Royal Devon University Healthcare
NHS Foundation Trust

Patient Safety Incident Response Plan

2026 – 2029

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1 Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how Royal Devon University Healthcare NHS Foundation Trust intends to respond to patient safety events over a period of three years. The plan is not permanent and will be refreshed on a regular basis. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The key principles of the Patient Safety Incident Response Framework (PSIRF) are closely aligned to our values as a healthcare provider; and our Board of Directors fully endorses the opportunity PSIRF provides for developing our approach to patient safety in a way which aligns to our own strategic objectives and values.

The Trust approved and published its first Patient Safety Incident Response Plan (PSIRP) in November 2023, prior to formally adopting the NHS Patient Safety Incident Response Framework (PSIRF) on 01 December 2024. To ensure that the plan remains fit for purpose it will be subject to an annual refresh, based upon a review of our patient safety data and any emergent trends which have become apparent. The review for the current plan commenced in September 2025.

The review of data looked at a three-year period of patient safety event data from 01 July 2022 to 31 August 2025. This included a light touch triangulation with other insight sources, including feedback (Complaints and Compliments), Mortality Data, the Trust Risk Registers, staff surveys, audit reports and safeguarding inquiries.

Responding proportionately and effectively to patient safety events plays a critical role in managing patient safety-related risks. As part of this PSIRP refresh, we have embedded risk management principles throughout the plan. By aligning the PSIRP with the Trust's broader risk governance framework, we ensure that patient safety incident response and risk management operate hand in hand, mutually reinforcing one another and enabling a more integrated, intelligence-led approach to learning and improvement. Our approach, as outlined in this plan, now incorporates principles of Safety II, which is a proactive methodology in healthcare that emphasises understanding and enhancing the conditions that lead to positive results. This recognises that, in most instances, Trust systems operate effectively, and learnings can be gained from these successful outcomes.

The review was not restricted to data but also included formative review of the Governance and Oversight Arrangements for Patient Safety.

Crucially, engagement with frontline staff took place throughout the review and implementation of this plan. Their insights, experiences, and reflections are essential to ensuring that our response to patient safety events is grounded in real-world practice and that it reflects the challenges experienced by clinical colleagues. This will also support the strengthening of our safety culture and facilitate continuous improvement.

2 Our Services

The Royal Devon University Healthcare NHS Foundation Trust (the RDUH) was established in April 2022, bringing together the expertise of the Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust. Stretching across Northern, Eastern and Mid Devon, we have a workforce of almost 16,000 staff, making us the largest employer in Devon. Our core services, which we provide for more than 615,000 people, cover over 2,000 square miles across Devon, while some of our specialist services cover the whole of the peninsula, extending our reach as far as Cornwall and the Isles of Scilly.

We deliver a wide range of emergency, specialist and general medical services through North Devon District Hospital and the Royal Devon and Exeter Hospital (Wonford). Alongside our two acute hospitals, we provide integrated health and social care services across a variety of settings including community inpatient hospitals, outpatient clinics, and within people's own homes. We also offer a range of specialist community services, Sexual Assault Referral Centres (SARC) and a GP practice (Castle Place, Tiverton).

In 2024/2025 The RDUH:

- Cared for 183,827 inpatients, 102,812 day cases, and 1,254,587 outpatients
- Our Emergency Departments had 161,482 attendances; our Minor Injuries Units had 24,005 attendances; and our Walk-In Centre had 27,157 attendances
- We looked after 1,588 people in our community hospitals
- We provided care to 24,242 people in their homes
- Our virtual ward (Acute Hospital At Home) provided care for a total of 4,014 patients
- 4,528 babies were delivered

2.1 The Royal Devon and Exeter (Wonford) Hospital

Royal Devon and Exeter Hospital (Wonford) is our largest hospital in the Trust, where many of our acute clinical services are based, including an Emergency Department and a number of highly acclaimed specialist units and centres.

As a teaching hospital, it delivers undergraduate education for a full range of clinical professions. We are the lead partner for the University of Exeter College of Medicine and Health and a leading centre for high quality research and development in the South West peninsula.

2.2 North Devon District Hospital

The North Devon District Hospital (NDDH) is our district general hospital in Barnstaple. We offer emergency and urgent care for people in North Devon and the surrounding areas.

This includes an emergency department, intensive care unit (ICU), women and children's services and diagnostics as well as many outpatient clinics and specialist services such as the North Devon Comprehensive Hernia Centre which is a specialist referral service for all aspects of hernia and abdominal wall surgery.

2.3 Integrated Community Health and Social Care Teams

Our teams of integrated health and social care community professionals across Eastern and Northern Devon work to rehabilitate patients, avoid admissions, and promote health, wellbeing and independence. We also support people who may need short term support until they regain their independence or specialist end-of-life care and provide local outpatient and self-referral services, such as sexual health clinics.

We manage a range of inpatient and outpatient services from 17 community hospital locations, including Axminster, Bideford, Crediton, Exeter (Whipton and Heavitree), Exmouth, Holsworthy, Honiton, Ilfracombe, Moretonhampstead, Okehampton, Ottery St Mary, Seaton, Sidmouth, South Molton, Tiverton and Torrington, which provide accessible local hubs for our communities.

Our community teams work closely with a wide number of health and care professionals, including colleagues working in the acute hospital, social care, primary care, mental health and other partner organisations to support people to self-manage their long-term conditions, improve their mobility and maintain their independence.

2.4 Specialist Community Services

The Trust is the main provider of specialist community healthcare services across Northern, Eastern, Mid and South Devon, including podiatry, dentistry and sexual health. We also run Sexual Assault Referral Centres (SARC) across Devon, Cornwall and the Isles of Scilly, as well as adult and paediatric bladder and bowel care services in these areas

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2.5 Specialist centres

2.5.1 Nightingale Hospital

The NHS Nightingale Hospital Exeter is a state-of-the-art healthcare facility providing non-urgent care to patients across Devon and it is located separately from the acute hospitals in Devon. This facility means patients can benefit from clinics and diagnostic services located in the same place, reducing the number of visits and wait times.

2.5.2 Fern Centre

Opened in 2020, the Fern Centre, funded by the hospital charity Over and Above and made possible through the generosity of the people of North Devon, provides a warm, welcoming, non-clinical environment offering information and support to people affected by cancer and their families. The Centre operates as a drop-in service supported by trained volunteers and offers information on cancer diagnoses, treatments, wellbeing, and staying healthy during a cancer journey, alongside counselling for patients, partners, and children. Patients, families, and carers can also access complementary therapies, support groups, and financial advice, or simply visit for information, support, or an informal conversation.

3 Aim of our PSIRP

Our PSIRP aims to enhance the Trust's approach to patient safety events by promoting a culture of learning and improvement. It focuses on the following key aims:

- Compassionate engagement and involvement of those affected by patient safety events.
- Application of a range of system-based approaches to learning from patient safety events.
- Considered and proportionate responses to patient safety events and safety issues.
- Supportive oversight focused on strengthening system functioning and improvement.
- Foster a culture of learning and improvement.
- Integrate with risk management system.

This plan provides a high-level overview of the patient safety priorities for the RDUH. This does not present the totality of Patient Safety Work undertaken by the organisation.

4 Our Restorative Just Culture

At the RDUH we recognise that our most valuable resource is our staff. As such, we want staff to feel supported to learn from mistakes rather than being blamed, to ultimately improve patient safety, care and staff morale.

To achieve this, we are implementing a Restorative Just Culture, whose key principles are:

- Learning over blame

At the heart of a restorative just culture is a shift from blame to understanding. When incidents occur, our focus is on exploring what happened, why it happened, and how we can prevent recurrence, rather than assigning fault to individuals. This approach ensures fairness and supports meaningful improvements across the system. It also reinforces that accountability is not about punishment but about owning our part in improving safety and outcomes.

- A supportive and accountable environment

We encourage staff to report errors, concerns, and near misses without fear of punitive consequences. By fostering an atmosphere of psychological safety, honesty, and trust, we create the conditions for openness and shared responsibility.

After an incident, we seek to understand who has been harmed, what they need, and how we can support them. Everyone involved is given the opportunity to share their experience and receive the care they require.

At the same time, restorative practice recognises that accountability still matters. Individuals, teams, and the organisation all have responsibilities, such as following safe systems of work, ensuring adequate support and supervision, and acting in line with expected behaviours. Accountability is therefore understood as a fair and transparent process grounded in context, not blame.

- Engagement and inclusivity

Restorative just culture is a shared endeavour. All staff, from senior leaders to frontline colleagues, are encouraged to contribute to shaping and sustaining this culture. Their diverse perspectives are essential in developing approaches that are meaningful, compassionate, and effective. Accountability is strengthened when everyone feels able to speak openly and participate in collaborative learning.

- Repairing relationships and restoring trust

Restorative practice helps rebuild relationships that may have been strained by incidents, misunderstandings, or system pressures. By coming together to discuss impact, needs, and

responsibilities, we support healing, promote mutual understanding, and reinforce trust within teams and across the organisation.

Our Being Fair Tool, developed by NHS England, which can be found on the Safety and Risk Resources page on HUB and in Appendix 7: Being Fair Tool is the decision making process we use to apply our Just Culture in a consistent and fair manner. It should only be used when concerns about an individual's conduct or fitness to practice are raised during a patient safety learning response and is not for routine use. More detail can be found in the Patient Safety Incident response Policy, and the Reporting, Reviewing and Learning from Safety Events Policy.

