..CoSign Partners in communication ltd

Patient safety incident response policy and plan

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	NAME	TITLE	SIGNATURE	DATE
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This policy will support the arrangements in place to comply with the NHS Patient Safety Incident Response Framework (PSIRF) It has been developed and has not identified any significant change in practice required.

Contents

Introduction

This patient safety incident response plan sets out how CoSign Partners in Communication ltd intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our services

Notes

We provide BSL Interpreters enabling health practitioners to interact with their BSL Users in a range of settings, from Primary care to secondary care settings, mental health, people with learning disabilities to people on end-of-life care plans. None of our Interpreters would ever be left alone in any situation following ICB guidance on protecting patients for grooming by spoken language Interpreters.

Defining our patient safety incident profile

BSL Interpreters are guidelines issued by our governing body NRCPD. This policy supports the requirements of the Patient Safety Incident Framework, (PRSIRF) and sets out how CoSign will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for learning and improving Patient safety.

Alongside our other relevant policies and procedures, including:

Serious incident notification policy and procedure

Complaints, comments and compliments procedure.

Duty of candour Policy and procedure.

Safeguarding adults. Policy and procedure.

NRCPD National recommendations.

Our policy is that a BSL user would never be alone with an interpreter without another clinician in attendance. The interpreters would also follow the PRSIRF of the setting they were in i.e a GP surgery which may be different to that of a Hospice.

Scope:

The following stakeholders will be affected by this policy:

Deaf patients.

Family members.

Professionals, including commissioners.

Interpreters.

Objectives:

To ensure all staff and freelance interpreters respond to patient safety incidents when they happen, to prevent recurrence.

To ensure that staff and freelancers have the relevant knowledge and training as outlined in the PSIRF.

To ensure the PSIRF is central to the overarching safety governance arrangements at CoSign.

Defining our patient safety improvement profile

Policy

CoSign is firmly committed to continuously improving the care and services it provides, learning from any incidents where the interaction does not go as planned or expected for clients to prevent recurrence.

Patient safety incidents are events where a client/customer experienced or could have experienced harm during an encounter with healthcare. This can range from the most minor to the other extreme.

The PSIRF sets out the NHS's approach developing and maintaining effective systems and processes for responding to patient safety incidents (PSIs) for the purpose of learning and improving patient safety to reduce risk. An effective patient safety incident response system will lead to more compassionate engagement and involvement for those affected by patient safety incidents and give staff space for reflection. An important factor is to understand how incidents happen. This allows staff/Interpreters to learn and improve, in turn creating a safer system for Clients.

The PSIRF is a contractual requirement under the NHS standard Contract and, as such, is mandatory for services provided under the contract, including acute, ambulance, mental health, and community healthcare providers.

The patient safety incident response framework (PSIRF) has replaced the serious incident framework. This new framework ensures that investigations are strategic, preventative, collaborative, fair and people focused. It looks at the cause of the incident within the system, rather than seeking someone to blame.

The serious incident framework (2015) described when and how to investigate a serious incident. The PSIRF focuses on learning and improvement and CoSign is responsible for the entire process including what to investigate and how. Beyond nationally set requirements, CoSign can explore patient safety incidents relevant to their context and their clients, rather than only those that can meet a certain defined threshold. The PSIRF does not mandate investigation as the sole method to produce meaningful learning from PSIs.

CoSign will develop a thorough understanding of its clients safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programs, to do so, information is collected and synthesised from a wide variety of sources, including wide stakeholder engagement.

The PSIRF no longer uses root cause analysis (RCA). It sees patient safety emerging from complex interactions and is not the result of an individual cause, such as one person, and:

- Recognises that outcomes in complex systems result from the interaction of multiple factors.
- Learning should not focus on uncovering a root cause but instead should explore multiple contributing factors.
- Does not distinguish between care and service delivery problems.

- Explores contributory factors, including individual acts in the context of the whole system
- Uses tools to explore multiple interacting contributory factors rather than forcing a single, analytical pathway

The PSIRF supports the development and maintenance of an effective patient safety incidence response system with 4 key aims.

