Regional Standards for the Conduct of Patient Safety Incident Learning Reviews

2024

1. Introduction

In delivering the overarching 'Framework for Learning and Improvement from Patient Safety Incidents (PSI)'[1] the following regional standards represent the **minimum standards** that must be met by HSC organisations.

The Regional Standards for the Conduct of Patient Safety Incident Learning Reviews[2] are designed to guide HSC organisations and those who provide care on behalf of the HSC on how they are expected to comply with the Framework.

The Standards are based on best practice elsewhere as well as the recommendations from relevant public inquiries and reports and are intended to ensure that organisations undertake Patient Safety Incident Learning Reviews in a robust manner by:

- placing All those Affected[3] at the heart of the learning review process;
- conducting the appropriate type of review, to the required quality;
- prioritizing a system-based approach; and
- enhancing patient safety, using evidence to demonstrate the impact of learning from Patient Safety Incidents.

They provide an agreed expectation and should give confidence to All those Affected by a Patient Safety Incident as well as ensuring the appropriate level of accountability.

In order to comply with the Standards, HSC organisations must establish robust and rigorous governance structures, policies and procedures, to ensure the consistency and effectiveness of their PSI Learning Review. These Standards will also be utilised by the regional oversight body (SPPG/PHA) to allow them to assess compliance and strength of the evidence provided to support this.

[1] Hereinafter known as The Framework
[2] Hereinafter known as the Standards
[3] One of the earliest steps in the Patient Safety Incident Learning Review process is to consider and identify in a structured way who 'All those Affected' include. Organisations should consider service users, patients, families, carers, victims, victims' families and visitors that may be affected by a Patient Safety Incident, when determining who All those Affected are.

The Standards should be referred to by the Regulation and Quality Improvement Authority (RQIA) and other bodies who have a legal or statutory function in relation to inspections, and registration of HSC services.

The Standards may undergo further refinement and additions as the Framework is implemented and embedded.

2. What are the Standards?

The Standards for the management of the review of PSI's are built upon and underpinned by the five key themes described in the Framework (See figure 1 below).