5 PSIRF database and key meetings

All reported patient safety events and all risks are recorded in the Datix Cloud system, which is accessible to every member of staff at the RDUH.

Three key governance groups oversee the PSIRF and ensure the effective delivery of this PSIRP:

The **Emerging Patient Safety Event Panel (EPSEP)** reviews incidents escalated by Care Groups against the RDUH PSIRP. Its role is to ensure that proportionate and consistent approaches to learning from patient safety events are applied across all clinical services.

Insight and Learning Into Action (ILIA) provides the essential link between Care Groups and the Central Patient Safety Team. The group monitors key performance indicators and supports the translation of insight and learning into sustainable, measurable safety-improvement activity.

Its work is structured around five core areas:

1. Insight
2. Learning into action
3. Sharing learning
4. Sustainable improvement
5. Effective safety systems

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The **Patient Safety Committee (PSC)** sets the Trust's strategic direction for patient safety and ensures delivery against the patient safety strategy. It provides assurance to the Board that robust governance systems are in place to monitor implementation, manage patient-safety risks, and meet statutory and regulatory requirements.

The Committee oversees the implementation of this PSIRP and ensures compliance with the associated policy. It also reviews and ratifies Patient Safety Incident Investigation Reports and monitors the effectiveness of the Patient Safety Improvement Programme, confirming that learning is embedded within quality-improvement activities.

Finally, the PSC receives reports from its subgroups and escalates risks or issues requiring attention to the Quality Committee.

Detailed terms of reference for these groups can be found in the Patient Safety Incident Response Policy.

6 Reflection on the past three years

To inform this plan, feedback was actively sought from colleagues to reflect on what has worked well with PSIRF over the past three years, what could be improved, and the key opportunities for learning going forward. Overall feedback indicates that PSIRF has supported a positive shift away from rigid processes towards a more proportionate, systems-focused approach to learning. Key strengths include improved collaboration across teams, greater use of systems thinking, increased staff and patient involvement, and stronger local ownership through Care Groups.

However, challenges remain, including visibility of incidents that are not reviewed through EPSEP, fragmentation between system learning and individual performance processes, variable quality of documentation and action planning, and challenges in aligning PSIRF outputs with external processes, including coronial inquests. Operational pressures and variable levels of familiarity with PSIRF continue to influence engagement.

This plan sets out how these challenges will be addressed, building on the progress made to date and strengthening the organisation's approach to learning, improvement and assurance.

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7 Patient safety improvement programme

The overall aim of our patient safety response is to ensure that learning activity is held by the Care groups. The central team and governance forums will operate in a supportive framework which will help adoption and spread of learning and improvement activity.

7.1 Improvement workstreams

The RDUH has established a number of patient safety workstreams that are actively supported by the central Patient Safety Team, reflecting their alignment with the priorities outlined in this plan. Each group will receive continually improving data insights to inform robust action planning, ensure appropriate oversight of relevant risks, and incorporate learning responses commissioned through EPSEP. This approach will strengthen focus, enhance the quality of actions taken, and help avoid duplication of effort across the organisation.

These improvement workstreams are as follows:

- Discharge Oversight Group
- Fatigue Steering Group – focusing on managing the patient safety risks associated with staff fatigue where fatigue is defined as *A physiological state of reduced mental or physical performance capability resulting from sleep loss or extended wakefulness, circadian phase, or workload (mental and/or physical activity) that can impair a person's alertness and ability to perform safety-related duties*.[1]
- Deterioration and Resuscitation Group
- Venous Thrombo-Embolism (VTE) Group
- Medication Safety Group
- Mental health assurance committee
- End Of Life (EOL) steering group

The following improvement groups are now well established and are fully led by the Care Groups. Their performance and progress will continue to be monitored; however, they no longer require routine involvement from the central Patient Safety Team. Support from the central team will therefore be provided on an ad hoc basis, as and when required:

- Tissue Viability (TV) Group
- Nutritional steering group
- Falls Steering Group
- Frailty Steering group

[1] Adapted from the International Civil Aviation Authority

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These improvement groups will continue to report progress and findings to the Patient Safety Committee.

7.2 Safety priorities

7.2.1 National requirements

These priorities are the patient safety incident types that must be responded to according to national requirements.

Patient Safety Incident Type	Required response	Anticipated Improvement Route
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII[2])	Incidents will be escalated to EPSEP. Considered for PSII ensuring it is proportionate.	The PSII will be reviewed by EPSEP, or a dedicated panel with the same attendance, to ensure learning is identified and action plan is effective and sustainable before being ratified at the PSC. Learnings and improvement activities will be shared with the Mortality Review Group who will offer expertise relating to improvement activity relating to the mortality agenda
Incidents meeting the Never Events criteria 2018, or its replacement	Proportionate learning response	The learning response (PSII or CLR) will be reviewed by EPSEP or a dedicated panel with the same attendance, to ensure learning is identified and action plan is effective and sustainable, before being ratified at the PSC.
Maternity and neonatal incidents meeting	Refer to MNSI for independent PSII.	The investigation and safety recommendations will be

[2] A death that has been clinically assessed using a recognised methodology of case record/note review (Medical Examiner Review or Structured Judgement Review) and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable

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Maternity and New-born Safety Investigations (MNSI) criteria	See section 7.2.3.	reviewed by EPSEP, or a dedicated panel with the same attendance, to ensure learning is identified and action plan is effective and sustainable. Maternity services will lead on improvement activity with support from the Patient Safety Improvement Team.
Maternity and perinatal and neonatal safety events meeting Mother and Babies: Reducing Risk though Audits and Confidential Enquiries across the UK (MBRRACE – UK) criteria	These cases will be reported to MBRRACE-UK and reviewed using the Perinatal Mortality Review Tool. Further detail can be found in section 7.2.3.2 and on the MBRRACE website. See also section 7.2.3.4 for reporting certain events to NHS Resolution's Early Notification Scheme. Monthly incident trend reports presented at governance meetings which highlight the number of incidents within each category to prompt discussion and enable regular monitoring of 'low level' incidents.	Maternity dashboard reviewed monthly through maternity governance – trends and themes are noted and if concerns thematic review/audit commissioned. MBRRACE figures published annually to trust.
Child deaths	Refer for Child Death Overview Panel to identify if the potential for significant learning may	The learning response and panel report will be reviewed by EPSEP, or a dedicated panel with the same

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	require a locally led PSII or other proportionate learning response alongside the investigation panel. Events will also be escalated at EPSEP or equivalent dedicated panel.	attendance, to ensure learning is identified and action plan is effective and sustainable.
Deaths of persons with learning disabilities or autism	Refer for Learning Disability Mortality Review (LeDeR) to identify if the potential for significant learning may require a locally led PSII or other proportionate learning response alongside the LeDeR review.	Learning will be shared with the Mortality Review Group, who will offer expertise relating to improvement activity relating to the mortality agenda. The learning response and panel report will be reviewed by EPSEP, or a dedicated panel with the same attendance, to ensure learning is identified and action plan is effective and sustainable.
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to Female Genital	Refer to local authority safeguarding lead. *Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding*	The Safeguarding Committee will lead on the identification of learning and potential improvement activity from safeguarding reviews within the Trust, and from system learning from the Devon Safeguarding system. See Appendix 6: Managing safeguarding inquiries

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Mutilation (FMG), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	*partnership (for children) and local safeguarding adults boards.*	
Incidents in NHS screening programmes	Refer to local Screening Quality Assurance Service (SQAS) for advice. They will consider the scale, risk of harm and potential for recurrence and advise the RDUH whether to complete the Screening Incident Assessment Form (SIAF). Discussion at EPSEP may be required to agree if a locally led PSII or other proportionate learning response is required alongside any review commissioned by SQAS.	

7.2.2 Local priorities

These PSIRF priorities have been selected to address areas where understanding is limited, and improvement is most needed. They were identified through horizon scanning, looking back at the previous plan, and reviewing existing data, making sure they're shaped by future thinking and backed up by real evidence (see Appendix 5: Defining our patient safety improvement programme). Qualitative input from the Care Groups about their main concerns and risks was also a valuable input. By focusing on these areas, we enable a deeper systems-based approach to patient safety events, not only examining what is happening, but also understanding why these events occur and determining what actions can be taken to prevent recurrence. This structured focus ensures that learning is embedded across the organisation,

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driving meaningful change and strengthening our ability to respond proactively to emerging risks.