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

The PSIRF offers:

- Increased patient safety by prioritising incident reporting and investigation
- Enhanced Quality of service – Learning from incidents leads to improved policy and practices and policies, resulting in better quality of service for patients
- Increased Transparency- creating trust amongst Deaf patients and professionals.
- Continuous Improvement – the culture of learning and improvement at CoSign can drive ongoing enhancements in the delivery of social care.
- Empowered staff/freelancers - Encouraging incident reporting and providing support to staff nurtures a sense of encouragement and dedication in providing safe Interpretations.

The Managing Director will ensure that any patient safety incident response processes support health equality and reduce inequality for Deaf people, professionals and staff/Interpreters

CoSign recognises and acknowledges the significant impact patient safety issues have on patients and their families.

Getting involvement right with patients in how we respond to incidences is crucial, particularly to improve the services provided. This involves being open and honest, wherever there is a concern that services have not been as planned or expected, or when a mistake has been made.

As well as meeting regular requirements for Duty of Candour, we will be open and transparent with Deaf people as it is the morally right thing to do.

This is regardless of the level of harm caused by an incident

The MD must ensure that those conduction knowledge and experience gained through training.

The PSIRF is supported by NHS guidance documents which include:

- Guild to reporting proportionally to patients safety incidents
- Response tools , templates and guides
- Engaging and involving Deaf people and professionals following a Patient safety incident.
- Oversight roles and responsibilities specification
- PSIR standards

We will ensure that these resources are available to staff/ Freelance Interpreters

All staff/freelance Interpreters are required to:

- Report all incidences, patient safety events and near misses via the reporting system at CoSign
- Raise any concerns with the MD that led up to, or could lead to, an incident, safety event or near miss.
- Actively participate in any subsequent reviews and learning from responses, providing a written account, attending multidisciplinary fact finding and feedback meetings as needed.
- Attend a coroner's inquest if called to do so.
- Undertake training in the reporting of incidents or safety events.
- Understand their responsibilities in relation to the PSIRF. And act accordingly.
- Know how to access help and support in relation to the patient safety incident response process.

The managing director:

- Ensures that the patient safety incident investigations. (PSiis) are undertaken for all incidents that require this level of response. As directed by CoSign's policy
- Has overall responsibility for ensuring there are processes that support an appropriate response to patient safety incidents. Including contribution to cross system or multi agencies reviews and/or investigations were required.
- Has overall responsibility for ensuring the development of the patient safety reporting, learning and improvement system.
- Ensures that systems and processes are adequately resource. Funding, management, time, equipment and training.
- Ensures that the PSIRF data findings, improvement plans and progress are discussed at quality meetings.
- Ensures compliance with internal and external reporting or notification requirements.
- Ensures that duty of candour is upheld.
- Encourages the reporting of all safety incidents. And ensures all staff and freelance interpreters are aware of the reporting system at CoSign
- Ensures that incidents are reported and managed in line with internal and external requirements.
- Supports and advises staff involved in the patient safety incident response. Ensures those affected by safety incidents have access to the support they need.
- liaises with external bodies that support CoSign. The managing director acts as a spokesperson for CoSign as required.

- Works with services to address identified areas for improvement in response to patient safety incidents, including gaps in resources such as skills and or training.
- Develops professional development plans to ensure that all staff or freelance interpreters have the training, skills and experience relative to their roles in patient safety incident management.
- Establishes procedures to monitor and review. PSII progress on the delivery of improvements.
- Demonstrates that we and our staff or freelance interpreters periodically review the PS, IRF an the organisations PSIRF to check that expectations are clearly understood. Supports the development and delivery of actions in response to patient safety. Reviews the PSIIs that relate to their area of responsibility.

Providers of NHS funded care.

The Managing Director is responsible and accountable for effective patient safety incident management at CoSign.

This includes supporting and participating in cross system multi agency responses and or independent patient safety incident investigations where required. oversight under PSIRF will focus on engagement and empowerment at CoSign, not command and control.

Information from a PSII should be shared, if required, with those leading other types of responses.

patient safety culture.

