PATIENT SAFETY INCIDENT RESPONSE POLICY

Non-Clinical Policy

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	x		
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Lead Division/ Directorate	*Corporate*		
Lead Specialty/ Service/ Department	*Governance Support Unit*		
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Associated Documents/ Information	Date Associated Documents/ Information was reviewed
Patient Safety Incident Response Plan (PSIRP)	*August-2023*

CONTENTS

APPENDICIES

1.0 INTRODUCTION

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out **Sherwood Forest NHS Foundation Trusts** approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

2.0 POLICY STATEMENT

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

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error’, are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

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

3.0 DEFINITIONS/ ABBREVIATIONS

PSIRF – Patient Safety Incident Response Framework
PSP's – Patient Safety Partners
PSII's – Patient Safety Incident Investigators
HSIB – Healthcare Safety Investigation Branch
HSE – Health & Safety Executive
RIDDOR – Reporting of injuries, diseases and dangerous occurrences regulations
MHRA – Medicines and healthcare products regulatory agency
PSIRP – Patient Safety Incident Response Plan

4.0 ROLES AND RESPONSIBILITIES

Responsibility for oversight of the PSIRF sits with the Trust Board. Executive Leads are the Medical Director and Chief Nurse who hold joint responsibility for effective monitoring and oversight of PSIRF. The 'Responding to patient safety incidents' section above also describes some of the more operational principles that underpin this approach.

The Trust is committed to close working, in partnership, with the ICB and other national commissioning bodies as required. Representatives from the ICB will be invited to sit on PSIRF implementation groups. Oversight and assurance arrangements will be developed through joint planning and arrangements must incorporate the key principles detailed in the guidance above, namely:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Policy, planning and governance
3. Competence and capacity
4. Proportionate responses
5. Safety actions and improvement

Under PSIRF there is a paradigm shift from monitoring of process, timescales and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients. The ICB's role will focus on oversight of PSIRF plans / priorities and monitoring progress with improvements. There will no longer be a requirement to 'declare' an SI and have individual patient safety responses 'signed off' by the ICB.

They will however seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety.

5.0 APPROVAL

The policy was ratified at the Patient Safety Committee (PSC) on the 8th August 2025.

6.0 DOCUMENT REQUIREMENTS

Our patient safety culture

Sherwood Forest Hospitals NHS Foundation Trust promotes a just culture approach (in line with the NHS Just Culture Guide) to any work planned or underway to improve safety culture. Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

The Trust encourages and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). Please refer to the incident management policy for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame.

Patient Safety Partners

The Trust has not set a definite number of Patient Safety Partners that it wishes to engage with. We have currently recruited 2 partners that are involved in patient safety . Patient Safety Partners (PSP) have an important role in supporting our PSIRF providing a patient perspective to developments and innovations to drive continuous improvement. A Patient Safety Partner (PSP) is involved in the designing of safer healthcare at all levels in the organisation. This means maximising the things that go right and minimising the things that go wrong for patients when they are receiving treatment, care and services from us. PSPs will use their lived experience as a patient, carer, family member or a member of the local community to support and advise on activities, policies and procedures that will improve patient safety and help us to deliver high quality care. PSPs will work alongside staff, volunteers and patients, attend meetings (face-to-face and online), be involved in projects to co-design developments of patient safety initiatives, and join (and participate in) key conversations and meetings in the Trust focusing on patient safety. They will have a mind-set for improving outcomes, whilst representing the patient, carer, family view and ensuring committee/meeting members are “walking in the patients’ shoes”.

Addressing health inequalities

The Trust has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system, for example our education system; economic and community development in our most deprived neighbourhoods; employment levels; pay and conditions; and availability and quality of housing.

Through implementation of PSIRF, we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to our Trust Board and partner agencies on how to tackle these. This holistic, integrated approach to patient safety under PSIRF will require the Trust to continue to collaborative with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda.

Our engagement with patients, families and carers following a patient safety investigation will recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues will be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Involving Patients & Families

The Trust recognises the importance of and is committed to involving patients and families following patient safety incidents, engaging them in the investigation process and to fulfil the duty of candour requirements. It is recognised from experience and research that patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents, and / or may have different questions or needs to that of the organisation.
The recruitment of a dedicated Family Liaison Officer demonstrates the trusts ongoing commitment to supporting patients, families and carers involved in incidents

This policy therefore reinforces existing guidance relating to the duty of candour and 'being open' and recognises the need to involve patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved. Further guidance in relation to involving patients and families following a patient safety incident is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/#heading-2
See also the trust policy on duty of candour/being open: KING'S MILL CENTRE FOR HEALTH CARE SERVICES NHS TRUST (sfh-tr.nhs.uk)

Appeals Process

Anyone receiving the results of a patient safety incident response report will have the right to appeal.

To ensure transparency and accountability in patient safety investigations, the Patient Safety Incident Response includes an appeals process by which individuals may formally appeal the Trust's response to a patient safety investigation, in line with national guidance.

Individuals wishing to submit an appeal must make contact with the Trust within 10 days of receiving the Trust responses. Details of contacts can be found on the documentation received post patient safety investigation.