Title	Patient Safety Incident Type	Required response	Anticipated Improvement Route
Deterioration	Patient harm occurring as a result of delays in recognising, escalating or treating deterioration. Focus improvement efforts based on Task & Finish group outputs. The initial focus will be on appropriate observations, appropriate escalation and appropriate stabilisation plan.	Incidents will be escalated to EPSEP where the most proportionate learning response will be agreed. Incidents and learning responses including findings, recommendations and action plan development will be escalated to the Deterioration and Resuscitation group.	Strengthened pathways for deteriorating patients, and clinical alignment across sites. Effective implementation of Martha's rule.
Medication issues	Patient harm associated with medication-related issues across the care pathway, including: • Transfers of care (prescribing, supply, and communication errors during admission, discharge, or transfer). • Omissions of medication, especially time-critical medication • Failure to complete an accurate medicines reconciliation process	Incidents will be escalated to EPSEP. Considered for PSII ensuring it is proportionate. Incidents and learning responses including findings, recommendations and action plan development will	Ongoing monitoring of drug-related incidents and near misses helps proactively identify emerging trends with specific medications, enabling a rolling focus on the most relevant issues and addressing concerns before

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	The focus will initially be on anticoagulants and potent opioids.	be escalated to the Medication Safety Group.	they escalate into critical problems.
Mental Health Care	Patient harm occurring as a result of not achieving appropriate pathways and safe environment for patients presenting with MH conditions.	Incidents will be escalated to EPSEP. Considered for PSII ensuring it is proportionate. Incidents and learning responses including findings, recommendations and action plan development will be escalated to the Mental Health Assurance Committee.	DPT pathway development. Skilling staff up Safe environment with adequate level of supervision
Operational pressures	Patient harm arising because of operational pressures experienced by the Trust, with an initial focus on harm occurring during, or as a result of, patient discharge processes undertaken at times of significant operational escalation (e.g., OPEL 4 or during a critical incident), including but not limited to patients discharged once medically optimised.	Incidents will be escalated to EPSEP. Considered for PSII ensuring it is proportionate. Incidents and learning responses including findings, recommendations and action plan development will be escalated to the Discharge Oversight Group.	

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7.2.3 Requirements for maternity services

The following requirements are based on Appendix B of Guide to responding proportionately to patient safety incidents.

Maternity services are fully embedded in our PSIRF in the same way as all our other services.

7.2.3.1 Reporting to MNSI

The following maternity patient safety events will be reported to MNSI:

- Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life.
- Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days).
- Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic–ischaemic encephalopathy; or was therapeutically cooled (active cooling only); or – had decreased central tone, was comatose and had seizures of any kind.
- Maternal deaths: death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).

Where such an investigation is undertaken, the Trust is not required to complete a separate learning response is not required. However, we must report the events onto Datix Cloud and take immediate actions as necessary to avoid and/or mitigate further serious and imminent danger to patients, staff and the public.

We should also complete Duty of Candour requirements ahead of handing over to MNSI, who will in turn will provide ongoing communication and involvement of the parents/family/carers in safety investigations, in collaboration with the Trust and encourage joint discussions at agreed points in the investigation.

In relevant cases, the Trust will also use the Perinatal Mortality Review Tool.

7.2.3.2 Reporting to the MBRRACE-UK scheme and the Perinatal Mortality Review Tool (PMRT)

Organisations should report the following safety events to MBRRACE-UK:

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- Deaths that should be reported to MBRRACE-UK are all women who die in the UK (or the Republic of Ireland):
    - during pregnancy, or
    - in the 12 months after the end of pregnancy.

  This is regardless of how the pregnancy ends or the circumstances of the woman's death.

Deaths eligible for inclusion in MBRRACE-UK's perinatal surveillance are:

- Late fetal losses – the baby is born at 22 or 23 completed weeks' gestation showing no signs of life, irrespective of when the death occurred.
- Stillbirths – the baby is born from 24 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- Neonatal deaths – the death of a live born baby born from 20 completed weeks' gestation (or from 400g where an accurate estimate of gestation is not available) occurring before 28 completed days after birth.

The eligibility criteria for notification to MBRRACE-UK is based on the baby's gestational age at birth. This means that babies born from 22 completed weeks' gestational age showing no signs of life must be reported to MBRRACE-UK regardless of when the death occurred.

Terminations of pregnancy resulting in a registered stillbirth (from 24 completed weeks' gestation) or neonatal death (from 20 completed weeks' gestation) should also be notified to MBRRACE-UK. Information about terminations of pregnancy is collected in order to exclude these cases from MBRRACE-UK reported statistics on perinatal mortality.

All these events should also be reported onto Datix Cloud.

7.2.3.3 Maternity patient safety incidents not referred to MNSI or MBRRACE - UK

The processes described in this plan apply to maternity patient safety events, regardless of whether they need to be reported to MNSI or MBRRACE-UK.

This means that Maternity patient safety events must be recorded on Datix Cloud and considered for a proportionate learning response. Any events that meet the national or local priorities outlined in this plan, or that raise concern within the Women and Children Care

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Group, must be escalated to EPSEP (or the equivalent forum) so that an appropriate learning response can be undertaken.

All responses must be carried out in accordance with the standards set out in this plan, the Patient Safety Incident Response Policy, and the Reporting, Reviewing and Learning from Safety Events Policy.

7.2.3.4 Reporting to NHS Resolution's Early Notification Scheme

The Trust will report to NHS Resolution's Early Notification Scheme all term births where the baby is diagnosed with potentially severe brain injury in the first seven days of life that has been accepted by MNSI for investigation. NHS Resolution will then review those babies who have an abnormal MRI scan and there is evidence of changes in relation to intrapartum hypoxic ischaemic encephalopathy (HIE).

8 Learning response toolkit

The Trust encourages the use of a range of system-based approached for learning from patient safety events, including but not limited to:

- Patient Safety Incident Investigation (PSII) – led by the Central Safety Team
- Concise Learning Review (CLR)
- Multi Disciplinary Team review (MDT)
- After Action Review (AAR)
- Mortality & Morbidity (M&M) Review
- Hot Debrief
- Huddle / SWARM
- Safety walk-through

Staff are encouraged to consider Human and Organisational factors when conducting these learning responses. This can be done through exploring the event through the SEIPS[3] lens. The SEIPS model (Systems Engineering Initiative for Patient Safety) is a framework used in healthcare to improve patient safety and quality by understanding the interactions within socio-technical systems. It describes how a work system (or socio-technical system, left) can influence processes (work done, middle), which in turn shapes outcomes. The SEIPS

[3] B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf

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framework acknowledges that work systems and processes constantly adapt. The model emphasises human-centered design, focusing on how work systems, processes, and outcomes influence each other. It integrates human factors and ergonomics to enhance healthcare delivery and safety. See Appendix 8:

Detail on processes and timeframes, templates, and further guidance on these learning responses can be found in the Patient safety Incident Response Policy, the Reporting, Reviewing and Learning from Safety Events Policy, and on the Patient Safety and Risk Resources page of the HUB.

9 Safety II: A proactive lens on patient safety

In alignment with Safety II principles, our PSIRP recognises that most care delivered across our Trust is safe, effective, and compassionate. Instead of focusing solely on what goes wrong, we also examine everyday successes that demonstrate resilience, adaptability, and excellence in clinical practice.

Safety II encourages us to understand how systems and staff succeed under varying and often complex conditions. This broadens traditional Safety I thinking by shifting from purely preventing errors to also identifying system strengths and building resilience. By exploring both vulnerabilities and successes, we gain a more complete picture of how safe care is achieved.

Capturing these positive responses allows us to reinforce good practice and embed resilience into future protocols. Integrating Safety II into PSII also supports reflective learning about what went well, ensuring that both corrective and positive insights translate into meaningful system improvements. This approach is consistent with NHS England's emphasis on system-based investigations that embrace variability and promote learning from everyday work.

Our PSIRP integrates Safety II through:

- Capturing Good Care events through our reporting system.
- Analysing successful adaptations in clinical workflows.
- Promoting simulation-based learning to reinforce effective responses and teamwork.
- Using forums like Insight and Learning into Action (IALIA) to share positive practices across care groups.
- Encouraging staff to reflect on what went right and capture those positive learnings when conducting learning responses.
- Learning from excellence.

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9.1 Learning from Excellence

Learning from Excellence (LfE) is a proactive patient-safety approach that shifts the focus from only analysing mistakes to also recognising and learning from positive everyday behaviours in healthcare. It encourages colleagues to highlight examples of excellent practice - such as high-quality clinical care, acts of kindness, teamwork, resilience, or effective communication - so that these behaviours can be better understood, celebrated, and replicated across the organisation.

Traditional safety processes concentrate on adverse events, which is essential but incomplete. LfE fills this gap by capturing what goes right in daily work. By understanding the human and system factors that contribute to success, teams can strengthen safety culture, boost staff morale, and reinforce behaviours that lead to safer, more effective patient care.

Colleagues can submit Learning from Excellence here.

9.2 Good Care Reporting and Simulation-Based Learning

Good Care reporting is a formal mechanism to document and reflect on instances of exemplary care. These reports are reviewed alongside incident data to identify protective factors and reinforce behaviours that contribute to safe outcomes.

We are also aiming to routinely capture simulation exercises in Datix. These provide rich insights into team dynamics, environmental challenges, and system resilience.

Care Groups are encouraged to share learnings from simulations at ILIA and incorporated into local improvement plans.

10 PSIRF and risk management

Although not classified as a learning response, effective risk management is fundamental to ensuring patient safety. Within the Trust's overarching safety strategy, PSIRF and risk management are closely aligned and operate in tandem to support safer care.

Proportionate and timely responses to patient safety events, whether adverse events or near misses, are essential for identifying and mitigating safety-related risks. We ensure that such incidents are reported, analysed, and used to improve services and reduce future risks. Risk management principles have been embedded throughout the plan to reinforce this integration. By aligning PSIRF with the Trust's broader risk governance framework, we enable a joined-

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up, intelligence-led approach where incident response and risk management complement each other to drive continuous learning and improvement.

