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Owner Stephen Jeffries:  
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## Patient Safety Incident Response Policy

### 1. Purpose

The Patient Safety Incident Response Framework (PSIRF) is a catalyst for change. This is a new approach to not only responding to patient safety incidents but encourages a change to language used in Trust documents to suit the needs of patients, families and carers.

This policy embraces that change in language and supports the requirements of the PSIRF. It sets out West Midlands Ambulance Services' 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 and data-driven 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 a patient safety incident.
- 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. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning

and improvement across West Midlands Ambulance Service University Foundation Trust (WMAS).

Responses under this policy follow a systems-based approach. Patient safety relies on all components of the system working together, i.e. the interactions between patients, colleagues, equipment, and the environment. These interactions, in our everyday roles, means that responses to patient safety incidents will focus on organisational learning rather than the individuals.

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 under PSIRF. There are other processes that exist within WMAS outside of the patient safety team where this could be managed such as:

- Claims handling
- Coronial Inquests
- Criminal Investigations
- Human resources/employee relations investigations into employment concerns
- Professional standards investigations
- Safeguarding concerns
- Complaints (except where a Patient Safety concern is highlighted)

The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy. For clarity, this means 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. Our Patient Safety Culture**

West Midlands Ambulance Service University Foundation Trust (WMAS) is committed to promoting a climate that fosters a just culture encouraging staff to feel safe and ensure their concerns are heard and responded to.

We take a positive approach and strive to be supportive of staff when incidents occur. A fair and just culture is a way of managing Patient Safety Incidents to not blame, criticise or discipline because of a genuine mistake, error of judgement or failure of systems that may lead to an incident.

Our leaders are encouraged to embrace this approach, pro-actively promote it amongst their staff and we welcome support from Staff Side colleagues which is imperative in supporting a just culture.

We encourage openness and constructive criticism within and between healthcare professionals. There should be ample opportunity for incidents to be discussed or debated so areas for learning can be identified and this learning shared organisationally.

To encourage a just culture the following principles should be adhered to:

- Fairness

- Respect
- Equality
- Dignity
- Autonomy

The PSIRF aligns with these principles by creating stronger links between patient safety incidents and learning for improvement. We embrace these principles and will work in collaboration with those affected by patient incidents including patients, their families, and our staff. This supportive approach will increase transparency and openness encouraging the reporting of incidents allowing for wider engagement and providing assurance to our staff that their concerns will be heard.

Our stance is clear, the purpose of patient safety incident responses is to identify learning and system wide improvements. They are not to apportion blame, liability or define preventability and cause of death.

Our safety culture continues to make positive progress and is a key Trust priority. We strive to improve this by:

- Focused improvement on Incident Management reporting and engagement
- Introduction of Patient Safety surveys across the organisation in conjunction with West Midlands Ambulance Service Research Department
- Patient Safety Training
- Focused improvement work on the visibility of the Patient Safety Department and engagement with staff, reinforcing the principles of PSIRF and those who deliver it.
- Focused improvement work on Duty of Candour and engagement with patients and their families
- Focused work on speaking up and Freedom To Speak Up

## 4. Patient Safety Partners

The Patient Safety Partner (PSP) role is a new and evolving role developed by NHS England to help improve patient safety across the NHS.

We will welcome PSPs who will offer support alongside our staff, patients, families and carers to influence and improve safety across the Trust.

PSPs can be patients, families, carers or other lay people (including NHS staff from another organisation) and offers great opportunities to share experiences and skills and provide a level of scrutiny. This exciting new role will evolve over time with the main purpose of the role being to be the voice for our patients and our community – whilst ensuring patient safety is at the forefront of all that we do.

PSPs will provide objective feedback focusing on maintaining safety and improvement. This may include

attendance at our governance meetings and involvement with producing and reviewing patient safety policies and procedures. This information may be complex, and PSPs will provide feedback to ensure patient safety remains our priority. PSPs will be provided with a full induction and training for the role including:

- Safeguarding Children Level 1
- Safeguarding Adults Level 1
- Equality and Diversity
- Information Governance
- Patient Safety Syllabus Training

Mentorship and welfare support will be provided by the Patient Safety Specialists and Head of Patient Safety,

## 5. Addressing health inequalities

The NHS has a duty to reduce inequalities in health by improving access to services and tailoring those around the needs of the local population in an inclusive way.