The managing director will ensure staff/Interpreters feel supported to speak up when things go wrong, rather than fearing blame. This will be achieved through a culture of fairness, openness and learning. The managing director will ensure they do not undermine just culture by requiring inappropriate automatic suspension of staff involved in patient safety incidents or their removal from the business as usual activities.

Patient safety partners.

Patient safety partners (PSPs) should be involved in safety at CoSign by supporting and contributing to the governance and management process at CoSign for patient safety.

Roles for patient safety partners include:

- membership of safety and quality committees whose responsibilities include the review and analysis of safety data. Involvement in patient safety improvement projects. Working with Cosign to consider how to improve safety. Involvement in staff and freelance interpreter safety training. Participation in investigation oversight groups.

Health Inequality's.

The managing director will ensure that any. Patient safety incident response process supports health equality and reduces inequalities by:

- Identifying any disproportionate risks to Deaf people with special characteristics and using this information to inform patient safety incident response.
- Exploring and responding to issues relating to health inequalities as part of the development. And maintenance of the patient safety incident response of CoSign
- Using the tools to respond to patient safety incidents. To prompt consideration of inequalities.
- Considering inequalities when developing safety action plans.
- Considering the different needs of patients, families and interpreters when engaging with them.
- Upholding a system-based approach and ensuring that staff have the relevant training to support the development of a just culture.

Compassionate engagement and involvement of those affected by patient safety incidents.

The PSIRF recognises that learning and improvement following a patient safety incident can only (Deaf People, Families, Professionals, Staff or Interpreters) be achieved if systems and processes that support compassionate engagement and involvement of those affected by the patient safety incidents are in place. Compassionate engagement and involvement means working with those affected by patient safety incidents to understand and answer any questions that they have in relation to the incident and signpost them to support as required. When a patient safety incident investigation. (PSII) or other learning responses undertaken CoSign should meaningfully involve those affected where they wish to be involved. The Managing Director and Cosine will demonstrate their commitment to compassionate engagement and involvement in their words and actions. Engagement and involvement must be communicated as a genuine priority and not a formality at CoSign.

When a family or staff member informs an organisation that something has gone wrong. They must be taken seriously from the outset and treated with compassion and understanding.

Engaging with those affected by a patient safety incident and involving them in a learning response has benefits:

- People affected by a patient safety incident may have a range of needs, including clinical needs. As a result and these must be met where possible. This is part of the duty of care at CoSign. Meeting a person’s needs helps alleviate the harm experienced and helps avoid compounding that harm
- Engaging with those affected by a patient safety incident improves the understanding of what happened and potentially how to prevent a similar incident in the future.
- Patients and their family members may be the only people with insight into what happened at every stage. Not including these insights could mean an incomplete picture of what happened.

- Staff have important contributions to make about their experience of the incident and the working environment at the time and should be supported to share their account. Creating much stronger links between a patient safety incident and learning and improvement.
- Cosign will continue to increase transparency and openness among staff in the reporting of incidents and the engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

  CoSign should ensure obligations relevant to the duty of candour are upheld. A learning response takes place. Those affected should be involved in a meaningful way:
- Fully informed about what happened. Allowed to bring the friend, family member, or advocate of their choice with them to any meeting. This is part of the learning response process.
- Given the opportunity to provide their perspective on what happened.
- Communicated with in a way that takes account of their needs.
- Given an opportunity to raise questions about what has happened and have these answered openly and honestly.
- Given the opportunity to receive information from the outset on whether there will be a specific learning response and what to expect from the process.
- Informed in a timely fashion of any delays with the learning response and the reasons for them.
- Updated at specific milestones. In the learning response, should they wish to be.
- Offered support and advice throughout a patient safety incident investigation.
- Assisted to access counselling or therapy where needed.
- Signposted to where they can obtain specialist advice and or advocacy and all support from independent organisations regarding learning response processes
- Receive a consistent level of timely, meaningful, and compassionate engagement, delivered an assured at every stage from notification of the incident through completion of investigation and during feedback of the report findings and required actions.
- . Invited to contribute to the development of safety actions resulting from the learning response.
- Given the opportunity to feedback on their experience of the learning, response and report. For example, timeliness, fairness and transparency.