The appeal will be reviewed through the Governance Support Unit and any subsequent divisions or departments, and further information may be provided.
Appropriate guidance and support will be made available to individuals throughout the appeals procedure, ensuring that the mechanism remains accessible and robust via the Family Liaison Officer.

Involving Staff, Colleagues and Partners

Involvement of staff and colleagues (including partner agencies) is of paramount importance when responding to a patient safety incident to ensure a holistic and inclusive approach from the outset. This policy reinforces existing guidance (Incident Reporting Policy), it is recognised this approach must not be restricted to only those incidents that meet a threshold of harm or predefined categories. We will continue to promote, support and encourage our colleagues and partners to report any incident or near-misses.

It is recognised that this new approach will represent a culture shift for the organisation which needs to provide support and guidance utilising the principles of good change management, so staff feel 'part of' rather than 'done to'.

We will therefore ensure regular communication and involvement through our communication framework and our wider organisational governance structures.

It is also recognised that staff and colleagues need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame. We will continue to closely monitor incident reporting levels and continue promote an open and just culture to support this.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

As a Trust we welcome this approach so we can focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improving safety. It is also recognised that our planning needs to account for other sources of feedback and intelligence such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. PSIRF guidance specifies the following standards that our plans should reflect:

1. A thorough analysis of relevant organisational data
2. Collaborative stakeholder engagement
3. A clear rationale for the response to each identified patient safety incident type

They will also be:

1. Updated as required and in accordance with emerging intelligence and improvement efforts
2. Published on our external facing website

Our Patient Safety Incident Response Plan (PSIRP) will reflect these standards and will be published alongside this overarching policy framework.

Resources and training to support patient safety incident response

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. It is therefore essential that as an organisation we evaluate our capacity and resources to deliver our plan. The PSIRP provides specific details.

The trust has invested a team of trained Patient Safety Incident Investigators (PSII) who can undertake PSII investigations, the majority have a substantive clinical or governance role, so they will have allocated time to complete investigations. PSIRP details which incidents will require a PSII and indicates how many of these we plan to complete based on current resources.

All staff are required to complete the patient safety training which covers the basic requirements of reporting, investigating and learning from incidents (Levels 1 & 2) and is found on the Sherwood e academy. (Trusts Learning platform).

Staff training in relation to the Patient Safety Incident Response Framework will be monitored by the Governance Support Unit. Participation in training is not mandated; however, communications regarding available sessions, resources, and opportunities will be proactively shared and staff are encouraged to engage in line with PSIRF principles. The organisation is committed to fostering a supportive learning culture where training is accessible and voluntary, and where continuous improvement is driven by staff engagement and open communication.

The Governance Support Unit will systematically review staff training activities to ensure alignment with current safety protocols and learning objectives.

Regular reports will be produced, and shared as part of Divisional Governance meetings, highlighting participation rates, areas for improvement, and notable outcomes from training initiatives.

Outcomes from monitoring will inform future training sessions and help to tailor resources to the needs of different staff groups.

In summary, while staff training is not mandatory within the PSIRF policy, its monitoring, communication, and encouragement remain foundational to the organisation's commitment to safety, learning, and quality care.

Our Patient Safety Incident Response Plan

The PSIRP sets out how we intend to respond to patient safety incidents over a period of 12 months. The plan is not a permanent set of rules that cannot be changed. We will remain

flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

The PSIRP is based on a thorough analysis of themes and trends from all incidents from 2019-2022 (including low harm, no harm and near misses), complaints and concerns, learning and recommendations from Serious Incidents (conducted under the previous framework), mortality reviews, legal claims and inquests, risks and risk registers and feedback from staff and patients. The priorities identified in the PSIRP will be regularly reviewed against quality governance reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

Reviewing our patient safety incident response policy and plan

Our Patient Safety Incident Response Plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date. It is recognised that with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing any previous versions.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

PSIRF guidance states:

"Where an incident type is well understood – for example, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness – resources may be better directed at improvement rather than repeat investigation (or other type of learning response)."

(PSIRF supporting guidance, Guide to responding proportionately to patient safety incidents. NHSE 2022)

Patient safety incident reporting arrangements

Patient safety incident reporting will remain in line with the Trusts Incident Reporting Policy. It is recognised that staff must continue to feel supported and able to report any incidents, or concerns in relation to patient safety, to promote a system of continuous improvement and a just and open culture.

Operational managers and governance teams will ensure any incidents that require cross system or partnership engagement are identified and shared through existing channels and networks, and that partnership colleagues are fully engaged in investigations and learning as required. Likewise, we will ensure we are responsive to incidents reported by partner colleagues that require input from the Trust, primarily by directing enquires to the relevant clinical teams or colleagues and seeking assurance that engagement, information sharing and learning has been achieved, or taken forward.

Certain incidents require external reporting to national bodies such as HSIB, HSE, RIDDOR and MHRA. Please refer to the Trusts Incident Reporting Policy for full details and guidance.

Structure of Governance Arrangements

Effective governance arrangements beneath committee level are critical for ensuring that strategic objectives and operational priorities are delivered consistently and transparently across the organisation. These arrangements serve as the link between high-level governance committees and the divisions or operational units responsible for the day-to-day work, acting as both a conduit for oversight and a mechanism for collaboration. This document outlines a robust framework for governance beneath committee level, with a particular focus on the role of the PSIRG weekly meetings for sign-off as required. It further details how the Governance Support Unit underpins these processes to ensure divisions remain aligned with PSIRP.