We recognise the diversity of the population we serve and that some communities suffer from health inequalities, which can have an adverse impact on their quality of life and health. As a service provider, we are committed to providing a high quality of care, where the patient is at the core of everything we do. We will provide a service that is accessible to all, which does not discriminate based on Protected Characteristics.

We are committed to delivering on its statutory obligations under The Equality Act, (2010) and will use data intelligently to assess any disproportionate patient safety risk to patients from across the range of protected characteristics. This data can be captured via our patient records (EPR and PRF), our incident reporting system and through the existing work under Learning from Deaths.

Within our patient safety response toolkit, we will directly address if there are any features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group which includes all protected characteristics. When implementing our safety actions in response to any incident, we will consider the potential impact these may have on health inequalities.

We understand that our services provide care to significant numbers of the Core20PLUS5 population cohort identified by NHS England and Improvement (2021) [NHS England » Core20PLUS5 \(adults\) – an approach to reducing healthcare inequalities](#). Using our population data and our patient safety data, we will identify variations that signify potential inequalities and consider this as part of the development process of our patient safety incident response plan and policy.

Engagement of patient, families and staff following a patient safety incident is critical to the review of patient safety incidents and their response. We will ensure that we use available tools such as translation and interpretation to make reports and interactions accessible for all, meeting the needs of those concerned and maximise their potential to be involved and included in our patient safety incident

response.

## 6. 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.

We are committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected to prevent recurrence. We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improvement to the services we provide. Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.

Alongside meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families and carers because this is the right thing to do, regardless of the level of harm caused by an incident.

As part of our new policy framework, we will be outlining procedures that support patients, families, and carers – based on our existing Duty of Candour Policy. This will be underpinned by our Patient Safety Learning Response Leads and our Family Liaison Officers who are able to guide patients, families, and carers through any learning response.

In addition, at West Midlands Ambulance Service we have a Patient Advice and Liaison Service (PALS) ([pals@wmas.nhs.uk](mailto:pals@wmas.nhs.uk)). PALS is a free and confidential service and the team act independently of clinical teams when managing patient and family concerns. People with a concern or complaint are encouraged to contact PALS as this allows us to review the concern, identify areas of learning and implement improvements where necessary.

We welcome compliments from our patients, families and carers which are used to highlight learning from excellence.

Our PALS team can help and support with:

- Raising a concern or complaint
- Saying thank you
- Advice and information

Our PALS Team can be contacted by following this [link](#).

We recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with patients, families, and carers to signpost to their preferred source for this.

- [National Guidance for NHS Trusts engaging with bereaved families.](#)
- [Learning From Deaths - Information For Families](#)
- [Help Is At Hand - for those bereaved by suicide](#)
- [Mental Health Homicide Support](#)
- [Your local Healthwatch](#)
- [Parliamentary and Health Service Ombudsman](#)
- [Citizen's Advice](#)
- [Child Death Support](#)
- [Complaint's Advocacy](#)
- [Healthwatch](#)

We also acknowledge that involvement in Patient Safety Incidents can be upsetting for our staff. We have invested in the wellbeing of our staff and would encourage staff affected by Patient Safety Incidents to visit the Trust's [Wellbeing website](#) where a vast array of resources are available. Staff can also seek support from the Staff Advice & Liaison Service, Trade Union representatives, as well as their local management teams.

## 7. 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.

West Midlands Ambulance Service will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. To achieve this, we will analyse our patient safety themes and trends and our quality improvement workstreams to gain insight into our position and culture.

Our Patient Safety Incident Response Plan (PSIRP) will detail how this has been achieved, as well as how the Trust will meet both national and local focus for patient safety incident responses and any specific contractually required variations to these.

### 7.1. Resources and training to support patient safety incident response

We have committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore

used the NHS England Patient Safety Response Standards (2022) to frame the resources and training required to allow for this to happen.

Responsibility for patient safety learning responses, as described within the PSIRP, sits with the Patient Safety Team.

