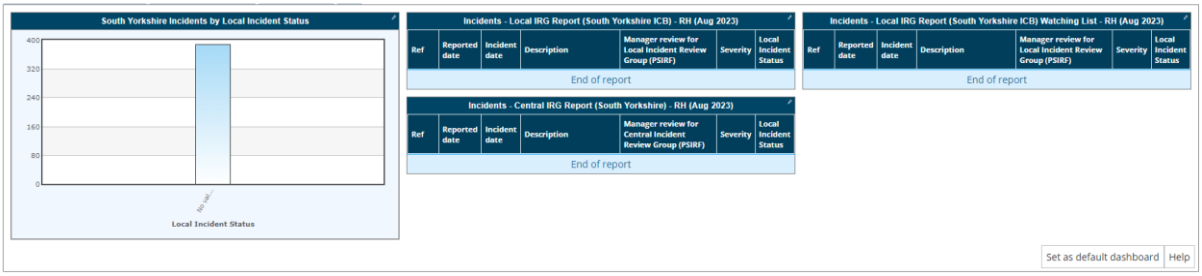


When the Dashboard loads, look for a Dashboard which name ends with “Local Incident Process” for eg:

When you click on this tab, it will open the dashboard for you, to make this dashboard be the default dashboard that loads when you go to the dashboard tab, follow the below instructions:

- Open the dashboard you wish to make default
- Scroll to the bottom of the screen and look to the bottom right
- Click the “Set as Default dashboard” button.

When the dashboard has loaded, it will look something like this (Please note, IUC and EOC dashboards will be slightly different, and this will be covered in its separate section later in this guide)



A brief run-down of these reports:

- The bar chart is key to this process working, this is your Local Incident Status bar chart, this report will display a bar for each status when it has records in those status (Explained later in this document)
- A Local IRG Report (This will populate as you work through the process and start to flag incidents to be discussed at the local IRG)
- A Local IRG Watching List report (This will populate when you work through the process and flag records to be added to the watching list)
- A Central IRG report (This will display records flagged to be discussed at Central IRG, this is also replicated on a Central IRG Dashboard)

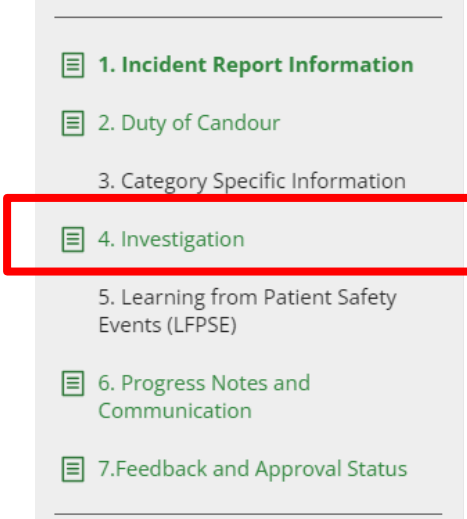
Managing the process through Datix

All new records made from the 29th of September 2023 will be made with a new question on the report form, this question has a default value and is read only. This Default value is “Local Initial Review required” and this field is the Local Incident Status field.
As reports are made, these will populate onto the dashboards relevant to your service lines.
These incidents will appear on the dashboard in a column above “Local Initial Review required” as incidents are moved through this process the dashboard will update to reflect the changes so you can see where records are in the process at a glance.
Click the graph on the dashboard and then click the bar you wish to look at.
You will be presented with a display similar to this:

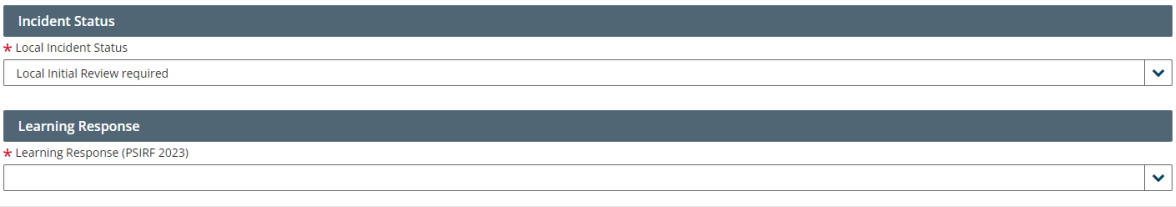
	ID	Ref	Name	Learning Response Lead (Previously Lead investigator)	Reported date	Incident date	Service	Type	Category	Sub category	Severity	Description	Approval status
	1	TEST1	BLOGGS JOE	Governance, 111	08/05/2019	01/01/2019	Yorkshire Ambulance Service / Planned and Urgent Care / Integrated Urgent Care (IUC)	Affected Patient - Non-Clinical	Response Related - Integrated Urgent Care (IUC) (NHS111)	Failure of care pathway	Moderate	PSIRF test test Leave Open RLD update 07/09/23 RLD update	Being reviewed

On this listing page you can see quickly who reported the incident (Service) for eg this record was reported by IUC, you can see the category, severity and description.
You can also see the Learning Response Lead. This is the person currently assigned as the owner of the record, this could be a Team Leader or other nominate manager, if this field is blank, this means that this record hasn’t been quality checked yet by the central team.
Even if not quality checked it doesn’t mean you cant look at them, however be aware that when you save the record it will save it and assign yourself as the Lead.