PSIRG Weekly Meetings

Purpose and Function

- PSIRG meetings are held twice a week and will ensure that the four main aims of PSIRF are implemented and embedded across SFH:

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

RESPONSIBILITIES

The following specific responsibilities will inform the work programme of the Group:

- Ensure there is a robust implementation plan in place, which responds to all recommendations for the Trust outlined within PSIRF.
- Ensure that there is an assessment of resource required to implement the PSIRF plan.
- Ensure that any resource implications are costed in line with Trusts policy / guidelines.
- Ensure that where the Trust cannot implement a recommendation, this is risk assessed and escalated appropriately, as per Trust Risk Management systems.
- Ensure that there is appropriate exception reporting established from the Working Group to Executive Directors, the Quality Committee, Patient Safety Committee and Board of Directors.

Agenda and Documentation

- Agendas are circulated in advance, prepared in consultation with divisional leads and the Governance Support Unit, to ensure focus on priority items requiring sign-off or escalation.
- Meeting minutes are recorded, capturing decisions, action items, and any required follow-up, with transparent documentation maintained for audit purposes.

Support from the Governance Support Unit

The Governance Support Unit acts as the backbone of operational governance beneath committee level, providing administrative, analytical, and strategic support to both PSIRG and divisional leads.

Responsibilities include agenda setting, minute taking, document management, preparation of briefing materials, and facilitation of follow-up actions.

Governance Support Unit staff work closely with divisional teams to track progress against key priorities, identify emerging risks, and coordinate cross-divisional initiatives.

They provide expert guidance on governance processes, support in the preparation of sign-off requests, and ensure that divisional outputs are consistent with organisational standards.

Through regular liaison, training, and coaching, the Governance Support Unit fosters a culture of accountability and continuous improvement.

Escalation and Issue Resolution

- Should divisions encounter barriers to delivery, the Governance Support Unit mediates solutions, facilitates escalation where necessary, and ensures lessons learned are captured and disseminated.
- Periodic review meetings with divisional heads and PSIRG leadership provide additional oversight and opportunity for course correction.

Maintaining Governance Quality and Responsiveness

Feedback and Process Improvement

- Regular feedback is provided from participants in weekly meetings to assess the effectiveness of governance arrangements and identify areas for improvement.
- Process changes are piloted and evaluated, with successful innovations embedded into standard operating procedures.

Documentation and Transparency

- All processes, decisions, and outputs are meticulously documented to ensure transparency, facilitate audits, and support effective knowledge management.
- Governance Support Unit maintains a central repository of governance materials, accessible to all relevant stakeholders.

Patient safety incident response decision-making

Reporting of incidents will continue in line with existing Trust policy and guidance. The Trust has governance and assurance system in place to ensure oversight of incidents at both a Divisional and Organisational level. Governance teams work with clinical and operational managers to ensure the following arrangements are in place:

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends or clusters of incidents within a specific service
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risks and issues
- Identification of any incidents requiring external reporting or scrutiny (eg – Never Events, Neonatal deaths, RIDDOR)
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures

The Governance Support Unit will provide regular reports to the Patient Safety Committee to identify and track emerging themes and trends outside of normal variation. This information will be reviewed regularly against our identified priorities in the PSIRP to determine whether any shift in focus is required, which will be agreed by the Patient Safety Committee.

As outlined in the Incident Reporting Policy, the process for completion of a Patient Safety Incident Review, rapid review, to determine any further investigation or escalation required will remain. This, however will now include a wider range of options for further investigation outlined in the PSIRF.

The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under the Trust's PSIRP. This may often mean no further investigation is required, especially where the incident falls within one of the improvement themes identified in the PSIRP.

Timeframes for learning responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

One of the most important factors in ensuring timeliness of a learning response is thorough, complete and accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team. These principles are set out in the current incident reporting guidance but must be reinforced through the PSIRF.

The PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident. Highly prescriptive timeframes for learning responses may not be helpful so the following are included as a guideline only:

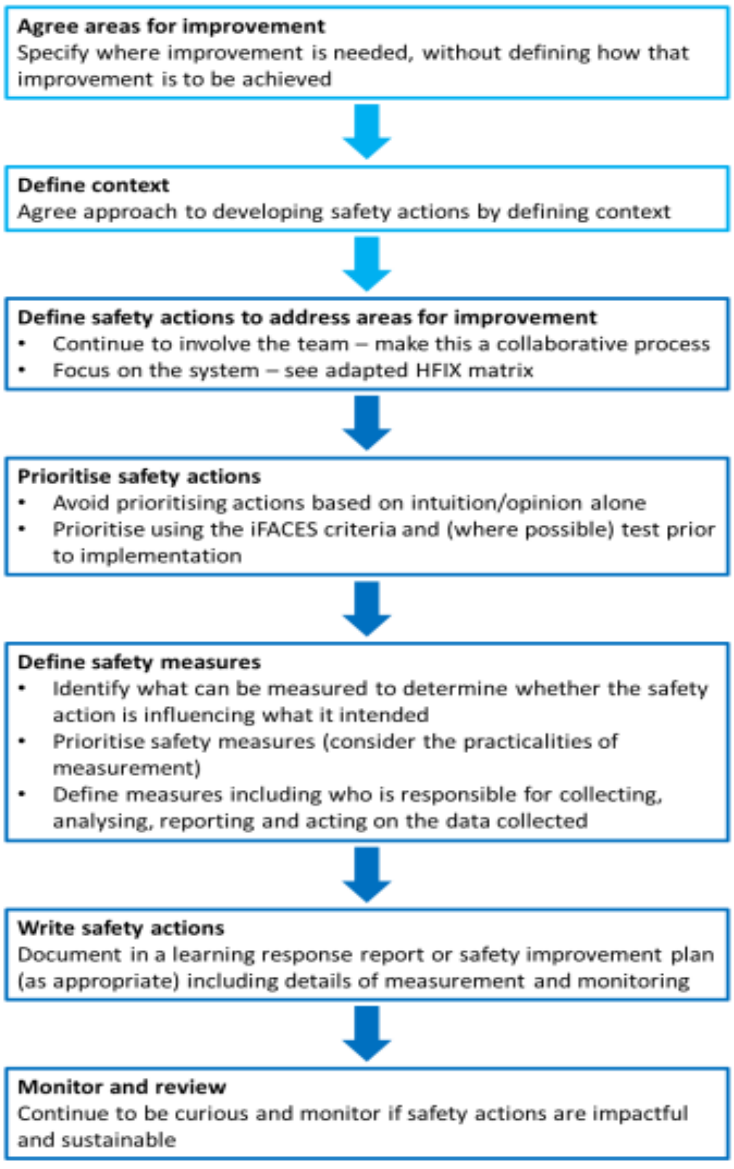
- Initial incident investigation – as soon as possible, within 5 working days of reporting
- Further learning response (eg: PSII, AAR, learning teams) – within 20 working days of reporting
- Comprehensive Investigation – 60 - 120 working days depending on complexity

A toolkit of learning response types is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

Safety action development and monitoring improvement

PSIRF moves away from the identification of 'recommendations' which may lead to solutionising at an early stage of the safety action development process.

The following diagram summarises how safety actions should be developed and overseen:



A Quality Improvement approach is valuable in this aspect of learning and improvement following a patient safety investigation. Close links with the Trusts Improvement Faculty already exist and will continue to be developed and maintained so their expertise and guidance can be utilised when developing the learning response and safety actions. This approach is recognised within the Trust and considerable work has taken place to educate colleagues in the principles of QI methodology. PSIRF therefore provides an opportunity to strengthen this.

Safety actions arising from a learning response should follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and thought must be given to monitoring and measures of success. Further guidance on this can be found in NHSE Guidance at https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Monitoring of completion and efficacy of safety actions will be through organisational governance processes with oversight at Divisional level reporting to the Patient Safety Committee.
The Governance Support Unit will maintain an overview across the organisation to identify themes, trends and triangulation with other sources of information that may reflect improvements and reduction of risk.

It is important that monitoring of completion of safety actions remains a means to improve safety and quality outcomes and reduce risk. The Trust will continue to develop governance systems focused more on measuring and monitoring these outcomes, utilising subjective as well as objective measures.

Safety improvement plans

The Patient Safety Incident Response Plan (PSIRP) clarifies what the Trusts improvement priorities are. The PSIRP details how we will ensure patient safety incidents are investigated in a more holistic and inclusive way, to identify learning and safety actions which will reduce risk and improve safety and quality.

The themes detailed in the PSIRP, are based on an extensive analysis of historic data and information from a range of sources (eg: incident trends, complaints, mortality reviews, risk registers, legal claims and inquests) and feedback from staff and patients. Each theme will have its own improvement plan utilising QI methodology, where appropriate, to determine what

the key drivers are to patient safety risks, how improvements can be made and how these can be monitored for completion and effectiveness. Whilst the PSIRP identifies the broad organisational priorities, it is recognised there may be more specific priorities and improvements identified at a Divisional, Specialty and Sub-specialty level, which although will not form part of the overarching plan, can still be approached utilising the more holistic and inclusive PSIRF approach. The Governance Support Unit will provide support and guidance, as required, to services and divisions. The Improvement Faculty will assist in improvements and identify where there is overlap with existing and developing QI programmes across the Trust.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Compassionate engagement and involvement of those affected by patient safety incidents	GSU and Divisional Management Teams	Review of engagement with Family Liaison Officer, feedback form those involved in Patient Safety Investigations and audit of Duty of Candour engagement and compliance	Six monthly	Patient Safety Committee
Application of a range of system-based approaches to learning from patient safety incidents	GSU and Divisional Management Teams	Review of the Datix incident reporting system for the number, type and trends of incidents reported.	Quarterly	Patient Safety Committee
Considered and proportionate responses to patient safety incidents and safety issues	GSU and Divisional Management Teams	Review of the Datix incident reporting system for the number, type and trends of incidents reported.	Quarterly	Patient Safety Committee

8.0 TRAINING AND IMPLEMENTATION

NHS Patient Safety Syllabus training programme levels 1 & 2 can be accessed on the Trusts e learning platform.