Those staff affected by patient safety incidents will be allocated an appropriate welfare officer by their local management team who will provide the necessary support throughout the learning response. Staff involved in patient safety incidents will be given time to participate in learning responses which can include their welfare officer should the staff wish. All Trust leaders will work within our just and restorative culture principles and utilise other teams such as Health and Wellbeing and SALS to ensure there is a dedicated staff resource to support such engagement, involvement and psychological safety.

We will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

## 7.2. Training

### 7.2.1. Trust-wide training

The Trust has made the NHS England Health Education Patient Safety Training Syllabus Mandatory for all staff and will also form part on the induction process for new starters.

- Level one – Essentials of patient safety for all staff.
- Level one – Essentials of patient safety for boards and senior leadership teams.
- Level two – Access to Practice for all clinical staff.

This comprises a local incident elearning module setting out the Trust's expectations of staff for reporting and responding to incidents, including an outline of staff responsibility for Duty of Candour. This has been aligned to the National Patient Safety Syllabus.

All staff, clinical and non-clinical are expected to undertake level one training and all clinical staff are expected to undertake level one and two training.

These modules are available as elearning via ESR/The Learning Portal access or [www.e-lfh.org.uk](http://www.e-lfh.org.uk).

### 7.2.2. Learning Response Lead training

Our learning responses will be led by those who have completed:

- The nationally mandated PSIRF training.
- A minimum of six hours training in engagement and involvement with those affected by a patient safety incident.
- Level one and two of the NHS England Patient Safety Syllabus.

Learning response leads will also undertake appropriate continuous professional development on incident response skills and knowledge ensuring those with responsibility for learning responses have the appropriate attributes to support those involved.

Records of training will be recorded on the individuals training record, which is held on Filestore and OLM.

Those who lead on learning responses will:

- Apply human factors and systems thinking principles when gathering qualitative and quantitative information from a wide range of sources.
- Summarise and present complex information in a clear and logical manner and in report form.
- Manage conflicting information from different internal and external sources.
- Communicate highly complex matters and in difficult situations.
- Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
- Listen and hear the distress of others in a measured and supportive way.
- Maintain clear records of information gathered and contact those affected.
- Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation.
- Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

### **7.2.3. Oversight roles training**

All patient safety response oversight will be led/conducted by those who have completed the nationally mandated PSIRF training.

Those with an oversight role on our Trust board and leadership team must have completed the appropriate modules from the National Patient Safety Syllabus level one and level one plus.

All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

Those who are in oversight roles will:

- Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
- Apply human factors and systems thinking principles.
- Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
- Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.



- Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
- Summarise and present complex information in a clear and logical manner and in report form.

## 7.3. Our Patient Safety Incident Response Plan

Our plan 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 and will have flexibility to adapt to emerging trend and themes and risks identified by West Midlands Ambulance Service. 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.

A copy of our plan will be published on the Trust's website and our internal platform PolicyStat.

## 7.4. Reviewing our patient safety incident response 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 months to ensure our focus remains up to date; 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 months.

Updated plans will be published on the Trust's website and our internal platform PolicyStat, replacing the previous version.

A rigorous planning exercise will be undertaken every three 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.

# 8. Responding to patient safety incidents

## 8.1. Patient safety incident reporting arrangements

All our staff are responsible for recording and reporting potential or actual patient safety incidents on the Trust's incident reporting system. The reporter will record the level of harm they believe to have been experienced by those affected

The Patient Safety Team will then review and report patient safety incidents on behalf of the Trust.

The Patient Safety Team will ensure all patient safety incidents reported via the incident management

systems are responded to proportionately and in a timely manner. This includes being open and Duty of Candour where appropriate.

Patient safety incidents are reported nationally via Learning From Patient Safety Events (LFPSE) and the Strategic Executive Information System (StEIS). There will be occasions where events require the efforts of cross-system working with relevant partners, and the ICB will support a collaborative approach with these arrangements if required.

## **8.2. Patient safety incident response decision-making**

Under PSIRF the Trust has a plan in place to meet the requirements to review patient safety incidents. Some of these will require a mandatory response, others will require review or referral to another body and/or team. The approach taken will be detailed in the Patient Safety Incident Response Plan (PSIRP).