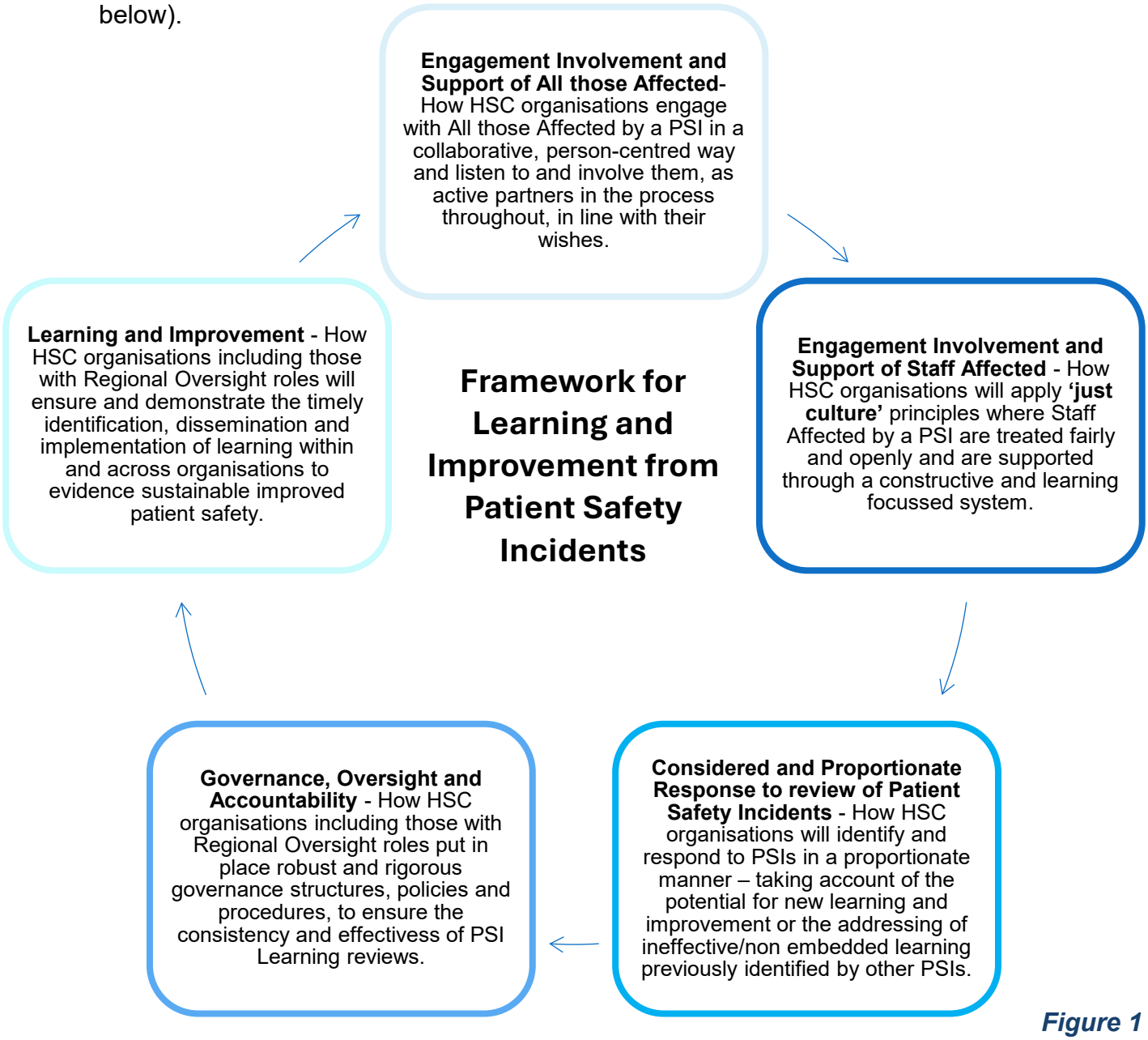

Figure 1

The Standards are outcome-based[4], with each Standard statement describing the high-level outcome each organisation **must** meet to deliver high-quality and effective management of PSI's.

Underneath each Standard is the list of core objectives and suggested evidence (not intended to be an exhaustive list) that an organisation might have in place to meet each Standard.

To provide assurance to the Trust Board that the Standard has been met, the supporting evidence for each standard must be robust, relevant, and of high quality. The overall strength of evidence such as whether there has been an internal or external audit/review must also be considered. Moreover, the evidence should demonstrate, for example, how the learning from a Patient Safety Incident has been embedded and how this has led to improvements in care, or how the evidence demonstrates effective governance of Patient Safety incidents. This evidence should be assessed and critiqued rigorously by the Trust Board particularly if the Standard has not been met or has only been partially met. If the Standard has not been met or has only been partially met an action plan must be agreed, documented and monitored through the organisation's internal governance processes. Progress on the action plan must be a standing agenda item at Trust Board meetings until Board members are assured that the Standard has been met.

3. Who are the Standards for?

The Standards are applicable to all HSC organisations including those organisations who provide care on behalf of the HSC described under the scope of the Framework and those tasked with a Regional Oversight or regulatory role[5]. They do not replace or remove the need to comply with current legislation or best practice guidance but rather should complement, support and underpin them.

[4] This means that each Standard provides a specific outcome for the service to meet. The statement identifies the Standard and describes the high-level outcome required to deliver high-quality and effective management of Patient Safety Incidents. National Standards for the Conduct of Reviews of Patient Safety Incidents. (2017). Mental Health Commission and Health Information and Quality Authority.

[5] For example, the Strategic Planning and Performance Group (SPPG) and RQIA.

Theme - Engagement, Involvement and Support of All those Affected

Standard: HSC Organisations engage with All those Affected by a Patient Safety Incident in a collaborative, person-centred way, listening to and involving them, as active partners in the process throughout, in line with their wishes.

An effective Patient Safety Incident Learning Review is best achieved by placing All those Affected at the heart of the process, to deliver and more complete and authentic review.

Core Objectives	Examples of Evidence[6]	Outcome
All those Affected must experience a compassionate and empathetic approach, be seen as equal partners in the review process and be treated in accordance with the Principles for Engaging, Involving and Supporting All those Affected. [7]	• Feedback from All those Affected following the review process which seeks their thoughts and feelings on how they were engaged with, involved and supported throughout the process. This could be obtained	• All those Affected understand what to expect from the beginning of the process, therefore managing expectations. • All those Affected's unique perspectives and experience are

[6] These are minimum examples of evidence organisations may provide to demonstrate compliance with this Standard, however individual organisations may have additional evidence which is relevant.

[7] Principles for Engaging, Involving and Supporting All those Affected by a Patient Safety Incident

	by, for example, face to face or virtual meetings, focus groups, questionnaires and surveys. • A record of the communication with All those Affected which provides and explains the Principles for Engaging, Involving and Supporting All those Affected.	taken into account, delivering a more accurate and complete review. • All those Affected are satisfied with the level of communication, engagement and support as part of the PSI Learning Review. • Assists All those Affected to rebuild trust in HSC Organisations following a PSI learning review.
An acknowledgement and offer of an apology that an incident has occurred, must be provided.	• A record documenting the acknowledgement and apology, for example email correspondence, entry in Datix, letter or minutes of meetings.	• All those Affected feel the incident has been genuinely acknowledged and as a result are more likely to engage in the Learning Review process. • Showing compassion by offering acknowledgment and an offer of apology when the incident occurs may help All those Affected to come to terms when something has gone wrong and help Staff Affected.
During the review process, All those Affected must be given the opportunity to share their unique perspectives and ask questions about what led to the PSI, with these reflections and questions listened to, answered honestly and openly in a timely manner and accurately reflected in the final PSI report.	• Examples of where All those Affected questions or concerns have been considered and included in the review process, for example email or written communications and meeting notes. • Questions or concerns documented in the final PSI report.	• All those Affected's unique perspectives and experience are taken into account, delivering a more accurate and complete review. • All those Affected will feel involved throughout the entire review process.