Key Integration Points:

- A shared governance structure, led by the Patient Safety Committee, connects PSIRF activity with risk management processes.
- Risk data and insights are routinely used to prioritise safety responses, guide improvement work, and inform thematic reviews.
- Trends and emerging risks are identified through combined safety and risk intelligence, supporting proactive mitigation.
- The ALARP register and ongoing monitoring provide a structured, risk-informed basis for decision-making across patient safety processes.
- Learning responses generated through PSIRF feed directly into risk identification and management, ensuring continuous feedback loops.
- Safety reporting and risk management mechanisms together monitor the effectiveness of risk controls and improvement actions.

11 Patient Safety Capacity and Capability

Central to effective patient safety is maintaining the Trust's capability to recognise, respond to, and learn from patient safety risks. To support this, the Trust has invested in a comprehensive programme of educational and developmental activity designed to strengthen our patient safety culture and build sustainable capability across the organisation.

11.1 Strengthening oversight through redesign of team structure

As part of the second phase of the Trust's Operational Site Integration Group (OSIG 2), a dedicated workstream reviewed the clinical governance teams within the newly established Care Groups. The aims of this workstream were to:

- Develop governance structures aligned to the NHS Patient Safety Strategy and the NHS Complaints Framework.
- Establish a standardised approach to clinical governance across all Care Groups.
- Apply a data-driven methodology to the allocation of patient safety and quality resources.
- Reduce unwarranted variation in governance processes and working practices.

The outcome of this work was the establishment of local Safety and Quality Teams within each Care Group. These teams provide integrated support across five core domains:

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- Audit and Clinical Effectiveness
- Patient Experience
- Patient Safety
- Risk Management

This model ensures clearer accountability, improved consistency, and stronger alignment with national patient safety expectations, while remaining responsive to local service needs.

11.2 Developing capability through education and training

The introduction of the Safety and Quality Team model was supported by a structured development programme delivered in partnership with the Trust's Transformation Team and the Healthcare Governance Academy. This programme focused on both technical competence and cultural maturity and included:

- Systems approach to learning from patient safety events.
- Engaging and involving people affected by patient safety events.
- Oversight and assurance for patient safety.
- Essentials of Patient Safety for Boards and Senior Leaders.
- Bronze Quality Improvement.
- Silver Quality Improvement.

In parallel, the Trust has invested in the development of a comprehensive Human Factors training programme, available to all staff and delivered through multiple platforms to maximise accessibility and reach.

11.3 PSIRF Training and ongoing development

Significant emphasis has been placed on PSIRF training and development. The Trust will continue to provide *Essentials for Patient Safety* through its online learning platform and has agreed to retain Level 1 PSIRF training as mandatory for all staff.

Over the next three years, the Trust's priority will be to further develop internal capacity to deliver the full range of essential patient safety education. A key first step will be the establishment of a core patient safety faculty, responsible for designing, delivering, and sustaining a coherent and high-quality patient safety training programme aligned to national standards and local priorities.

11.4 PSIRF Safety Communication

The Trust recognises that effective communication of patient safety priorities across a large and diverse organisation is both challenging and critical to maintaining and enhancing our patient safety capability.

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To address this, a dedicated PSIRF Safety Communication task and finish group has been established under the joint leadership of the Clinical Risk Manager and the Clinical Director for Patient Safety. This work will strengthen the Trust's safety culture by improving awareness, understanding, and practical application of PSIRF, underpinned by restorative just culture principles.

11.4.1 Objectives of the PSIRF Safety Communication Programme

The core objectives of this work are to:

- Increase staff engagement by ensuring every individual understands their role within PSIRF and feels empowered to contribute to a safer culture.
- Improve organisational awareness and understanding of PSIRF and its benefits for both staff and patients.
- Ensure that the right information reaches the right people at the right time, with clear messages about what PSIRF means in practice and what actions are required.
- Promote restorative just culture as the foundation for openness, learning, accountability, and psychological safety.
- Communicate consistently on key, relevant, and practical topics that support staff to apply PSIRF principles in real-world clinical and operational settings.
- Celebrate and share learning from excellence, innovation, and improvement initiatives to reinforce positive behaviours and support ongoing cultural maturity.

Together, these actions will support the Trust in building a confident, capable, and compassionate patient safety system that is aligned with national expectations and responsive to the needs of patients, families, and staff.

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Appendix 1: Infection Prevention & Control Patient Safety Incident Response Framework Learning Matrix

Incident	Apportioning	Mandatory reporting	Datix	IPC Incident response document required	Formal Duty of Candour (DoC)	EPSEP requirement	Internal governance/ communication (in addition to IPC team daily communication and via DATIX system)	External governance/ communication
MRSA (Methicillin-resistant Staphylococcus aureus) bacteraemia	HOHA	Yes UKHSA (UK Health Security Agency) HCAI Data Capture System	Yes	MRSA Bacteraemia Infection Control (IC) Review	To be determined for appropriateness by the responsible clinical team following review and documented when required. Governance team input ensures DoC follow up upon receipt of DATIX	Yes	• Each case fed back to relevant clinical team & governance following the MRSA bacteraemia proportionate response guide • Monthly Audit and Surveillance Infection Prevention & Control (IPC) Multidisciplinary Team (MDT) meeting • Monthly Integrated performance report (IPR) • Care Group notification of HCAI cases • Quarterly Infection Prevention and	• UKHSA regional and national mandatory enhanced surveillance (MES) teams • Integrated Care Boards (ICB) • Regional and National trends raised at NHS England Regional Network meeting • Regional and National trends raised at professional body Infection Prevention Society

							Decontamination Assurance Group (IPDAG) meeting including source data	regional and national meetings • Targeted regional NHS England South West HCAI sharing & resource group
	COHA COCA	Yes UKHSA HCAI Data Capture System	Not routinely	MRSA Bacteraemia IC Review	To be determined for appropriateness by the responsible clinical team following review and documented when required	Only if IC review identifies Trust learning requiring escalation	• Cases fed back to relevant clinical team & governance following MRSA bacteraemia proportionate response guide • Monthly Audit and Surveillance IPC MDT meeting • Monthly IPR • Care Group notification of HCAI cases • Quarterly IPDAG including source data	
MSSA (Methicillin-Sensitive Staphylococcus Aureus) Bacteraemia	HOHA COHA	Yes UKHSA HCAI Data Capture system	Not routinely	MSSA Bacteraemia IC Review with full enhanced surveillance detail completed	No	Not routinely	• Any learning fed back to clinical teams • Monthly Audit and Surveillance IPC MDT meeting • Monthly IPR • Care Group notification of HCAI cases	• UKHSA regional and national mandatory enhanced surveillance (MES) teams • Integrated Care Boards (ICB)

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							• Quarterly IPDAG including source data	• Regional and National trends raised at NHS England Regional Network meeting • Regional and National trends raised at professional body Infection Prevention Society regional and national meetings • Targeted regional NHS England South West HCAI sharing & resource group
	COCA	Yes UKHSA HCAI Data Capture System	Not routinely	MSSA Bacteraemia IC Review with targeted enhanced surveillance data	No	Not routinely	• Monthly Audit and Surveillance IPC MDT meeting • Monthly IPR • Quarterly IPDAG including source data	
Gram-negative bacteraemia identified via the UK HSA mandatory surveilla	HOHA COHA COCA	Yes UKHSA HCAI Data Capture System	Not routinely	Localised IC Data Collection Form. Note that targeted surveillance data collection, gathered on adapted,	Where appropriate	Not routinely	• Monthly Audit and Surveillance IPC MDT meeting • Quarterly IPDAG including source data • Monthly IPR • Care Group notification of HCAI cases	• UKHSA regional and national mandatory enhanced surveillance (MES) teams • Integrated Care Boards (ICB)

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nce programme				localised data collection forms, is undertaken in addition to UKHSA MES data requirements. The mandate for this will change in response to active MES organism reduction and infection prevention improvement initiatives			• Cases pertaining to care homes are monitored for further input by the IPC CIMS team.	• Regional and National trends raised at NHS England Regional Network meeting • Regional and National trends raised at professional body Infection Prevention Society regional and national meetings • Targeted regional NHS England South West HCAI sharing & resource group
C difficile toxin positive	HOHA COHA	Yes UKHSA HCAI Data Capture System	Yes, for all cases	PSIRF huddle led by CNM, required to complete template for presentation to CD MDT to determine severity of infection/harm and lessons to	To be determined for appropriateness following CD MDT. If required, to be undertaken by responsible clinical team	Only if PIR/PSIRF review identifies Trust learning requiring escalation	• Datix by IPCT • Datix will then be completed by CNM and Governance will review and feed back to clinical team any shared learning	• UKHSA regional and national mandatory enhanced surveillance (MES) teams • Integrated Care Boards (ICB)