An in-house training course called Incident Reporting Using Datix can be booked using the on-line booking system via the Training, Education and Development intranet site. This is for new starters to the Trust and staff already using Datix as a refresher. Handler training is provided to all new handlers and on request or identified through the quality checking process

On-going Datix handler guidance is provided through the communication section within Datix web. Investigation training has been facilitated by Med led (an external training company) and update training will be provided - details to be decided.

All staff involved in any aspect of reporting and management of incidents must be aware of and be able to access this policy. They should be familiar with the content of this policy, particularly their responsibilities and the tools provided.

9.0 IMPACT ASSESSMENTS

This document has been subject to an Equality Impact Assessment, see completed form at Appendix C

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- NHS Patient Safety Strategy 2019
- NHS Patient Safety Incident Response Framework 2022

Related SFHFT Documents:

- Patient Safety Incident Response Plan
- Duty of Candour Policy
- Incident reporting Policy

11.0 KEYWORDS

N/A

12.0 APPENDICES

Appendix A: After Action Review Template

Appendix B: SWARM Huddle template

Appendix C – Equality Impact Assessment Form (EQIA)

Appendix A

After Action Review Template

Do not write in the blue boxes. When you have finished writing your report, do remember to delete all guidance in the blue information boxes and green text.

Notes on the AAR summary report template

This template standardises the reporting of AARs. It is not intended to be an AAR facilitation guide. The template has been co-designed with staff leading AARs in a range of healthcare organisations.

The structure is purposefully simple so that AARs can focus on reflective conversation and do not become a bureaucratic documentation exercise.

This structure will continue to be evaluated and developed by the National Patient Safety Team.

General writing tips

An AAR report must be accessible to a wide audience and make sense when read on its own. Assume the report may be shared both internally and externally.

Refer to the Learning response review and improvement tool when reviewing this summary report.

The report should:

- use clear and everyday English wherever possible
- explain or avoid technical language
- use lists where appropriate
- keep sentences short
- avoid including tick boxes to demonstrate compliance (for example, with Duty of Candour)

Patient name:		NHS Number:	
Datix number:		Incident date:	
Date of AAR:			

Report Author and Job Title:	
Proofread by	

If sharing externally you may wish to only record participating departments and professional groups

AAR participants			
Version Control *[Enter a **X** in the appropriate box to indicate status of this version]*	**RED** **Draft -** Not for distribution	**AMBER** **Final Draft -** Quality Assured send to other contributors or 3rd party(s)	**GREEN** **Approved -** Fully amended can be signed off as FINAL
	[enter **X** if applicable]	[enter **X** if applicable]	[enter **X** if applicable]

Directorate Sign off:

All completed reports and action plans must be read, approved and signed by a senior manager in the Directorate. Please sign and date below:

Approved by:	
Job Title:	

Date:	

About After-Action Reviews

An After-Action Review (AAR) is a learning response method that supports organisations to respond to a safety event or other event for the purpose of learning and improvement. AARs are structured around four questions:

1. **What was expected?** Participants describe what they would expect to happen in situations such as this.
2. **What actually happened?** Participants describe what they did, saw or experienced during the event.
3. **Why was there a difference?** Participants explore what got in the way of expectations being met and what enabled expectations to be achieved or exceeded. This includes consideration of the work environment, technology and tools, tasks, people, organisation and external influences.
4. **What has been learnt?** Participants describe what they have learnt – this may be about themselves, about the team(s) and/or about the wider organisational context that influenced the event.

AARs are led by trained facilitators and follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.
Further information on AARs are provided in the 'AAR essentials' table at the end of this report.

About the Person

Write a paragraph about the person

- Age and Name - use the persons first name throughout unless the family have requested otherwise.

Include:

- Details of their family situation
- Something about where they grew up, where they went to school, did they go to college, university what qualifications did they have etc.
- As adults what did they do? Did they have a job, where did they work, what was their career etc.
- Include something about the individual as a person.
- Try to avoid too much medical information in this section.
- Try to avoid negative or pejorative terms such as difficult, problematic, challenging etc.
- Be aware of sensitive family information particularly relating to any abuse or hearsay about the behaviour of the person or any member of their family.

Safety event summary

Notes on writing the 'Safety event summary'

Add a brief, plain English description of the safety event.

- Use third person language and do not include people's names. If the incident report is long you don't need to include all of it in this section just the basics of what the incident was.
- ENSURE THAT THE DUTY OF CANDOUR HAS BEEN CARRIED OUT - Following the duty of candour phone call and subsequent follow-up there may be additional information to add in this section.

If the incident relates to a death include the cause of death (from the coroner if possible) / time of death.

Scope of AAR

Notes on writing the 'Scope of AAR'

Add a brief, plain English description of why the AAR was held. This may be no more than one or two sentences or a bullet point.

In some cases, multiple AARs may be called in relation to a single safety event, and the scope of the AAR may change over time.

For example:

- The AAR was called to learn from a patient fall that resulted in a late diagnosis of a hip fracture.
- The AAR was called to learn from family engagement following a patient's fall that resulted in a complaint.

Family Engagement

Notes on Family Engagement

Family engagement is essential in AARs to gain a comprehensive understanding of incidents and foster meaningful improvement. Here are key steps to ensure effective family involvement:

1. **Engage Early and Provide Clear Information**: Involve and speak with families at the outset, providing clear information about the purpose, process, and their role in the writing of the AAR report. Families/carers do not need to attend the AAR meeting however they must be provided with the opportunity to share their views / concerns and to see the draft report for comment before it is finalised.