		• All those Affected are more likely to be satisfied with the outcome of the review if their questions and concerns are answered.
All those Affected must have access to all relevant information related to the review in line with the organisations internal information governance policies and adhering to GDPR regulations. Information should be provided in an accessible format and at the appropriate time. In circumstances where information cannot be shared because it is not relevant or due to the duty of confidentiality these reasons should be explained clearly, as soon as possible, in a supportive manner with the rationale recorded appropriately.	• Documentation detailing the request for information and the information provided. • Documentation outlining the rationale for information which is not relevant or possible to share. • Record of how an explanation has been provided regarding the information which cannot be shared and the reasoning for this decision this could include, minutes of a meeting, via email or in writing.	• Assists in fostering an open, honest and transparent culture. • Allows All those Affected to have a full understanding of the circumstances of incident and provide informed input to the PSI Learning Review. • Builds a more open and transparent relationship between All those Affected and the HSC Organisation. • By the organisation providing an open explanation on the reasoning for their decision not to provide information, All those Affected are less likely to feel that the organisation is not being open and transparent.
A single point of contact with the appropriate skills, values, knowledge and regional standardised training to provide information and advice, must be provided. This single point of contact must liaise with All those Affected throughout the review process in a supportive way that takes account of their needs and answer any questions they may have, providing	• Evidence that those responsible for the engagement have the appropriate skills and training for example training records, certifications and any relevant accreditations. • Minutes from relevant governance meetings which detail the	• Enhanced and consistent communication, engagement and involvement experience of All those Affected, ensuring an empathetic and compassionate approach. • All those Affected will feel involved throughout the entire review process.

information on the review process and offering support when required.	communication undertaken with All those Affected. • Evidence of how All those Affected were kept involved in the review process for example records of communication via telephone, email or notes of meetings • Evidence of where All those Affected questions have been addressed.	• All those Affected are aware of who to contact with any questions delivering a more accurate and complete review.
Signposting to support services must be provided, as required, through the organisation or via an independent advocacy service.	• Records of how All those Affected have been signposted for example minutes of meetings, via email or in writing. • Details of the support systems in place within the organisation. • Patient information leaflet on advocacy.	• All those Affected receive professional support and advice to appropriately navigate the Learning Review process. • All those Affected have support to manage the trauma experienced as a result of being involved in a PSI. • All those Affected can receive independent support if required to have their voices heard. • All those Affected feel more confident and comfortable and as a result are more likely to engage in the Learning Review process, providing a more accurate and complete review. • Support services can explain to All those Affected what they can expect from the Learning Review process and advise of the processes to follow

		if these expectations are not being met.
All those Affected must have a copy of the Draft report shared with them and be given the opportunity to comment on the factual accuracy of the report/ and or meet with the Chair of the review team to discuss the draft report. All those Affected views and opinions must be accurately reflected in the final report.	• Evidence to demonstrate that the draft report has been shared with All those Affected for example the written correspondence providing the report or minutes of meetings to discuss the draft report. • A draft report which reflects the views and opinions of All those Affected and acknowledges any comments or concerns that could not be resolved to their satisfaction.	• All those Affected have the opportunity to review the draft report and comment on factual accuracy prior to the finalisation of the report. When the final report has been issued no further changes can be made unless new material information is provided. • All those Affected have an opportunity to be involved and participate in the draft report before it is finalised. • All those Affected can help shape the learning and recommendations.
Following the final review report, All those Affected must be given the opportunity to feedback on their experience of the review (e.g. timeliness, fairness, transparency, content of the final report and learning) and be provided with an update on how this feedback has been acted upon. All those Affected must also be updated on the implementation of safety actions.	• Feedback from All those Affected following the review process which seeks their thoughts and feelings on how they were engaged with, involved and supported throughout the process. This could be obtained by, for example, face to face or virtual meeting, focus groups, questionnaires and surveys. • Evidence of how an update has been provided to All those Affected on how feedback has been acted upon for	• HSC organisations are provided with feedback on the PSI Learning Review Process which can provide valuable learning for the organisation and allow them to improve the review process. • All those Affected feel their experiences of the review process are valuable and are being listened to and acted upon.

	example, written communication, email, minutes of meetings. • Evidence by the organisation of how All those Affected have been advised on the implementation of safety actions and how these have led to improvement.	• All those Affected are aware of any changes made as a result of their feedback. • All those Affected are aware of the learning and changes made as a result of the PSI Learning Review.