Once you click into the record you will be displayed the normal incident investigation form but with some changes for PSIRF. On the menu on the left you will see the Investigation Panel (Number 4):



In order to proceed this incident record through the process you will need to go to the investigation panel.
Once in this section underneath the people involved section you will see two new sections:



The first section Incident Status holds the Local Incident Status, it is this question that powers the dashboard view, the changes you make to this field will change the display on the dashboard to reflect the change.
Also depending on the option selected may trigger further information required which we will cover below. The options are detailed below along with any further information required:

- **Local Initial Review Required**

This Status is the default status for all new incidents, this is the status that will display on the dashboard and require review by the service lines to determine what form of response is required to the incident (If any). Leaving an incident in this status will indicate it hasn't been reviewed.

- **Local Closure**

As part of your review you may feel that the incident can be closed without needing the nominated manager to investigate it.

Important
If you do close the incident without an investigation you need to ensure you change the lead investigator to your own name, so the reporter knows who has provided the feedback.
You will still also need to complete the form and change the Approval to Awaiting Final Approval.

- **Local Incident Review Group**

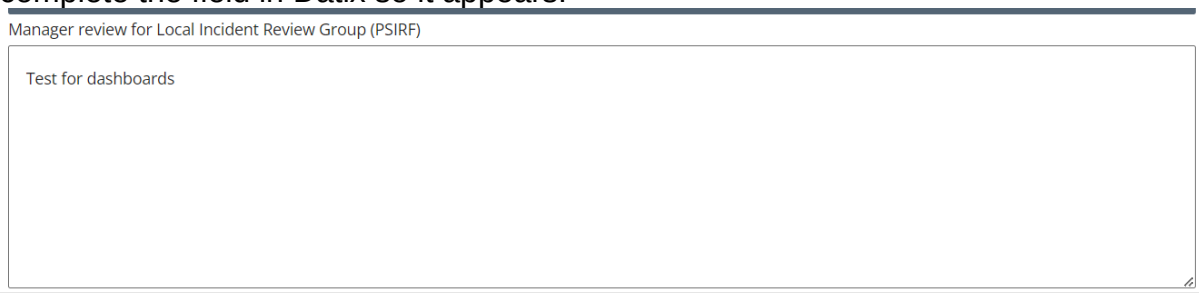
This status is your way of flagging a record to be discussed at your next Local Incident Review Group, when selecting this option, the incident will display on the dashboard under the Incident Review Group report:

Incidents - Local IRG Report (South Yorkshire ICB) - RH (Aug 2023)

Ref	Reported date	Incident date	Description	Manager review for Local Incident Review Group (PSIRF)	Severity	Local Incident Status
TEST1	08/05/2019	01/01/2019	PSIRF test test Leave Open RLD update 07/09/23 RLD update	Test for dashboards	Moderate	Local Incident Review Group

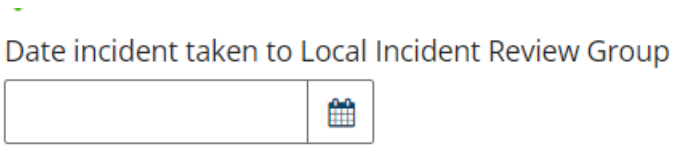
End of report

In order for the Local IRG to have the reviewer's information on this dashboard you must complete the field in Datix so it appears:



This will build your agenda for your Local IRG meetings, once the meeting has been held you will need to then update the progress notes with an update from the meeting and any decisions made.

Once the case has been to Local IRG you need to complete a date into this field, otherwise the case will display forever on this report:



- **Local Incident Review Group – Watching List**

Some incidents once discussed at the Local IRG will need some further information gathering before the case can have a decision made as to whether it can be investigated / closed locally or if it needs a further learning response and subsequently then discussed at Central IRG. When you select this option, the report on the dashboard updates and moves the case to the Watching list report:

Incidents - Local IRG Report (South Yorkshire ICB) - RH (Aug 2023)

Ref	Reported date	Incident date	Description	Manager review for Local Incident Review Group (PSIRF)	Severity	Local Incident Status

End of report

Incidents - Central IRG Report (South Yorkshire) - RH (Aug 2023)

Ref	Reported date	Incident date	Description	Manager review for Central Incident Review Group (PSIRF)	Severity	Local Incident Status

End of report

Incidents - Local IRG Report (South Yorkshire ICB) Watching List - RH (Aug 2023)

Ref	Reported date	Incident date	Description	Manager review for Local Incident Review Group (PSIRF)	Severity
TEST1	08/05/2019	01/01/2019	PSIRF test test Leave Open RLD update 07/09/23 RLD update	Test for dashboards	Modera

End of report

- **Central Incident Review Group**

Once Local IRG has made a decision OR the incident is serious enough to be escalated to Central IRG bypassing the Local IRG you will then need to select this option, once this option is selected the case will move on the Dashboard to the Central IRG Report AND also populate on the Central IRG dashboard.
When taking a case to Central IRG you must input the SBAR update in Datix so this is visible to Central IRG members.

This is done by selecting the below options:

Any text entered in the Manager Review field will appear on the dashboard.
Again, when Central IRG has met you will need to update the Progress Notes with any decisions made.

You then need to change the Local Status field to reflect the decision made, this could be Local Closure or Local Response confirmed and initiated. If you don't change this status, the incident will remain on the Central IG dashboard and report indefinitely.

- **Local Response confirmed and initiated**

This status is usually identified once Local or Central IRG has met and a response has been identified for the incident, once you select this status you will then be prompted to identify the type of learning response to be undertaken.
All you need to do is ensure that you select the correct learning response from the list as this will then generate the relevant response question set within the form.

You will also need to ensure that the Learning Response lead field is updated to reflect the correct manager completing this learning response otherwise they may not be aware of the incident or be able to access it.

The incident should then be reviewed, the Datix fields completed and then submitted to Awaiting Final Approval.