During the work to create the PSIRP, we considered our insight and engagement with key stakeholders to identify our patient safety profile. We have used and will continue to build on this intelligence to understand our local priorities and our toolkit for responding to patient safety events.

PSIRF sets no national thresholds to determine what method of response should be utilised for learning and improvement and therefore we have developed a range of response mechanisms to balance the efforts between learning and exploring emerging issues alongside ongoing improvement work. The PSIRP will establish a process for our response to events that allows for a clear set of mechanisms enabling oversight of our learning responses.

## **8.3. Responding to cross-system incidents/issues**

The Patient Safety Team will assist in the coordination of these events identified to other providers directly, via each organisation's reporting processes. Where required summary reporting can be utilised to share insights with other providers about their patient safety profile.

We will work with partner providers and relevant ICBs to establish and maintain robust procedures to facilitate flow of information and minimise delays to joint working on cross-system events.

The Patient Safety Team will co-ordinate this workstream to ensure this is effectively managed. The Trust will refer to ICBs to assist with the co-ordination where a cross-system event is felt to be too complex to be managed by a single provider, we anticipate the ICB will provide support and advice with identifying a suitable reviewer, should this circumstance arise.

## **8.4. Timeframes for learning responses**

Timescales will be set where possible for all response methods. A response will start as soon as possible after an incident is identified and those outside of a Patient Safety Incident Investigation (PSII) should be completed within three months.

The timescale for completing a PSII will be agreed with those affected by the incident, as part of setting the terms of reference, provided they are willing and able to be involved in that decision. PSII's should take no longer than a maximum of six months to complete.

In exceptional circumstances, a longer timeframe may be needed to respond to an incident. In this case, any extension to timescales will be agreed with those affected (including the patient, family, carer and staff).

## 9. Safety action development and monitoring improvement

We acknowledge any form of patient safety learning response will allow the circumstances of event or set of events to be understood, but this may only be the beginning. To reliably reduce risk, system safety actions are fundamental.

The Patient Safety Panel will meet bi-monthly to implement and monitor safety actions to reduce risk and limit the potential for future harm. This will follow on from the initial findings of any form of learning response which might result in identification of aspects of our working systems where there may be areas of improvement. We will generate safety actions in relation to each of these defined areas of improvement. The Trust will monitor any safety action and set out review steps by monitoring themes and trends within the incident reporting system, and other existing areas of governance such as Learning From Deaths.

### 9.1. Development of safety actions

West Midlands Ambulance Service will utilise processes for development of safety actions as outlined by NHS England Safety Action Development Guide (2022) as follows:

- Agree areas for improvement: specify where improvement is needed, without defining solutions.
- Define context: this will allow agreement on the approach taken to safety action development.
- Define safety actions to address areas of improvement: focussed on the system and in collaboration with teams involved.
- Prioritise safety actions to decide on testing for implementation.
- Define safety measures to demonstrate whether the safety action is influencing what is intended, as well as setting out responsibility for any resultant metrics.
- Safety actions will be clearly written, follow SMART principles and have a designated owner.

### 9.2. Safety action monitoring

Safety actions will be monitored within The Patient Safety Team and through the Learning Review Group to ensure any actions put in place remain impactful and sustainable.

# 10. Oversight roles and responsibilities

## 10.1. Principles of oversight

Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.

West Midlands Ambulance Service follows the “mindset” principles to underpin the processes we have in place to allow us to implement PSIRF as set out in the framework and supporting guidance (NHS England, 2022):

- **Improvement is the focus.**  
PSIRF oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality.
- **Blame restricts insight.**  
Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.
- **Learning from patient safety incidents is a proactive step towards improvement.**  
Responding to a patient safety incident for learning is an active strategy towards continuous improvement, not a reflection of an organisation having done something wrong.
- **Collaboration is key.**  
A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation – it must be done collaboratively.
- **Psychological safety allows learning to occur.**  
Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.
- **Curiosity is powerful.**  
Leaders have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge.

## 10.2. Responsibilities

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission, we have specific organisational responsibilities with the Framework.

To meet these responsibilities, we have designated the Patient Safety and Paramedic Practice Director to support PSIRF as the executive lead.