2. **Create a Safe Environment**: Ensure a supportive and non-judgmental space for families to share their perspectives. Acknowledge emotions and validate their experiences.

3. **Be Transparent**: Explain how their input will influence outcomes and provide updates on actions taken as a result of the review.

4. **Collaborate Respectfully**: Treat families as equal partners in the process, emphasising the value of their insights in driving positive change.

Effective family engagement builds trust, enhances accountability, and ensures lessons learned are inclusive and impactful.

In this section, please describe how the patient and/or their family have been included and how they engaged with the patient's care and in the After-Action Review process.

Key learning points

What led to the event occurring?

WRITE A BRIEF HISTORY
Mental health / Learning disability / Autism to be considered here

- When did the person have their first contact with services?
- What teams has the person had contact with and for how long.
- If the person has had inpatient admissions list when these were and what basis they were detained (informal, S2, S3 etc.).

Include

- A **very brief** history. Include when the person's issues started, what services they have been in contact with.
- Any recent diagnosis.
- The person's typical symptoms.
- Medications

Chronology of contact with services

- Be as brief as possible while retaining key information.
- It is helpful to use exact dates (day/month/year) as these can be checked later and are easier to find in the clinical record.

- You can write the chronology in bullet point form to avoid large blocks of text and for brevity.
- End the chronology at the incident.

Notes on writing the 'Key learning points'

This section can be completed as text or using a bullet point list.

The discussion will have been structured by the four questions, but it is not necessary to capture the discussion under each question.

Do not use language that directly or indirectly infers blame of individuals, teams, departments or organisations and/or focus on human failure – for example, the nurse failed to follow policy. Instead use system focused language – for example, we learned that there were challenges in following the policy in practice, because…, we learned that out of hours a number of factors affect the quality of escalation, including…

Focus on what happened and how it happened, and **not** what people, departments or organisations could or should have done during or before the event, use system focused language – for example, we learned that there were challenges in following the policy in practice, because…, we learned that out of hours a number of factors affect the quality of escalation, including…

Include adaptations, trade-offs or behaviours that helped everyday work.

Outputs

Notes on documenting 'Outputs' findings, learning and safety actions.

- It may be helpful to share insight gathered during an AAR with other groups across the organisation (for example, at a monthly governance meeting, learning from experience group etc.). The person taking responsibility for sharing findings and at which meeting should be defined in the action plan table below.
- No actions may arise from an AAR. However, when actions are agreed, these should be described and a responsible lead named.
- As well as these outputs, participants may identify learning for themselves (for example, about their behaviour or way of interacting with colleagues). These are valuable outputs from an AAR but do not need to be detailed in the AAR report.

Noted practice

- Include a brief section on any practice you believe is notable in the case you are reviewing.

Any areas for improvement **outside the sphere of control** of the participants to be shared with oversight groups should also be defined.

As well as these outputs, participants may identify learning for themselves (for example, about their behaviour or way of interacting with colleagues). These are valuable outputs from an AAR but do not need to be detailed in the AAR report.

Sharing the learning

include a list of those who will receive a copy of the report e.g.:

- The Family
- The staff team
- The Directorate Managers
- The Coroner

Who else needs to know about this learning?

Where to be shared	Responsible lead

Action Plan

This should be developed by the services involved in the care following consideration of the areas of learning identified in the review. The agreed action plan will be added to the Risk Management System (RMS) and updates will be required and approval for closure must be provided by the identified 'Action Owner (Manager).

Issue/ Recommendation / Area of Learning identified	Action to address recommendation	Person(s) Responsible for completion	Action Owner (Manager)	Start Date	Target date for completion (or date completed)	What will the evidence of completion be / how will this be demonstrated?
Learning 1 xxx	*Action 1*					
Learning 2 xxx	*Action 2*					
Mandatory Action	Final review of all actions and supporting evidence to be completed by the identified service lead before agreement of the completion and closure of the action plan.	(as identified below as the Service Lead(s)	(as identified below as the Service Lead(s)	Date to be set for 1 month following completion of the last action	Date to be set for 2 month following completion of the last action	The identified service lead will provide written confirmation to the Experience, Safety and Risk Team authorising the closure of the action plan on the risk management system.

Service Lead(s) for Action Plan (Overall responsibility for plan)

Name	
Role	
Directorate	

Areas for improvement outside the sphere of control of participants to be shared with oversight group.