Theme - Engagement, Involvement and Support of Staff Affected

Standard: HSC Organisations will apply 'just culture' principles where Staff Affected by a Patient Safety Incident are treated fairly and openly and are supported through a constructive and learning focussed system.

HSC Organisations must create a psychologically safe space where staff are supported and encouraged to report and participate in Patient Safety Incident Learning Reviews.

Core Objectives	Examples of Evidence	Outcome
HSC Organisations must foster a safety culture based on trust, openness and strong collective leadership across all levels of the organisation where staff are required to report and participate in Patient Safety Incident Learning Reviews.	• Staff safety culture survey results. • Communications with staff that demonstrates support and encouragement to report Patient Safety Incidents. • Relevant training event records.	• Patient Safety Incidents are more readily identified and reported. • Staff Affected feel more confident and comfortable participating in Patient Safety Incident Learning Reviews, leading to a more open, honest and accurate review. • A move away from blame culture, towards a more proportionate

		approach to accountability, where required.
Staff involved in PSI's must receive a compassionate and empathetic approach that takes account of their individual needs and that they are treated in accordance with the Principles for Engaging, Involving and Supporting Staff Affected.[8]	• Feedback from Staff Affected following the review process which seeks their thoughts and feelings on how they were engaged with, involved and supported throughout the process. This could be obtained by, for example, face to face or virtual meeting, focus groups, questionnaires and surveys. • A record of the communication with Staff Affected which provides and explains the Principles for Engaging, Involving and Supporting Staff Affected.	• Staff Affected feel better engaged with and supported and will therefore be more likely to openly engage in the Learning Review. • Staff Affected understand what to expect from the beginning of the process, therefore managing expectations. • Staff Affected are satisfied with the level of communication, engagement and support as part of the PSI Learning Review.
Staff Affected must be provided with a single point of contact with the appropriate skills, knowledge and regionally standardised training to provide information and advice, who will keep them updated throughout the Learning Review process and signpost them to appropriate support services, as required, based on individual need.	• Minutes from relevant governance meetings which detail the communication undertaken with Staff Affected. • Evidence that those responsible for the engagement have the appropriate skills and training for example training records, certifications and any relevant accreditations.	• Enhanced communication, engagement and involvement experience of Staff Affected, ensuring an empathetic and compassionate approach. • Staff Affected feel supported and are aware of who to contact with any questions throughout the process.

[8] Principles for Engaging, Involving and Supporting Staff those Affected by a Patient Safety Incident

	• Evidence of how Staff Affected were kept involved in the review process for example records of communication via telephone, email or notes of meetings.	
HSC Organisations must ensure that staff who are involved in reviews of PSI's are communicated with, listened to, and supported in a timely manner throughout the process in line with Just Culture principles. This support should continue following the completion of the process if required.	• Evidence of how Staff Affected were kept involved in the review process for example records of communication via telephone, email or notes of meetings • Details of the support services in place and when these were offered throughout the Learning Review process.	• Enhanced communication, engagement and involvement experience of Staff Affected, ensuring an empathetic and compassionate approach. • By listening to the Staff Affected a more accurate Learning review will be undertaken and with more relevant learning identified.
Staff involved in a PSI must be given time to read and input to the draft review report at the time it is shared with All those Affected and must be actively involved in the identification of learning and engaged in the design of the action plan	• Evidence that the report has been shared e.g. emails, minutes of meetings. • A record of how Staff Affected's reflections or suggestions on the draft review report have been considered.	• Staff Affected have the opportunity to review the draft report and comment on factual accuracy prior to the finalisation of the report. When the final report has been issued no further changes can be made unless new material information is provided. • Relevant learning and realistic action plans which lead to demonstrable improvement can be developed.
The services in place to support engagement, involvement and support of Staff Affected must be clearly identified, and HSC organisations	• Support mechanisms demonstrated e.g. peer support, buddy support, staff wellbeing.	• Staff Affected feel more confident and comfortable and as a result are more likely to engage in the Learning