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				be learnt. If C diff on part 1 of the death certificate, an after-action review will be undertaken	and documented. Governance team input ensures DoC follow up upon receipt of DATIX		• Monthly Audit and Surveillance IPC MDT meeting • Care Group notification of HCAI cases • Monthly IPR • Quarterly IPDAG	• Regional and National trends raised at NHS England Regional Network meeting & NHS England South West HCAI sharing & resource group • Regional and National trends raised at professional body Infection Prevention Society regional and national meetings
	COIA COCA	Yes UKHSA HCAI Data Capture System	Not routinely	Localised IC data collection form. COCA and COIA infection episodes managed as part of CIMS workstreams – targeted surveillance	Where appropriate	Not routinely	• Information retrieved, reviewed by antimicrobial pharmacist, IPC and Microbiologist • Monthly Audit and Surveillance IPC MDT meeting	• UKHSA regional and national mandatory enhanced surveillance (MES) teams • Integrated Care Boards (ICB)

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				activity and response to be updated through ICB Annual Programme			• Quarterly IPDAG • Learning fed back to relevant clinical teams, governance and external prescribers or external care providers as appropriate	• Regional and National trends raised at NHS England Regional Network meeting and targeted regional NHS England South West HCAI sharing & resource group • Regional and National trends raised at professional body Infection Prevention Society regional and national meetings • External prescribers & care providers as appropriate •
Surgical Site Infections identified	Superficial, Deep, Organ/Joint space per UKHSA	Yes UKHSA Surgical Site Infection	Not routinely unless cluster outbreak	Surgical Site Infection (SSI) IC Review	Where appropriate	Not routinely unless cluster outbreak or event	• Each case fed back to relevant clinical team & speciality	• UKHSA Surgical Site Infection Surveillance Service,

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via UKHSA protocol led surgical site infection surveillance	surveillance definitions	Surveillance Service, HCAI, Fungal, AMR, AMU & Sepsis Division				requiring escalation	governance groups • Monthly Audit and Surveillance IPC MDT meeting • Relevant Infection MDTs • Quarterly SSIS report (official and localised summary) • Reports and specific learning presented at specialist governance / safety meetings • Quarterly IPDAG	HCAI, Fungal, AMR, AMU & Sepsis Division • Integrated Care Boards (ICB) • Regional trends raised at NHS England South West Regional Network meeting and targeted regional NHS England South West SSI group • Regional and National trends raised at professional body Infection Prevention Society regional and national meetings
Central Intravascular & Peripher	All Eastern laboratory blood cultures processed per Nosocomial	No	Yes for Royal Devon University	Central Intravascular & Peripheral Vascular	To be determined for appropriatene	Not routinely	• Monthly Audit and Surveillance IPC MDT meeting	Nil

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al Vascular Device Related Bacteraemia	Infection National Surveillance Service (NINSS) definitions with learning shared Trust wide		Healthcare NHS Foundation Trust cases	Device Related Bacteraemia IC Review	ss by the responsible clinical team following review and documented when required. Governance team input ensures DoC follow up upon receipt of DATIX		• Quarterly line bacteraemia report distribution Trust wide • Each case fed back to relevant specialist clinical & governance teams • Quarterly IPDAG	
Outbreaks & other IC incidents	As guided by NHSE / UKHSA requirement	No (except voluntary reporting of Norovirus outbreaks)	Yes, for all outbreaks or cases resulting in bay or ward closure	Ward huddle/swarm documentation if required as identified by the IPCT	To be determined for appropriateness by the responsible clinical team following review and documented when required. Governance team input ensures DoC follow up upon receipt of DATIX	Only if IPC Review identifies Trust learning requiring escalation	• Monthly Audit and Surveillance IPC MDT meeting • Each case fed back to relevant specialist clinical teams • IPDAG by relevant care group	• Guided by NHS England / UKHSA requirements • Regional and National trends raised at professional body Infection Prevention Society regional and national meetings • Regional trends raised at NHS England South West

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								Regional Network meeting and targeted regional NHS England South West HCAI sharing & resource group
New isolates of multi drug resistant organisms (MDRO) including MRSA (screening or clinical isolates)	New inpatient or regular attender cases in the absence of same prior organism	No	Only if learning identified. HOHA/COHA cases	IPC team review with shared learning fed back to clinical area	To be determined for appropriateness, flowing review by the IPCT. If required, to be undertaken by the responsible clinical team. Governance team input ensures DoC follow up upon receipt of DATIX	Not routinely unless cluster outbreak or event requiring escalation	• Monthly Audit and Surveillance IPC MDT meeting • If investigation completed, cases fed back to relevant specialist clinical teams & governance • Quarterly IPDAG	Nil

Healthcare associated infection definitions for the purpose of this matrix are defined as the follows: For MRSA, MSSA & Gram-negative bacteraemia; new MRSA positive clinical isolates & screening isolates from augmented care; new isolates of MDRO:

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Hospital Onset Healthcare Associated (HOHA) – Any NHS patient specimens taken on the third day of inpatient admission onwards (i.e. ≥ day 3 when day of admission is day 1).

Community Onset Healthcare Associated (COHA) - Any case reported by an NHS acute trust not determined to be HOHA but where the patient was discharged from the reporting organisation within 28 days prior to the current specimen date (where date of discharge is day 1).

Community Onset, Community Associated (COCA) - Any case reported by an NHS acute trust not determined to be HOHA but where the patient has not been discharged from the reporting organisation within the past 28 days, to the current specimen date (where date of discharge is day 1). For C difficile infection there is further stratification for onset within the community as follows:

Community Onset Indeterminate Associated (COIA) – Any case reported by an NHS acute trust not determined to be HOHA or COHA but where the patient was discharged from the reporting organisation within 84 days prior to the current specimen date (where date of discharge is day 1).

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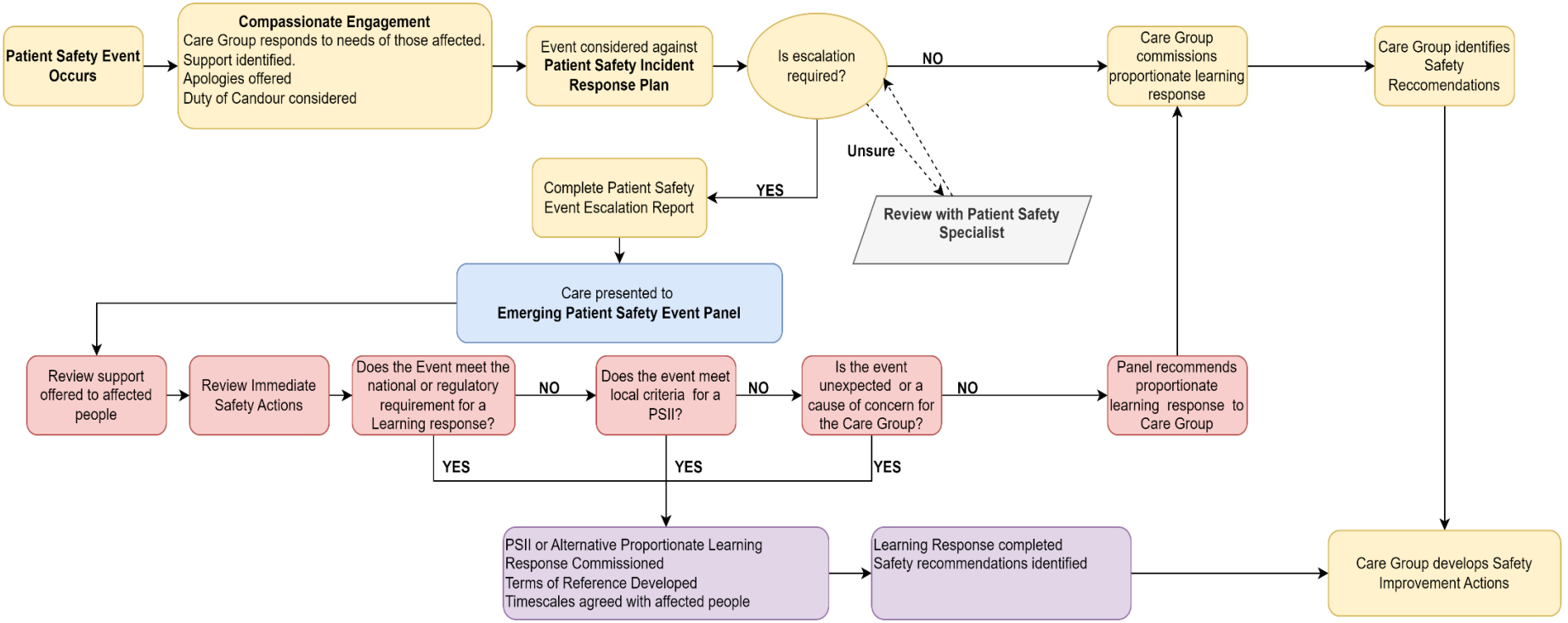
Appendix 2: Patient safety incident response decision making tree