Essentials of AAR

AAR is	AAR is not
A method for enabling an open and honest conversation about an event that can be used on its own or as part of a wider suite of methods	The same as an investigation
A debrief for those involved, led by a skilled facilitator	A meeting undertaken by an untrained person
Primarily for those directly involved in an event although others may attend if helpful to aid learning	A managerial meeting about an event without those directly involved present
A conversation structured around four AAR questions that is allowed to evolve for the purpose of learning	A bureaucratic documentation exercise to collect information about an event to be reported through governance structures
An opportunity to involve patients, families and carers in the learning conversation providing doing so maintains a psychologically safe space for all those affected	A space where patients, families and carers are expected to attend without considering the psychological safety and welfare of all those affected
A psychologically safe space where people can speak openly without fear of blame or judgement	A debrief that drifts into a scrutiny of people's actions and decisions
A space where all those present are heard and all contributions are valued equally, irrespective of rank or status	An opportunity for a few individuals to 'have their say' and dominate the conversation
Focused on exploring 'work as done' by asking 'What would you **expect** to happen?	Focused on what **should have** happened (for example, as described in policy and protocols)
A debrief that **may** result in a written document that summarises collective learning and is written in the third person (we learnt that….)	A minuted meeting where information shared by participants in the AAR is detailed in a written report
An opportunity to talk about everyday work and the lived reality and experiences of participants	A place where people are judged or blamed for the expectations and experiences that they describe
A space to understand the perspectives and experiences of those in the room	A space for rigid exploration and theming of different elements of a 'work system' (that is, organisation, work environment, task, technology and tools, external influences, person)

An opportunity to develop and agree actions that can be agreed and enacted by people participating in the review	An opportunity to dictate actions for others to complete
A space to highlight concerns about the wider system that may need to be shared with and taken forward by relevant safety/governance groups	A place to decide actions outside the sphere of control of those present

Appendix B

SWARM Huddle Template

Purpose and Principles

National guidance emphasises the following principles:

- Timeliness: Initiate the huddle as soon as possible after the event, ideally within one working day.
- Inclusivity: Involve all staff directly connected to the event, alongside quality/safety leads or facilitators.
- Blame-free environment: Foster psychological safety to encourage honest discussion and shared learning.
- System focus: Shift from individual blame to system improvements.
- Action and escalation: Identify actions that can be taken immediately ("quick wins") and those requiring further escalation or review.
- Documentation and learning: Ensure outcomes are recorded, shared, and reviewed at relevant governance forums.

Recommended Structure

Most national guidance suggests a standardised format for SWARM huddles, which typically includes:

- Brief description of the event or concern
- Timeline of what happened, when, and who was involved
- Identification of contributing factors (human, system, environmental, etc.)
- Discussion of how similar events can be prevented in the future
- Agreement of immediate actions, responsible individuals, and deadlines
- Follow-up and escalation plan for unresolved or systemic issues

SWARM huddles represent a proactive, team-based approach to learning from incidents and near misses in healthcare. National guidance supports their use as part of an overall patient safety and quality improvement strategy. Comprehensive, standardised documentation underpins the effectiveness of SWARM huddles by ensuring transparency, accountability, and shared learning. By following the elements outlined above, healthcare organisations can ensure their SWARM huddles are robust, meaningful, and result in real improvement for patients and staff.

Patient Name:	**NHS Number**	**Age:**
Time & date of incident:	**Injury Sustained:**	**Level of harm reported:**
Length of Stay in trust **Time in days:** **Time in hours:**	**Location/Department:**	**Datix Number:**
Date & time of SWARM Huddle:	**Person leading SWARM:** **MDT members present:**	

SWARM HUDDLE TEMPLATE

Step 1: **Introduce everyone by name.**

Step 2: Create a safe space to ensure everyone's voice is heard.

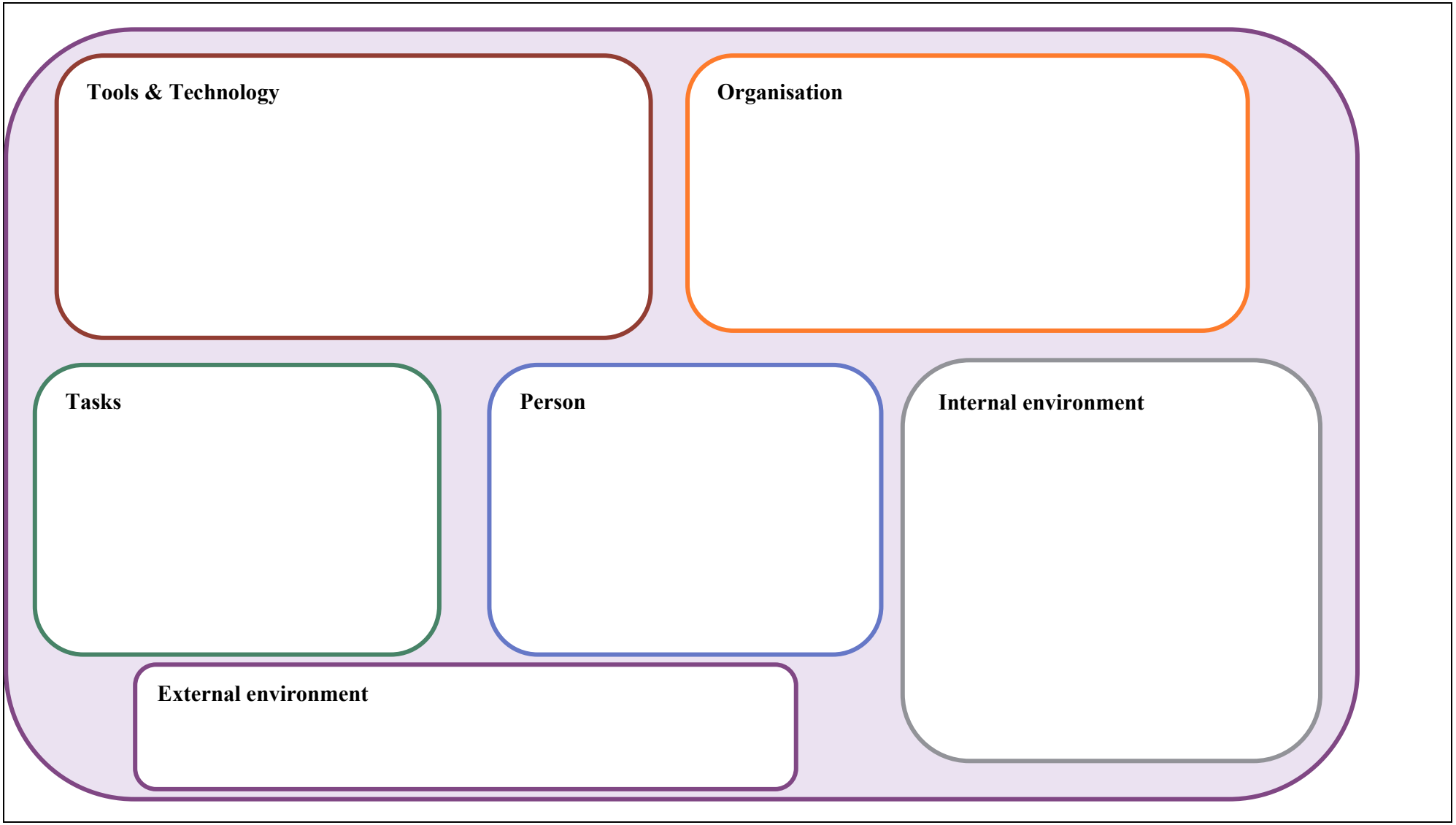
Step 3: Replay the event that prompted the SWARM Concise summary of the incident, near miss, or concern Context and circumstances (e.g., patient factors, environment, workload) Relevant clinical and operational details Chronological account of what happened, including key times and actions Who was involved at each stage