must ensure that these are operating effectively.	• Details of how support services have been assessed to ensure they are operating effectively. • Staff support information leaflets. • Usage of support services.	Review process, providing a more accurate and complete review. • Staff Affected have support to manage the trauma experienced as a result of being involved in a PSI.
HSC Organisations must ensure that staff have the appropriate skills, values knowledge, time and ongoing training for the roles they undertake in the review of PSI's.	• Training database which shows the training records of staff. • Documentation displaying the protected time allowed for staff to participate in PSI Learning Reviews. • Numbers of staff accredited through the regional training programme. • Job plans. • Specific job roles and responsibilities.	• Staff are prepared and understand the expectations when participating in a PSI Learning Review and have the appropriate time to engage in the process. • A more complete, accurate and timely review is achieved. • Staff facilitating or chairing learning reviews ensure high quality and consistent reviews.
Where a review of an incident identifies an issue that must be addressed under a separate process, the handover to these processes, where possible, must be explained fully to those involved including All those Affected, and Staff Affected and Just Culture principles must be applied.	• Evidence of how this information has been communicated to both All those Affected and Staff Affected for example, written communication, emails, minutes of meetings. • Open just learning policy.	• Staff Affected are aware of how and by which separate process any issues are being addressed. • All those Affected are aware that any issues that cannot be resolved via the PSI Learning Review process are being actioned under a separate process.
Following the final review report, Staff Affected should be given the opportunity to feedback on their experience of the review and be provided with an update on how this feedback has been acted upon. Staff Affected should also be updated on lessons learnt and the	• Feedback from Staff Affected following the review process which seeks their thoughts and feelings on how they were engaged with, involved and supported throughout the process. This could be obtained by, for	• HSC organisations are provided with feedback on the PSI Learning Review Process which can provide valuable learning for the organisation and allow them to improve the review process.

implementation of recommendations and safety actions from the findings of the review.	example, face to face or virtual meeting, focus groups, questionnaires and surveys. • Evidence of how an update has been provided to Staff Affected on how feedback has been acted upon for example, written communication, email, minutes of meetings. • Evidence of how Staff Affected have been advised on the implementation of recommendations and safety actions and how these have led to improvement.	• Staff Affected are aware of the outcome of the PSI Learning Review, and learning identified, and changes made as a result.

Theme - Considered and Proportionate Response to review of Patient Safety Incidents

Standard: HSC Organisations will identify and respond to Patient Safety Incidents in a proportionate manner – taking account of the potential for new learning and improvement.

HSC Organisations must use a data driven approach to understand their own unique Patient Safety risk profile forming a holistic understanding which will then inform the decision regarding which approach/type of review is most appropriate to an individual Patient Safety Incident to identify learning and ensure sustainable improvement.

Core Objectives	Examples of Evidence	Outcome
The review of PSI's must be conducted using appropriate methods and tools in line with the Methodology guidance, assuring closure within agreed and realistic timescales.	• Feedback from All those Affected as to the type and quality of review carried out. • A record of the method and tool used and the reasoning for this approach. • HSC Organisations demonstrating that they have conducted PSI Learning Reviews with the method and tool outlined in their agreed Patient Safety	• A well written final PSI report that identifies relevant learning, produces effective recommendations and satisfies All those Affected and Staff Affected. • Ensures more timely reviews and early identification of learning.

	Incident Learning and Improvement Plan.	
Proportionality should be achieved in reviews - this means safety incidents are reviewed proportionately at an appropriate level, depth and breadth of review and where mandated in line with the framework.	• Peer-peer audit • BSO internal audit • Review and discussion at appropriate governance groups. • Feedback from All those Affected and Staff Affected that proportionality has been achieved. • Feedback/discussion with All those Affected as to the type and quality of review carried out. • HSC Organisations demonstrating that they have conducted PSI Learning Reviews with at the level outlined in their agreed Patient Safety Incident Learning and Improvement Plan.	• A timelier review is completed which answer's All those Affected's questions and identifies relevant learning. • Less complex incidents can be completed using a concise review, and this rebalancing allows more resources for those more complex incidents that require it most.
HSC organisations must ensure that the requirement for and appropriate level of independence (both internal and external) as part of a PSI Learning review is considered, documented and discussed with All those Affected.	• A record of the HSC Organisations assessment and decision making around the level of independence. • A record of the HSC Organisations communication to explain their decision on independence to All those Affected for example, email, written or minutes of meetings. • Internal or external review of the level of independence.	• PSI Learning Reviews are conducted to the appropriate level of independence. • All those Affected are involved in the decision making surrounding the level of independence required.