1. **Ensuring that PSIRF is central to overarching safety governance arrangements meeting the National Patient Safety Standards.**

The Patient Safety and Paramedic Practice Director will oversee the development, review and

approval of the Trust's policy and plan, ensuring that they meet the expectations set out in the Patient Safety Incident Response Standards. The policy and plan will promote the restorative, just working culture that the Trust aspires to achieve.

To achieve the development of the plan and policy, the Trust will be supported by internal resources within the Patient Safety Team led by the Head of Patient Safety and the Patient Safety Specialists who report to the Patient Safety and Paramedic Practice Director.

To define its patient safety and safety improvement profile, the Trust will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders.

## **2. Ensuring that PSIRF is central to overarching safety governance arrangements.**

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Learning Review Group (LRG) and Quality Governance Committee (QGC). LRG and QGC safety reporting will comprise oversight question responses to ensure that the Trust Board has a formative and continuous understanding of organisational safety.

The PSIRF Working Group will provide assurance to the LRG and QGC that PSIRF and related workstreams have been implemented to the highest standards. The Patient Safety Team will be expected to report on their patient safety incident learning responses and outcomes. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.

The Patient Safety Team will have arrangements in place to manage the local response to patient safety incidents and ensure that learning actions are completed.

The Trust will source necessary training such as the NHS England Workforce, Training and Education (NHSE, WTE) Patient Safety Syllabus and other patient safety training across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years to comply with Trust guidance on policy development alongside a review of all safety actions.

## **3. Quality assuring learning response outputs**

The Patient Safety Panel will ensure that Learning Responses are conducted to the highest standards and to support the executive sign off process of PSIs, ensuring that learning is shared, and safety improvement work is adequately directed.

# 11. Complaints and appeals

West Midlands Ambulance Service recognises that there may be occasions when patients, their families or carers or Trust employees are dissatisfied with aspects of response to a patient safety incident. The process for this will be confirmed in the information that is provided to all persons involved in the patient safety incident.

It is important to address any issue raised at the earliest opportunity and may reduce the risk of escalation and increases the possibility of finding a satisfactory resolution to the problem. It may be more appropriate to deal with and resolve in a more immediate and timely manner if this is with the agreement of the person raising the concern.

Where a Trust employee has a complaint or concern about the learning response, then this should be raised, in the first instance, with the Patient Safety Specialist. This can be either in person or through another Trust employee acting on their behalf e.g. welfare officer or line manager. If the concern can not be resolved by the Patient Safety Specialist, this will be escalated to the Head of Patient Safety, and if still not resolved the final stage will be Paramedic Practice and Patient Safety Director.

Where a patient, their family or carers have a complainant or concern, whilst a learning response is being conducted, the first point of contact should be the assigned Patient Safety Learning Lead. Should the concern not be resolved, contact should be made with the Patient Safety Specialists who will attempt to resolve the complaint. Where the resolution has not been acceptable, contact should be made with the [Patient Advice and Liaison Service \(PALS\)](#) who will support the resolution of any concerns raised.

Complaints are defined as expressions of dissatisfaction from a patient, service user, their family or carer, a person acting as their representative, or any person who is affected or likely to be affected by the action, omission or decision of the Trust and requires review by the Patient Experience Team (PALS).

The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve service outcomes and recommendations from a complaint will be shared organisationally to ensure that changes can be considered and implemented where appropriate.

# 12. Equality and Diversity Statement

## 1. Equality, Diversity & Inclusion statement:

This policy has been reviewed in line with the Equality Act 2010 which places a duty on the Trust to have due regard to the need to:

1. Eliminate discrimination, harassment, and victimisation.
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

## 13. Implementation Plan

1. All staff will be made aware of its existence via the Trust Weekly Briefing once approved.

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### Attachments

[WMAS PSIRF Plan.pdf](#)

### Approval Signatures

Step Description	Approver	Date
Professional Standards Group	Nicky Shaw: PA to Director of Nursing & Medical Director	02/2024
Regional Partnership Forum	Dawn John: PA to Director of Workforce & Organisational Devel	02/2024
Policy Group	Carrie Summers	01/2024
PSIRF Working Group	Stephen Jeffries: Patient Safety Specialist	01/2024
	Stephen Jeffries: Patient Safety Specialist	01/2024