The engagement and involvement with those affected by PSIS.s Should be led by staff with a specific level of training in ‘Involving those affected by patient safety incidents in the learning process’ Further information can be found on the NHS Oversight roles and responsibilities specifications.

Engagement Principles

Nine principles should inform the design of the systems and process is at CoSign for engaging and involving those affected by patient safety incidents. Due to the range of incidents that can occur and the different needs of the patients affected, the principles

should be flexibly applied when engaging with or involving those affected by patient safety incidents in an investigation:

- Apologies are meaningful.
- Approach is individualised.
- Timing is sensitive. Those affected are treated with respect and compassion.
- Guidance and clarity are provided.
- Those affected are listened to.
- Approach is collaborative and open.
- Subjectivity. Is accepted.
- Strive for equity.

Further details can be found on the NHS England PSIRF supporting guidance, 'Engaging and involving patients, family and staff following a patient safety incident'

Four steps of engagement:
Cosign should consider using the NHS Engagement framework

Duty of candour and being open.

The Managing Director provides support and guidance to staff in adhering to the Duty of Candour requirements. Staff and interpreters should refer to the Duty of Candle policy and Procedure at CoSign.

Patient safety incident investigation (PSII)
It is up to CoSign to decide when a patient safety incident investigation should take place depending on the circumstances and factors However, there are some categories of incidents where carrying out a PSII is mandatory and these include:

- Patient deaths thought more likely than not to be due to problems in care under the 'Learning from Deaths' criteria.
- Deaths of patients detained under the Mental Health Act or where the Mental Capacity Act (2005) applies where there is reason to think that the death may be linked to problems in care
- Deaths of patients with learning disabilities.
- Incidents that meet the 'never events' criteria.
- Safeguarding incidents.

These are set out in the NHS Guide to 'responding proportionately to patient safety incidents'. If the PSI does not meet these criteria's, it may still meet the threshold for statutory duty of candour.

Patient safety priorities.

CoSign should determine PSIRS priorities. To focus on for the year, these should be chosen based on. Patient safety insights and thematic themes.

CoSign should work with a range of stakeholders to create a list of PACE patient safety incident types that are jointly identified as areas of interest in terms of risk and potential learning and improvement. The managing director can. List as many incident types as deemed appropriate. The stakeholders that CoSign should work with should be diverse and include but not limited to:

- Patient safety partners. And or patient and public representative groups such as the Local Health Watch.
- Integrated care board. ICB. Patient safety specialists. CQC and other professional regulators. Specific and distinct clinical governance teams, conditions and safety champions.
- Safeguarding incidents.

These are set out in the NHS Guide to responding proportionately to patient safety incidents. If the PSI does not meet these criteria, it may meet the threshold for statutory duty of candour.

While planning supports proactive allocation of patient safety incidents response resources. There will always need to be a reactive element to responding to incidents.

A response should always be considered for the patient safety incidents that is significantly an unexpected high level of risk and or potential for learning an improvement but falls outside the issues or specified as described in the organisation plan.

CoSign recognises that there may be occasions when patients, families or carers are dissatisfied with aspects of their service. We are committed to dealing with any complaints as quickly as possible. Complaints will be handled respectfully ensuring that all parties feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner. Our complaints procedure can be found at the bottom of our emails, on our website and is available upon request as a hard copy.