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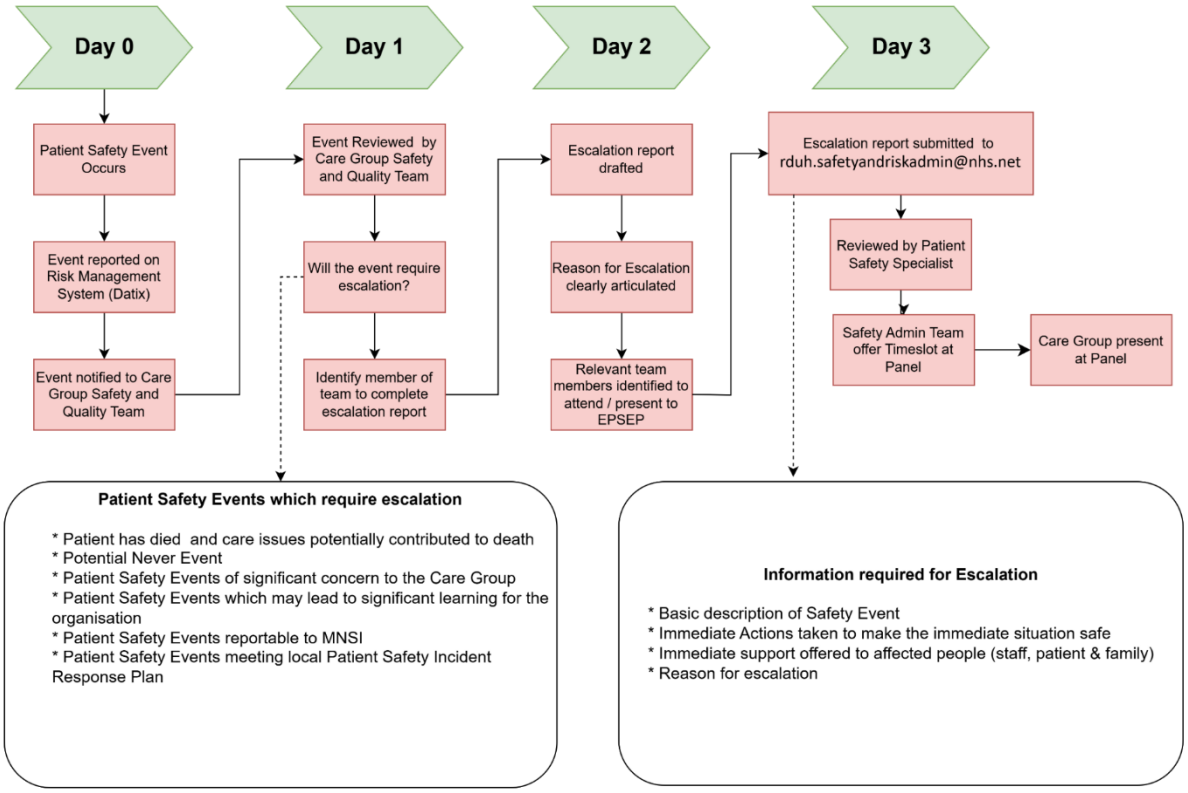
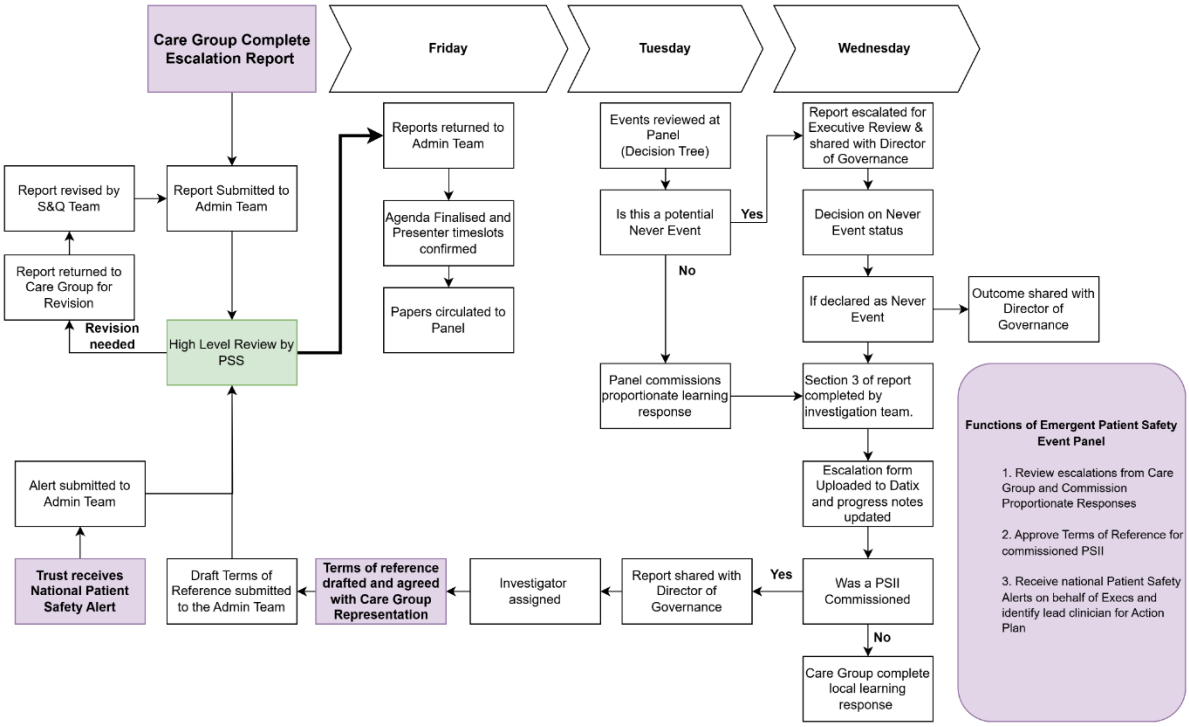
Appendix 3: Patient safety escalation process

The escalation report form to present safety events to EPSEP is available on the Safety and Risk Resources page of the HUB.





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Appendix 4: Summary of Never Events

Full detail can be found on the NHS website.

- **Wrong Site Surgery**

An invasive procedure performed on the wrong patient or at the wrong site (eg wrong knee, eye, limb). The incident is detected at any time after the start of the procedure.

- **Wrong implant/prosthesis**

Placement of an implant/prosthesis different from that specified in the procedural plan, either before or during the procedure. The incident is detected any time after the implant/prosthesis is placed in the patient

- **Retained foreign object post procedure**

Retention of a foreign object in a patient after a surgical/invasive procedure

- **Mis-selection of a strong potassium solution**

Mis selection refers to: when a patient is intravenously given a strong potassium solution rather than the intended medication.

- **Administration of medication by the wrong route**

The patient is given one of the following:

  - intravenous chemotherapy by the intrathecal route
  - oral/enteral medication or feed/flush by any parenteral route
  - intravenous administration of an epidural medication that was not intended to be administered by the intravenous route

- **Overdose of insulin due to abbreviations or incorrect device**

Overdose refers to when:

  - a patient is given a 10-fold or greater overdose of insulin because the words ‘unit’ or ‘international units’ are abbreviated; such an overdose was given in a care setting with an electronic prescribing system
  - a healthcare professional fails to use a specific insulin administration device – that is, an insulin syringe or pen is not used to measure the insulin
  - a healthcare professional withdraws insulin from an insulin pen or pen refill and then administers this using a syringe and needle

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- **Overdose of methotrexate for non-cancer treatment**

Overdose refers to when: a patient is given a dose of methotrexate, by any route, for non-cancer treatment that is more than the intended weekly dose; such an overdose was given in a care setting with an electronic prescribing system

- **Mis-selection of high strength midazolam during conscious sedation**

Mis-selection refers to when:

  - a patient is given an overdose of midazolam due to the selection of a high strength preparation (5 mg/mL or 2 mg/mL) instead of the 1 mg/mL preparation, in a clinical area performing conscious sedation

- **Failure to install functional collapsible shower or curtain rails**

Involves either:

  - failure of collapsible curtain or shower rails to collapse when an inpatient attempts or completes a suicide
  - failure to install collapsible rails and an inpatient attempt or completes a suicide using non-collapsible rails.

- **Falls from poorly restricted windows**

A patient falling from a poorly restricted window. This applies to:

  - windows ‘within reach’ of patients; this means windows (including the window sills) that are within reach of someone standing at floor level and that can be exited/fallen from without needing to move furniture or use tools to climb out of the window
  - windows located in facilities/areas where healthcare is provided and that patients can and do access
  - where patients deliberately or accidentally fall from a window where a fitted restrictor is damaged or disabled, but not where a patient deliberately disables a restrictor or breaks the window immediately before they fall
  - where patients can deliberately overcome a window restrictor using their hands or commonly available flat-bladed instruments as well as the ‘key’ provided.

- **Chest or neck entrapment in bed rails**

Entrapment of a patient’s chest or neck between bedrails or in the bedframe or mattress, where the bedrail dimensions or the combined bedrail, bedframe and mattress dimensions do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidance.

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- **Transfusion or transplantation of ABO-incompatible blood components or organs**

Unintentional transfusion of ABO-incompatible blood components

- **Misplaced naso- or oro-gastric tubes**

Misplacement of a naso- or oro-gastric tube in the pleura or respiratory tract that is not detected before starting a feed, flush or medication administration.

- **Scalding of patients**

Patient scalded by water used for washing/bathing.

- Unintentional connection of a patient requiring oxygen to an air flowmeter

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Appendix 5: Defining our patient safety improvement programme

In order to define our patient safety improvement programme, we needed first to understand our patient safety incident profile. When doing so, it was essential to ensure it reflected the breadth and diversity of the services we provide and the communities we serve. A key part of this work was applying proportionality, focusing our priorities on those areas where further learning would be most meaningful and where improvement activity could have the greatest impact, rather than simply the areas with the highest volume of incidents. Engaging directly with Care Groups and frontline staff was invaluable in achieving this. Their insights ensured that the incident profile captured the realities of day-to-day care, highlighted concerns that may not be visible in quantitative data alone, and helped us differentiate between noise and genuinely emerging risks. The richness of the qualitative feedback strengthened our understanding considerably, giving assurance that our priorities reflect what matters most to those delivering care and those affected by safety issues.