Step 4: Identification of Contributing factors

Human factors (communication, fatigue, training, etc.)
System/process factors (workflow, equipment, policy, etc.)
Environmental factors (distractions, layout, etc.)
Brief analysis of root causes or contributing factors
Use of relevant tools (e.g., fishbone diagram, '5 whys' method) where appropriate.

Step 5 : Explore this via the lens of the SEIPS framework below:

SEIPS framework



Step 6: Actions and Next Steps. Agreed actions (immediate and longer-term) Assignment of responsibility for each action Timescales for completion or review of actions Plan for escalation if issues cannot be resolved at team level
Step 7: Learning and Dissemination Key learning points identified during the huddle How learning will be shared within the team/service (e.g., safety briefings, newsletters, governance meetings) Opportunities for sharing learning across wider organisation or system Who will check on progress of actions and when How and when the huddle and its outcomes will be revisited or audited

Duty of candour	
Duty of candour completed: Date completed: Completed by: Completed how :	Yes / No
Discuss any concerns raised by the patient or their family.	

Sign off					
Review led by:		**Signed:**		**Date:**	

APPENDIX C - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Equality Impact Assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

Name EIA Assessor: Sally Whittlestone	**Date of EIA completion:** 18/08/2025
Department: Governance Support Unit/ Patient Experience	**Division:** Corporate
Name of service/policy/procedure being reviewed or created: Patient Safety Incident Response	
Name of persons responsible for service/policy/procedure: Candice Smith/ Sally Whittlestone	
Brief summary of policy, procedure or service being assessed: Patient Safety Incident Response	
Please state who this policy will affect: Patients or Service Users, Carers or families, Commissioned Services, Staff, Stakeholder organisations.	

Protected Characteristic	Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)	Provide a brief summary of what data or supporting information was considered to complete this assessment?
Race and Ethnicity	No	Legislation covering Patient Safety Incident Responses.
Sex	No	
Age	No	
Religion and Belief	No	
Disability	No	
Sexuality	No	
Pregnancy and Maternity	No.	

Gender Reassignment	No	

Marriage and Civil Partnership	No	
Socio-Economic Factors (i.e. living in a poorer neighbour hood / social deprivation)		

If you have answered 'yes' to any of the above, please complete Stage 2 of the EIA on Page 3 and 4.

What consultation with protected characteristic groups including patient groups have you carried out?

Patient Safety Partners.

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

No.

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)

Positive			Negative			
High	**Medium**	**Low**	**Nil**			

If you identified positive impact, please outline the details here:

Stage 2

Protected Characteristic	Please explain, using examples of evidence and data, what the impact of the Policy, Procedure or Service/Clinical Guideline will be on the protected characteristic group.	What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening.	Please outline any further actions to be taken to address and mitigate or remove any in barriers that have been identified.
Race and Ethnicity			
Gender			
Age			
Religion			
Disability			
Sexuality			
Pregnancy and Maternity			
Gender Reassignment			
Marriage and Civil Partnership			
Socio-Economic Factors (i.e. living in a poorer neighbour hood / social deprivation)			

Signature: S.Whittlestone *I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form*
Date: 18/08/2025

Please send the complete EIA form to the People EDI Team for review.
Please send the form to: sfh-tr.edisupport@nhs.net