Patient safety incident investigation.(PSII)

All incidents will be reported through LFPSE regardless of the level of investigation required at:

NHS England >>learn from patient safety events (LFPSE) service

Investigations explore decisions or actions that relate to the situation. The method is based on the thought that actions or decisions are consequences, not causes, and is guided by the principle that staff 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 in that at the time,

Cosign will work with a wide range of stakeholders to create a list of patient safety incident types that are jointly identifies as areas of interest in terms of risk and potential learning and improvement. The general manager can list as many incident types as deemed appropriate. The stakeholders that Jeff Wave should work with should be diverse and include but not be limited to:

- Patient safety partners and or patient and public representative groups such as the Local Health Watch.
- The integrated care board. ICB patient safety specialists.
- Professional bodies such as NRCPD (The governing body for British Sign Language interpreters.
- Specific and distinct clinical governance teams. Clinicians. And safety champions.)
- Any patient safety incident types should be agreed with CoSign. They could include.
- Unexpected death. after unrecognisable physical health deterioration.
- Lack of prompt intervention.
- Medication errors.
- Violence and distressed behaviour resulting in significant injury.
- Misinformation. Due to interpreter error

While planning supports proactive allocation of patient safety Incident response resource is there will always need to be a reactive element in responding to incidents.

A response should always be considered for patient safety incidents. That signify an unexpected level of risk and or potential for learning and improvement but fall outside the issues of specific incidents described in the organisations plan.

Investigations explore decisions or actions as they relate to the situation. The method is based on the thoughts that actions or decisions, are consequences, not causes, and is guided by the principle that staff were well intended and strive to do the best they can. The

goal is to understand why an action and or decision was deemed appropriate by those at the time.

Planning safety incident investigation stages:

Planning:

- Identify a team/learning response lead
- Commence engagement with those affected
- Agree terms of reference

Synthesis:

- Gather information
- Build Narrative
- Analysis
- Safety action development
- Report preparation.
- Safety improvement.

Patient safety priorities.

Cosign should determine PSIS priorities to focus on for the year. Chosen based on patient safety insights and the MATIC analysis. COSIGN should work with a range of stakeholders to create a list of patient safety incident types that are jointly identified as areas of interest in terms of risk and potential learning and improvement. The general manager can list as many incident types as deemed appropriate.

Patient safety incident investigators.

Patient safety incidents Investigators must have been trained over a minimum of two days in systems based PSII. They will:

- Ensure that they undertake PSIIs in line with the national PSII standards.
- Ensure that they are competent to undertake the PSII assigned to them and if not, request it is reassigned.
- Undertake PSSI and PSI related duties in line with the latest national guidance and training.
- Identify those affected by patient safety incidents and their support needs.
- Provide those affected by patient safety incidents with timely and accessible information and advice.

Training.

The PSIRF requires a degree of training to ensure that those conducting investigations, as well as those providing oversight of the process, have an adequate level of knowledge and experience. To ensure that investigations lead to learning and improvement.

CoSign is committed to ensuring it fully embeds PSIRF and meets its requirements.

CoSign will use the NHS England Patient Safety Response Standards (2022) to frame the resources and training required

- Learning responses are led by those who have 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. (Essential of patient safety) and level 2 (access to the practise) of the NHS Practise safety syllabus.
- Learning responsibly, 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 contributes to a minimum of two learning responses per year.
- CoSign will contact a Consultant to provide support in this area.

Support systems.

The managing director will recognise that full staff involved with a PSI. This can be a traumatic experience. And ensure well-being support for all staff.

Families and staff may need to be signposted to support. At any point during engagement or involvement in the learning response. Cosign will ensure it is fair in the support offered to families and staff and that systems exist for internal and external support so that those affected can access support in. Away they prefer wherever possible. Sources of support for families may include the bereavement and mental health services as well as via independent advocacy services and for staff, mental health first aid, 2nd Victim Support and local occupational health services. The general manager should review, where possible, the support offering. Of the organisation they signpost to to ensure they have the resources to respond.

Risk assessment.

The managing director must ensure the safety of deaf patients. And others. During contact with cosine.

Risk assessments need to be dynamic throughout the engagement and investigation process.

Record keeping.

All communication should be documented, even when not successful and what was discussed recorded. This ensures an accurate audit trail. Records should contain:

- Date and time of all contacts and meetings.
- Method of contact, (telephone or e-mail).
- Who was in attendance?

- Purpose of contact and information exchanged.
- Who initiated the contact?
- Any contacts unsuccessful or refused/declined.

Other responses.