Stakeholder engagement

The Trust formed a PSIRF Working Group to develop the new plan and define our patient safety incident profile and a PSIRP Delivery Group to oversee the work.

The Delivery Group involved the following stakeholders;

- Director of Nursing (East);
- Medical Director (North);
- Director of Nursing (North)
- Medical Director (East)
- Clinical Director for Patient Safety
- Patient Safety Specialists
- Head of Patient Safety & Patient Safety Specialist Devon ICB
- Clinical Risk Manager
- Care Group Triumvirate Representatives (DMD or DPC)
- External stakeholders

The Delivery Group reported into the Trust's Patient Safety Committee, which appraised the Quality Committee. This ensured executive oversight of the project.

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The Working Group explored the following themes:

- Data available
- LFPSE
- Improvement work
- Horizon scanning

Data sources

The review covered data from July 2022 to August 2025.

The Working Group agreed to analyse data by care group, location, and ward, including specific focus areas like ED, maternity, and dementia.

The following data points were explored:

- Current or emerging Care Groups patient safety priorities and risks
- Incident data including maternity patient safety events
- Complaints data
- Mortality
- Claim data
- Active risks
- Care opinion Data
- Frontline engagement through Care Matters and care group forums
- Safety culture survey
- HSSIB

Trust wide, the highest number of reported incidents were slips, trips, falls, discharge and waiting times transfer issues and pressure ulcers.

The burden of harm from patient safety events is low, with over 99% (94297/95060) of all incidents being reported as no harm or low harm. This is significant because where Trusts are reporting high numbers of low / no harm incidents this indicates a positive reporting culture. Trusts with a poor reporting culture would tend to focus upon reporting incidents which have resulted in actual patient harm, and this would lead to an increased proportion of incidents being reported with significant harm.

The analysis also included a review of over 4083 complaints, 296 of which were associated with patient safety events. This allowed consideration of the impact on patient experience of our safety event profile.

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Pressure damage and falls have not been included within the PSIRP priorities because these areas are already well understood, with established themes and limited additional learning expected from undertaking further PSIIs. The events currently fall within normal variation, and existing steering groups, led effectively by the relevant care groups and which will continue to report into the PSC, are already overseeing ongoing improvement work in these areas and continuing to monitor the data. Should any Care Group identify emerging concerns in these areas, they can continue to escalate individual events and trends through EPSEP and/or Patient Safety Committee.

National themes emerging from Health Services Safety Investigation Body investigation, such as the systemic impact of staff fatigue, patient care in temporary care environments and the management of patient safety risks across organisational boundaries, offer valuable insights that can directly inform our PSIRP. By integrating these themes, we can proactively address contributory factors to patient safety events and align our local improvement priorities with national learning.

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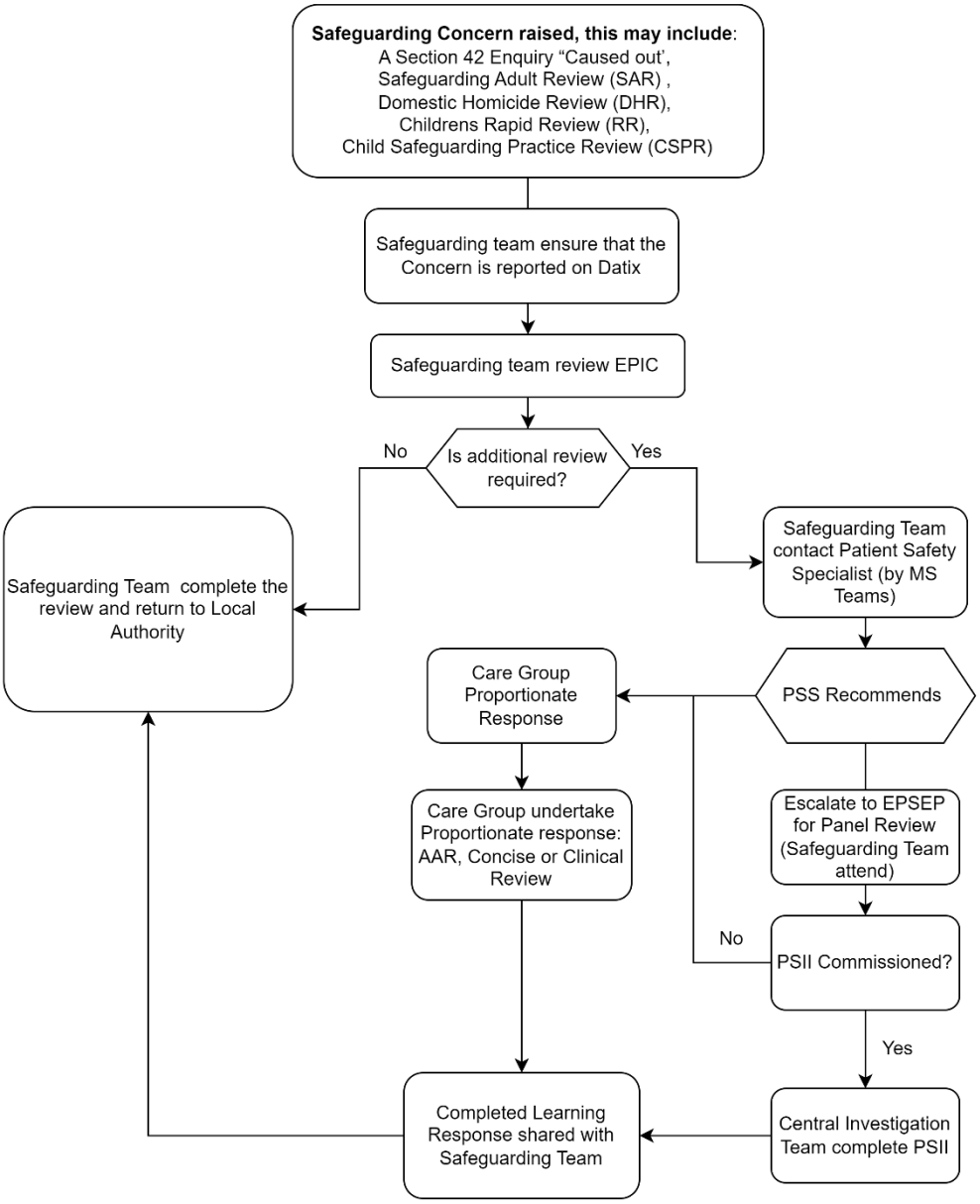
Appendix 6: Managing safeguarding inquiries

This flowchart has been developed in partnership with Safeguarding colleagues to provide this clarity and ensure we are able to provide a proportionate response to all safeguarding issues.

Royal Devon Process for managing safeguarding enquiries through PSIRF



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Appendix 7: Being Fair Tool

⚠ **The tool is not used for safeguarding concerns, suspected criminal activity, or routine performance matters, for which separate Trust processes are in place. See Reporting, Reviewing and Learning from Safety Events Policy for further detail.**

NHS England

Being fair tool: Supporting staff following a patient safety incident

This tool should only be used when concerns about an individual's conduct or fitness to practise are raised during a patient safety learning response. It is not for routine use.

Patient safety incidents are usually signs of underlying systemic issues that require wider system-level action. Action singling out an individual is rarely appropriate.

By treating staff fairly, the NHS can foster a culture of openness, equity and learning where staff feel confident to speak up when things go wrong. Supporting staff to be open about mistakes allows valuable lessons to be learnt and prevents errors from being repeated.

However, in rare circumstances a learning response may raise concerns about an individual's conduct or fitness to practise. It is in these specific circumstances that the being fair decision-making tool can help you decide what next steps to take.

Where criminal activity is suspected to have contributed to death or serious life-changing harm, you should refer the healthcare incident to the police and be guided by the memorandum of understanding between healthcare organisations and regulatory, investigatory and prosecutorial bodies.

Before using the tool, consider the following questions (Sidney Dekker, 2022):

- Who is hurt? (for example, staff, patients, family, public)
- What do they need? (for example, wellbeing support, information on what happened)
- Whose responsibility is it to meet that need? (for example, occupational health,patient safety team)

Preconditions of use	
Do the concerns raised relate to a patient safety incident?	If **no** – **do not use this tool**. This tool is designed to help decide next steps in relation to patient safety incidents. Other processes should be followed for: • **safeguarding concerns** – follow your organisation's safeguarding policies • healthcare incidents where **criminal activity is suspected** to have contributed to death or serious life-changing harm – refer to the police and use the memorandum of understanding between healthcare organisations and regulatory, investigatory and prosecutorial bodies
Has a patient safety learning response that takes a systems-based approach been started or completed?	If **no – do not use this tool**. Healthcare is complex, characterised by multiple interactions between different human and technological factors. A systems-based approach looks at their interplay to understand the wider system issues, not the actions of individuals. **Only use this tool if a learning response begins to raise concerns about an individual's actions.**
Will the tool be used jointly by a member of the patient safety team and the workforce team?	If **no** – **do not use this tool**. This tool is designed to combine systems thinking and safety science expertise relevant to the patient safety incident alongside workforce expertise in supporting staff

Questions	**Action to take**
Q1 Substitution test – to ensure wider system issues have been fully considered	
1a. Does the learning response indicate that staff in the same peer group as the individual involved and with comparable experience and qualifications would have acted in the same way in similar circumstances?	**If yes**, continue with the systems-based learning response. Only continue with the tool if there are ongoing concerns that an individual's action may have been reckless, wilfully neglectful or malicious.