A comprehensive and accessible review report must be produced which accurately describes what happened and why it happened and makes realistic and achievable recommendations to reduce risk of harm and reoccurrence and to improve patient safety.	• Feedback from Staff Affected and All those Affected on the accuracy and appropriateness of the review report. • Recommendations that are relevant and effective which have led to improved patient safety.	• All those Affected and Staff Affected are satisfied and can fully understand the outcome of the PSI Learning Review. • Practical and achievable recommendations are made which can be successfully implemented and as a result improve patient safety.
Implement the recommendations and actions from PSI's which achieve and evidence demonstrable improvement.	• Audit of recommendations/ safety actions. • Quality improvement projects aligned to recommendations and actions.	• Improvement is made to the HSC system which mitigates the chances of recurrence and ultimately improves patient safety.
Where a cross-system/agency PSI occurs all parties involved engage, work together, and cooperate with any review process and agree on the recommendations and actions required.	• A record of communication between organisations when a cross-system PSI occurs. • Memorandum of understanding between organisations.	• A more coherent, joined up approach is taken to cross-system/agency PSIs, which results in an improved experience for All those Affected and Staff Affected and produces an accurate, balanced final report.
In line with the defined circumstances set by the Department of Health in the methodology guidance ensure that the Patient Safety Incident Learning Review undertaken is appropriate and of the required standard.	• Organisational Board level assessment and reporting. • Regional assessment and reporting. • HSC Organisations demonstrating that they have conducted PSI Learning Reviews with at the level outlined in their agreed Patient Safety Incident Learning and Improvement Plan.	• There is robust oversight and assurance of the decision making around the appropriate level of review to undertake. • PSI Learning Reviews are conducted to a required standard which satisfies all involved.

HSC Organisations must develop Patient Safety Incident Learning and Improvement Plans using the regional template provided, which describe their approach to PSI's and set out the roles and responsibilities within a Learning Review. The plans should be available on the organisations website and should be signposted to All those Affected.	• Documented plan, subject to regular review and available on the organisation's website. • Reference to the plan in patient information. • Sign off by trust board of plan. • Record of signposting.	• All those involved in a Patient Safety Incident Learning Review are able to access an organisations plan to understand how those affected will be engaged, what governance processes for oversight are in place and how Learning Reviews integrate with other processes such as complaints. • Organisations are able to demonstrate, using their plan, how they have analysed their overall patient safety risk profile to determine which approach/method to use when reviewing a Patient Safety Incident. • All staff understand their roles, responsibilities, and accountability and can articulate these.
HSC Organisations must be aware of, actively consider, assess and monitor for inequalities in their response to PSI's.	• Equality screening. • Patient Safety Incident Learning and Improvement Plans which consider inequalities.	• By better addressing health and social care inequalities through PSI Learning Reviews there will be equity in the delivery of services which leads to better outcomes for everyone. • Consideration is given to how certain groups of staff may be disproportionately affected by a PSI and they can be better supported as a result.

Theme –Governance, Oversight and Accountability

Standard: HSC Organisations including those with Regional Oversight roles must put in place structures, policies, procedures and processes for the governance and oversight of Patient Safety Incident Learning Reviews.

Patient Safety Incident Learning Reviews must be at the core of the organisation, with robust oversight at Board and regional level, supported by effective governance processes.

Core Objectives	Examples of Evidence	Outcome
There is a formal up to date Patient Safety Incident Learning and Improvement Plan which has been agreed in collaboration with SPPG and approved by the HSC organisations Board.	• Documented plan, subject to regular review, at least annually and available on the organisation's website. • Approval of the plan in the organisations Boards minutes. • Reference to the plan in patient information.	• All those involved in a Patient Safety Incident Learning Review are able to access an organisations plan to understand how those affected will be engaged, what governance processes for oversight and accountability are in place and how Learning Reviews integrate with other processes such as complaints.

		• Organisations are able to demonstrate, using their plan, how they have analysed their overall patient safety risk profile to determine which approach/method to use when reviewing a Patient Safety Incident. • Agreement of the plan in a collaborative way with regional oversight to ensure that there is a level of consistency between HSC organisations.
HSC organisations must demonstrate a clear commitment to Patient Safety Incident Learning Reviews at all levels in the organisation based upon HSC core values fully aligned with the HSC Open, Just and Learning Charter.	• Included in the organisations corporate plan. • Corporate plan available on the organisation's website. • Referenced in patient information. • Included in the organisation's induction programme.	• Organisation's Board, Executive teams and all staff understand and are able to articulate the organisations commitment to Patient Safety Incident Learning Reviews.
All staff have clear roles, responsibilities and accountabilities regarding Patient Safety Incident Learning Reviews.	• Included in job descriptions. • Available on organisations website. • Included in the Patient Safety Incident Learning and Improvement Plan. • Included in induction for all staff.	• All staff understand their roles, responsibilities, and accountability and can articulate these.