All the responses may take place concurrently with or following the response of cosign to a patient safety incident, including:

- Complaint.
- Fitness to practise.
- Health and Safety Executive.
- Coroner's inquest.
- Litigation.
- Police investigation.
- Social Services.

The managing director. Will ensure that CoSign assists and complies with other relevant investigation and bodies.

Report preparation.

When writing a report, the following should be considered:

- Who is going to Be reading it? Are there language implications?
- Who needs to be involved? When is the report required? Can this time line be met?
- How will the needs of the readers be accommodated?
- How should the report be formatted, including how will findings be described?

Patient safety. Incident response planning.

A patient safety incident response plan. (PSIRP) Sets out how cosine. Will respond to patient safety incidents reported by staff. Deaf people. As part of their work to continually improve the quality and. Safety of the service provided.

The Managing Director will develop the PS IRP to learn and improve through patient safety incidents, investigations, PS. IIS. It should be based on a thorough understanding of the patient safety in incident profile of cosine. On Boeing improvement priorities, available resources and the priorities of stakeholders, including deaf people.

The managing director. Should ensure that the plan;

- Demonstrates a thorough analysis of relevant organisational data.
- Demonstrates a collaborative stakeholder engagement process. Informed by through service and stakeholder mapping activities to ensure all areas are involved and represented appropriately.
- Is a living document that will be appropriately amended and updated as it is used to respond to patient safety incidents.

- Is reviewed every 18 months. To ensure the focus remains up to date. With ongoing improvement work, the Patient Safety Instant profile is likely to change. It will also provide an opportunity to re engage with stakeholders to discuss and agree any changes made in the previous 18 months.
- Provides a clear rationale for the response to each identified patient safety incident type.
- Is updated as required and in accordance with the emerging intelligence And improvement Efforts.
- Is updated to incorporate any new learning. The changing risk profile of Cosine as well as any of its ongoing improvement initiatives. This will ensure that incident response becomes a key element of the approach taken by cosine to Wider's. Service Management.
- The patient safety Incident response plan must be agreed by the ICB. Although commissioning leads where required. And by the Managing Director of Cosine.

The patient safety incident response framework , Each organisations. Patient safety incident response plan. Will outline how they will respond to PS size over a period of 12 to 18 months. The four stages of planning response methods are.

- Examine patient safety incident records and safety data. Describe safety issues demonstrated by the data. Identify improvement works underway. Agreed response methods.

A rigorous planning exercise. That includes a review of the data. Including PS I I reports improvement plans and reporting data and wider stakeholder engagement should happen at a minimum every four years and more frequently if appropriate, as agreed with the Integrated Care Board. To ensure. Efforts continue to be balanced between learning and improvements for years is suggested before performing original rigorous planning exercise to allow enough time for safety actions and subsequent improvements to embed.

Patient safety incident Response activity.

The PSIRF does not mandate investigation as the sole method to produce meaningful learnings from PSIs PSIRF focuses on the system based approach which involves an examination of the components of the system. A person(s), task, tools and technology, the environment and the wider organisation to gain a deeper understanding of how their interdependencies might impact patient safety.

This suggests that in that patient, safety emerges from complex interactions and is not the result of an individual cause such as one persons actions.

Patient safety incident response activity can be divided into 3 overarching categories depending on the key objective:

Learning to inform improvement.

Several system-based learning response methods are available to use in response to a PSI:

- Where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influence the outcome.
- Several system-based learning response methods. Are available to respond to a patient safety incident or cluster of incidents. Patient safety incident investigation.
- MDT Review.
- Swarm Huddle.
- After action review.
- This is the greatest potential for new learning and development.
- An understanding of everyday work. How work is done and how staff perform routine tasks adjusting to this. Ever changing conditions and demands can supplement in the finding out of what happened
- Understanding everyday work is central to any learning response to inform improvement.
- Tools to explore everyday work include:
- Observation guides.
- Walkthrough guide.
- Link analysis guide.
- Interview guide.
- Other tools to gather information include:
- Timeline mapping.
- Work system scan.