If no or unsure, continue by asking the further substitution test questions

1b. Was the individual included when their peer group received relevant training? **1c Have you considered the experience and background of the individual (including differences in training practices between organisations or internationally and cultural differences)?** **1d. Was supervision in line with expected practice?**	**If no to any,** or the answer is unknown, discuss with the individual's supervisor or education lead. Continue with the systems-based learning response. Only continue with the tool if there are ongoing concerns that an individual's action may have been reckless, wilfully neglectful or malicious.

If yes to all, continue to Q2 Foresight test – **to ensure wider system issues have been fully considered**

2a. Does the learning response identify any agreed protocols or accepted practices that apply to the individual's action or omission in question? **2b. Does the learning response find these protocols to be workable and reflective of accepted practice?**	If **no to any**, continue with the systems-based learning response. Only continue with the tool if there are ongoing concerns that an individual's action may have been reckless, wilfully neglectful or malicious.

If yes to all, continue to Q3 Deliberate harm test

Q3. Based on what is known, is there any suggestion of recklessness, wilful neglect or an intention to cause harm?	**If yes,** follow organisational guidance for appropriate action, including contacting any relevant external organisations: for example, professional regulatory bodies, the police or, if statutory safeguarding processes need to be adhered to, the relevant lead – that is, person in position of trust (PIPOT) for adult abuse and local authority designated officer (LADO) for child abuse.

If no, continue to Q4 Health test

4a Based on what is known, is there any indication of substance use by the individual (for example, drugs or alcohol)? **4b. Based on what is known, is there any indication of physical or mental ill health that may have affected the individual's actions?**	**If yes to either,** follow organisational guidance for health issues affecting work.

If no to both, continue to Q5 Mitigating circumstances

Q5. Does the learning response or other information identify any significant mitigating circumstances for the individual's actions?	**If yes,** action directed at the individual may not be appropriate. Follow organisational guidance for appropriate action.

If no, follow organisational guidance for appropriate management. This could include remediation,supervision, additional training or disciplinary action.

If required, revisit the tool as further information from the learning response becomes available.

This is a continuous process with restorative just culture principles maintained throughout.

Appendix 8: SEIPS

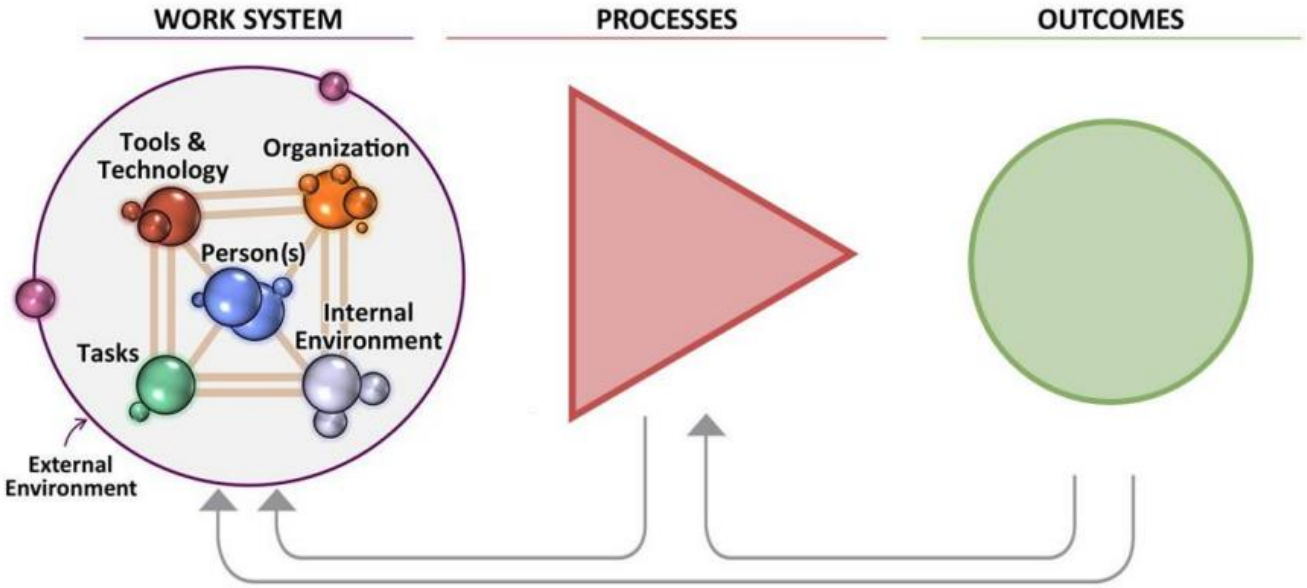

Figure 1: Overview of SEIPS framework

BETTER TOGETHER
C Collaboration and partnerships
A A great place to work
R Recovering for the future
E Excellence and innovation in patient care

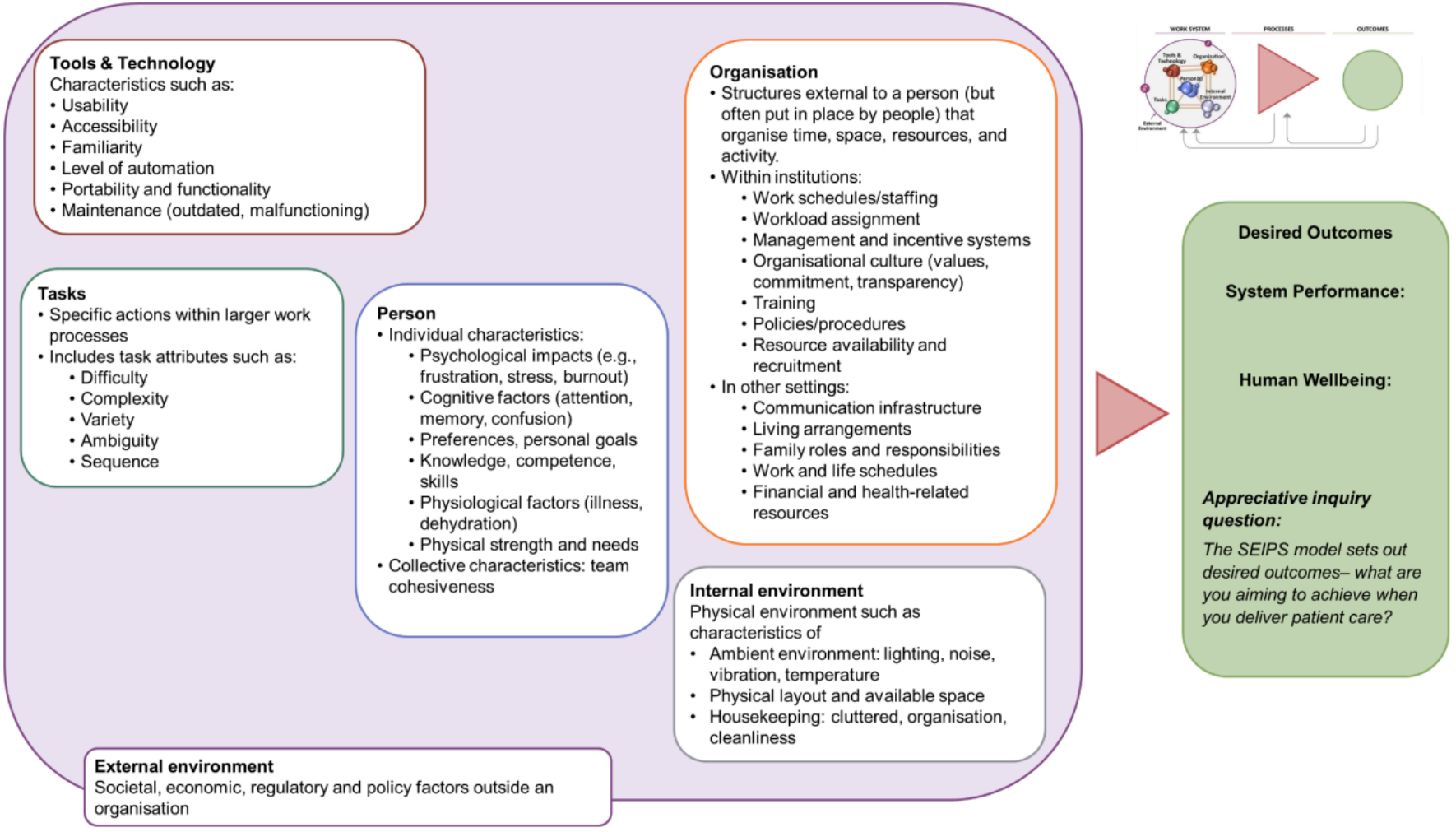

Figure 2: Overview of the SEIPS work system