Governance processes are effective and provide assurance on the implementation of the Framework and accompanying standards.	• Governance structures and processes clearly articulated in the Patient Safety Incident Learning and Improvement Plan. • Patient Safety Incident Learning and Improvement Plan available on the organisation's website. • Internal or external audit of the governance processes. • Peer review of the governance process.	• A governance process is in place which demonstrates the robust monitoring systems and assurance mechanisms for the framework and standards.
Implement an effective system to monitor and evaluate the effectiveness of reviews of PSI's and for verifying that learning and improvement has been implemented and has resulted in demonstrable improvement in patient safety.	• Regular reviews of PSIs for adherence to plan and standards. • Overview report of the conduct of PSI learning reviews e.g. type of review, timeliness, how recommendations and learning are taken forward. • Evaluation of the system in place for monitoring and evaluation. • Report from relevant governance committee on the implementation and learning from PSI's. (annual)	• Organisations can demonstrate the appropriate level of review has been undertaken in a timely manner in adherence with their plans. • Organisations can demonstrate relevant learning is being identified and is leading to an improvement in patient safety.
HSC organisations and those in a Regional oversight role must have clear links and alignment between patient safety and quality improvement systems and processes, and related governance systems and processes, including complaints and compliments.	• Documented sharing of information between relevant processes and systems. • Demonstration that the recommendations identified from a Patient Safey Incident Learning Review	• A balance is reached between review and delivering safety improvements. • A significant cultural shift towards systematic patient safety management by embedding Patient Safety Incident Learning Reviews

	have considered ongoing quality improvement initiatives. • Audit of quality improvement projects.	within a wider organisational system of learning and improvement is supported.
HSC organisations must have effective and reliable systems (digital and non-digital) to support a data driven approach to Patient Safety Incidents using quantitative and qualitative patient safety data from a wide range of relevant sources.	• Description of digital systems used to record information and how these will be used to improve patient safety. • Audit of the appropriate use of digital systems to identify patient safety incidents. • Guidelines on the use of digital systems for triangulating data on patient safety. • Demonstrate mapping of information sources to the development of the Patient Safety Incident Learning and Improvement Plan. • Strategy for integrating existing and new digital systems for organisational and system wide surveillance.	• Patient safety data is used to inform the organisations response to patient safety incidents. • Allows a more proactive holistic response to patient safety incidents with robust triangulation of patient safety data.
Robust and rigorous information governance processes must be in place for the management of information related to PSI's.	• Included in the organisations Information Governance plan. • Referenced in patient information. • Guidelines for the sharing of information in PSI learning reviews.	• Information in relation to PSI's is appropriately stored and managed. • Relevant information related to the review is accessible to All those Affected in line with the organisations internal information governance policies and adhering to GDPR regulations.

		• Information is provided in an accessible format and at the appropriate time. • Staff are appropriately trained and are aware of the expectations in relation to the management and sharing of information.
HSC Organisations and SPPG must work closely and collaboratively to understand the approach to reviewing PSIs and to ensure that the assurance process is robust and demonstrates effective implementation of the framework and standards.	• Documentation which demonstrates the collaborative relationship between HSC organisations and SPPG for example, emails, written communication and notes of relevant meetings. • Internal or external review of governance processes. • Standing agenda item on trust board meetings. • A record of the frequency of contact and meetings.	• Board and regional Oversight and Governance roles are redefined and rebalanced '*in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures'* • Patient Safety Incident Learning and Improvement Plans are reviewed and agreed by SPPG meaning there is regional oversight of the HSC organisations approaches. • The Framework and Standards are effectively implemented and result in improved patient safety.

Theme - Learning and Improvement

Standard: HSC Organisations including those with Regional Oversight roles will ensure the timely identification, dissemination and implementation of learning within and across organisations to sustainably improve patient safety.

The ultimate goal of a Patient Safety Incident Learning Review is to learn from an incident, understand what can be done to prevent its recurrence, and restore relationships with All those Affected.

Core Objectives	Examples of Evidence	Outcome
A positive learning culture should be fostered by and with senior leadership who are committed to promoting, empowering, facilitating, and supporting this culture within their organisations.	• Staff Surveys/Feedback. • Communications with staff that promote a positive learning culture. • Included in the organisations corporate plan.	• Staff are encouraged to learn and grow and therefore are more likely to feel valued, remain engaged, and committed to their roles, resulting in improved patient safety.
Structures and systems must be in place to actively share the learning (system wide), share the meaningful impact of the learning and	• Evidence that learning letters have been shared with staff and discussed at the relevant forums.	• Lessons learnt are shared across the system and the risk of recurrence is

resultant changes in practice from reviews of PSI's to also include partners in other sectors where appropriate.	• Safety newsletters. • Evidence of active staff participation in learning from safety huddles or workshops, ECHO sessions and mortality and morbidity groups etc. • Digital resources for example safety messages use of apps. • Record of discussion at Regional patient safety conferences.	reduced, leading to demonstrable improvement in patient safety. • Create the ability to continually learn and improve using new technologies.
All learning arising from the reviews of PSI's must be implemented, monitored and verified for effectiveness.	• Audit of awareness of safety actions from PSI's. • Learning repository/library and audit of use. • Minutes of relevant governance meetings where implementation and verification of learning and improvement have been discussed. • Review of appraisals to ensure reflections of learning[9]. Evidence of methods used to implement change from learning	• Learning from PSI Learning Reviews is leading to demonstrable improvement and change.
Learning and improvement should be balanced, cross-referring any learning and improvement recommendations with any quality improvement initiatives where the outcome is yet to be evaluated/implemented, which will embed or	• QI strategy. • PSI Learning Review reports which acknowledge ongoing quality improvement initiatives.	• PSI Learning Reviews and the resultant learning are duplicated less, allowing more resource for those incidents that require it most