Improvement based on learning:

- Wherein incident type is well understood because previous incidents of this type have been thoroughly investigated. Any national or local improvement funds targeted at the contributory factors are being implemented and monitored for effectiveness. Resources may be better directed at improvement rather than investigation.
- If CoSign and its ICB are satisfied, risks are being appropriately managed and or improvement work is ongoing to address known contributory factors in relation to an identified patient safety incident type. That efficiency of safety actions is being monitored. It is acceptable not to undertake individual learning response to an incident other than recording that it occurs and ensuring those affected are engaged.
- A learning response may not be required. Or may not be the best way to address concerns and questions raised by those affected. If only affected patient. Family or staff member requested a learning response. Cosine should should carefully consider their request.
- If such incidents involve moderate or greater harm, cosine must fulfil its duty of candour obligations.

Assessment to determine required response.

If Cosign is unable to easily identify if a learning response is required, it may need to perform an assessment to determine if there were any problems in care that required further exploration action.

Patient safety incident response methodology.

- Responses are conducted for the sole purpose of learning an identifying improvements that reduce the risk and or prevent or significantly reduce RE occurrence.
- Responses are insulated from remit that seek to. Determine avoid ability. Preventability. Predictability. Legal liability. Blame. Professional conduct, competence, fitness to practise criminality or cause of death.
- With reference to the culture guide. Referral for individual management, performance review or disciplinary action only occurs if for acts of wilful harm or wilful neglect. Patient safety incident investigation reports are produced using this standardised national template. Patient safety incident investigation reports are written in clear and accessible way.
- National tools or similar system based tools are used and guides followed for learning response methods. Learning and improvement work are adequately balanced. Cosine does not continue to conduct individual learning responses when sufficient learning exists from improvement.

Patient safety incident response resource is:

- Learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage the staff. Learning responses. Leeds should have an appropriate level of seniority, an influence within the organisation. This may depend on the nature and complexity of the incident. An response required. Learning responses are not undertaken by staff working in isolation. A learning response team should be established. Support the learning responses wherever possible. Staff affected by patient safety incidents are given time and are supported to participate in learning responses. Learning Response leads have dedicated paid time to conduct learning responses if necessary. Their normal roles are backfilled.
- Subject matter experts with relevant knowledge and skills are involved when necessary throughout the learning response process to provide expertise, EG clinical or human factor review advice. Proofreading. There is dedicated staff resource to support the engagement and involvement of those affected.

Competency and capacity:

Learning response leads. Those leading engagement and involvement, as well as those in PS I RF oversight roles are required to have specific knowledge and experience. The Patient Safety Incident Response Standards distinguish between training requirements and competence is for these two roles but recognise they may be fulfilled by the same individual.

Local priorities:

It is feasible that an Incident could occur on a local level, if this was the case:

1) We would Identify safety Incident
2) The response procedure would be implemented
3) Based on the results a comprehensive improvement route would be implemented

An example of this could be a delay in allocating a referral, this could be a serious issue which potentially would impact on patient safety. The referral process would be reviewed in order to understand why the delay had occurred, in the past we have highlighted that in emergency situations requests can be made out of hours via email. However out of hours, it is only the emergency phone which is manned. As a result of this, a policy was created to ensure that at the end of each working day. A bounce back email would be sent, informing the originator that the emails are not monitored out of hours and the mobile number would need to be called. The email included the emergency contact details.

A further example could be a confidentiality breach. As previously mentioned, we take confidentiality extremely seriously. We have a number of fail safes in place to ensure this cannot happen, however on occasion, we have received confidential information from the originator. The response procedure was implemented, the information trail was reviewed, and a potential breach was identified, and although we didn't instigate the breach, forwarding that information would compromise a persons confidential information. As result, a policy was implemented and prior to forwarding an further information, the original email would be amended to ensure we do not inadvertently pass on confidential information.

Notes

CoSign's policy has been influenced by the following policies/guidance:

Equality Act 2010

Safeguarding Vulnerable Groups Act 2006

NRCPD guidelines, roles and responsibilities of BSL Interpreters 2025

Accessible Information Standard 2016

Version 2

Review date 2026