[9] This should be anonymised by the relevant manager of the appraisal process before it is submitted to Trust Board as evidence.

compliment the learning from a Patient Safety Incident Learning Review.	• PSI Learning Review reports which do not duplicate recommendations.	and can lead to the most improvement.

Glossary

Unless stated otherwise these definitions are from the 'Conceptual Framework for the International Classification for Patient Safety.

Term	Definition
All those Affected	One of the earliest steps in the Patient Safety Incident Learning Review process is to consider and identify in a structured way who 'All those Affected' include. Organisations should consider service users, patients, families, carers, victims, victims' families and visitors that may be affected by a Patient Safety Incident, when determining who All those Affected are. (Adapted from the Conceptual Framework for the International Classification for Patient Safety definition of Person Affected.)
Apology	'An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty'. (Compensation Act 2006) As soon as possible after you become aware something has gone wrong, you should seek out the patient and or their family and say sorry and acknowledge what has happened and tell them that you will find out more. (NHS Resolution)
Advocate	An individual speaking on behalf of an individual affected by a patient safety incident, and/or supporting them to speak for themselves when they can. (PSIRF)
Carer	A carer is someone who regularly provides a substantial amount of care to a family member, friend or neighbour who is ill, disabled or is an older person. Carers (also referred to as informal carers or family carers) generally provide unpaid care as opposed to care workers who work in care and support jobs (e.g. domiciliary care) (The Department of Health and Social Care - Carers | Department of Health)

Term	Definition
Culture	The shared attitudes, beliefs and values that define a group or groups of people and shape and influence perceptions and behaviours.
Family	Family refers to the person or patient (the individual) to whom the patient safety incident occurred, their family and close relationships. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who had a direct and close relationship with the individual to whom the incident happened. (PSIRF)
Harm	Impairment of structure or function of the body and/or any deleterious effect arising there from, including disease, injury, suffering, disability and death, and may be physical, social or Psychological
Just Culture	Staff, patients, service users, their families and carers are treated fairly, with empathy and consideration when they have been involved in an adverse incident or have raised a safety issue.
Openness	Being Open is a core value of the Health and Social care system in Northern Ireland. It is described as a commitment to 'being open and honest with each other and acting with integrity and candour'. (Regional Being Open Framework)
Patient	A person who is receiving, or has received, care provided by, or on behalf of, a HSC body. (The Health and Social Care Complaints Directions NI 2009)
Patient safety	The term used nationally and internationally to describe the freedom from unnecessary harm or potential harm associated with healthcare services and the reduction of risk of unnecessary harm to an acceptable minimum (World Health Organisation, 2009).
Patient Safety Incident	A Patient Safety Incident is an incident or circumstance (including omissions) which could have resulted or did result in harm to a patient or group of patients,

Term	Definition
	and which provides an opportunity for system learning. (Adapted from the WHO patient safety curriculum guide 2011.)
Patient safety risk profile	Assess all patient safety risks, identify what could cause harm, who it could harm and how, and what you will do to manage the risk deciding what the priorities are and identifying the biggest risks for the organisation. (Adapted from Managing from Health and Safety (HSG65) Health and Safety Executive 2013)
Person	This refers to individual people e.g. service users, patients, members of staff, carers, relevant person(s) and visitors.
Safety Culture	An integrated pattern of individual and organisational behaviour, based upon shared beliefs and values, which continuously seeks to minimise service user harm which may result from the processes of care delivery.
Service User	The term “service user” in relation to a health services provider means a person to whom a health service is, or has been, provided.
Staff	Defined as anyone charged with carrying out the work of the HSC or sometimes on behalf of the HSC (ie working for, employed by or contracted to the HSC). (PSIRF)
Staff Affected	Staff Affected are those staff who have been directly involved in or impacted by a Patient Safety Incident. HSC organisations should at an early stage consider and identify in a structured way who all Staff Affected include. (Framework for Learning and Improvement from Patient Safety Incidents)
Standard	This describes the high-level outcome required to achieve a quality, safe service.
Victim	For the purpose of Patient Safety Incidents, a victim must be a close

Term	Definition
	relative or someone acting lawfully on behalf of the “patient” and who witnessed the Patient Safety Incident or its immediate aftermath.

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