Bradford Teaching Hospitals
NHS Foundation Trust

Patient Safety Incident Response Policy

Document Control

Policy reference	To be assigned by library
Version:	1
Status	Final (02/11/2023 - seeking approval or ratification) Consulted - 01/11/2023
Supersedes:	Incident Reporting and Investigation Policy (Including Serious Incidents and Never Events) version 2.
Category (Defines where the policy is grouped on the Intranet)	Governance (Quality, Corporate Governance, Communications and Corporate Affairs)
Strategic objective	To provide outstanding care for patients To be a continually learning organisation To collaborate effectively with local and regional partners

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Approval Committee/Meeting	Board of Directors
Date Approved:	
Date issued:	Date the document uploaded to the Intranet.
Review date:	December 2026

Target audience	All staff employed by Bradford Teaching Hospitals NHS Foundation Trust (the Foundation Trust)
Summary	This policy supports the requirements of the national Patient Safety Incident Response Framework (PSIRF)[1]. It sets out the approach of the Foundation Trust in developing and maintaining effective systems and processes for responding to patient safety incidents, for the purposes of learning and improvement, as set out in the Foundation Trust's Patient Safety Incident Response Plan (PSIRP).
Changes since last revision	Nil. This is a new policy.
Monitoring arrangements	The implementation and effectiveness of this policy will be monitored by: • Weekly review at the Quality of Care Panel (QuOC) • Monthly Clinical Service Unit (CSU) Quality and Safety Meetings • Monthly reports to the Patient Safety Group (PSG) • Quarterly and annual reports to the Quality and Patient Safety Academy

[1] Patient Safety Incident Response Framework (PSIRF). NHS England, August 2022.

	The Foundation Trust will also seek independent assurance that there is an effective system of internal control in place through its established Internal Audit assurance mechanisms.
Training requirements	Mandatory for all staff: Human factors Training (via ESR) Patient Safety Syllabus level 1 (via ESR) All other training is being delivered to staff in line with the NHS England Patient Safety Incident Response Standards[2] and includes training with the Board of Directors by an approved provider.
Equality Impact Assessment	This Policy was assessed on 03 August 2023 and is subject to an in-depth Equality Impact Assessment to confirm any disproportionate impact on protected groups affecting our services users, employees, or the wider community.

[2] NHS England Patient Safety Incident Response Standards

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1. Introduction

Bradford Teaching Hospitals NHS Foundation Trust (BTHFT, the Foundation Trust) is committed through its Health and Safety and Risk Management Policies, to the maintenance of safe working practices and a provision of an environment, which is safe for staff, patients, and others; in accordance with Health and Safety, Fire Safety, Security and Environmental Legislation and the requirements of the Patient Safety Incident Response Framework (August 2022). This will enable BTHFT to be a learning organisation with the aim to continuously improve patient safety and the quality of care we provide to our patients.

This policy applies to all staff employed by the Foundation Trust. It relates to the requirement of all personnel employed in all areas of the Foundation Trust to report and respond to all safety incidents, including near misses, regardless of whether they involve patients, visitors, staff, volunteers, or contractors and is to be used in conjunction with other relevant local policies and guidelines as indicated by the nature of the incident reported.

The reporting of safety incidents and near misses is an integral part of our Risk Management Strategy[3] which enables the identification of new and emerging risks, risk mitigation and elimination where possible, or reducing to an acceptable level to ensure quality and safety is maintained and improved across the Foundation Trust.

Capturing learning responses to safety incidents, events and near misses will allow the Foundation Trust to develop and maintain effective systems and processes within a wider system of continual safety and quality improvement.

The Foundation Trust's patient safety incident response plan (PSIRP) sets out how this policy will be implemented and both documents should be read together.

2. Purpose and scope of the policy

2.1 Purpose

This policy supports the requirements of the national Patient Safety Incident Response Framework (PSIRF) and sets out the Foundation Trust's 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 responses within a wider system of learning and

[3] Risk Management Strategy

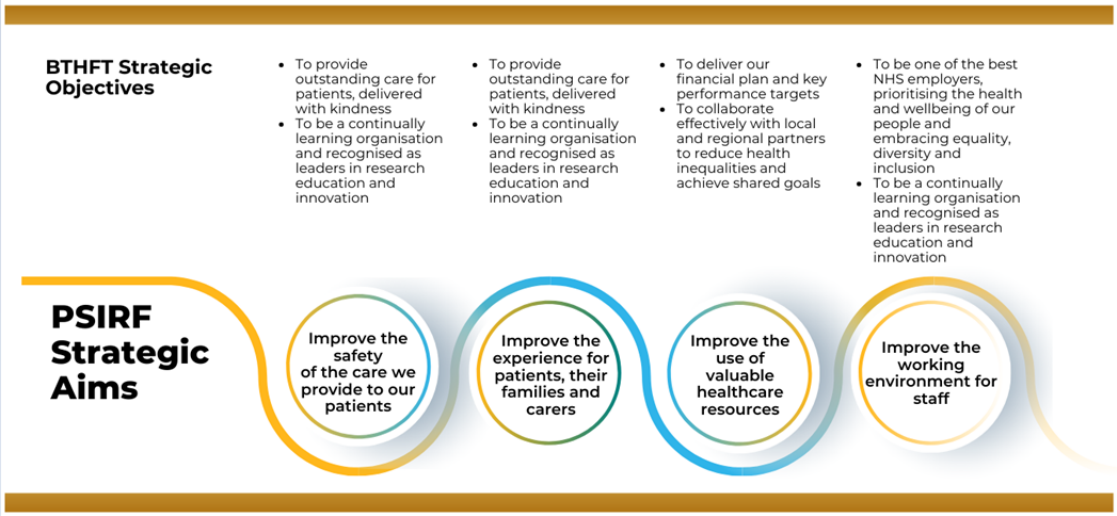
improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports the development and maintenance of an effective patient safety incident response system at the Foundation Trust which 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.

Figure 1 illustrates that the aims of the PSIRF to improve the safety and experience of care for patients, carers, families, and staff align with the Foundation Trust's overarching corporate strategic objectives.

Figure 1



2.2 Scope

This policy refers solely to the management of patient safety incidents with responses conducted purely for the purpose of learning and improvement across the Foundation Trust. However, it is expected that the principles laid out in this policy will be applied to all types of incidents reported and the responses to them covered in the relevant Foundation Trust policies.

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

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

- Claims handling.
- Human resources investigations into employment concerns (such as performance and capability, staff suspension).
- Professional standards investigations as performed by professional bodies such as the Nursing and Midwifery Council (NMC), General Medical Council (GMC) or Health Professions Council (HCP).
- Coronial inquests and criminal investigations.
- Information governance concerns and incidents.
- Complaints (except where a significant patient safety concern is highlighted).
- Other investigations by regulatory bodies such as the Health and Safety Executive (HSE).

The principle aims of these processes and responses differ from those of a patient safety response and are outside of the scope of this policy. Information from a patient safety learning response can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident learning response.

3. Aims and objectives

The aims of this policy are:

- To ensure that the national Patient Safety Incident Response Framework is implemented effectively within the Foundation Trust.
- To ensure staff are aware of their roles and responsibilities.
- To encourage the reporting of patient safety incidents to ensure the Foundation Trust has full oversight and our reporting to the Learning from patient safety events service (LFPSE), formally the National Reporting and Learning System (NRLS) is accurate when data is extracted from the Foundation Trust's Integrated reporting, learning and improvement system (IRLIS).

In order to achieve these aims the following objectives will ensure:

- The Foundation Trust operates within an open and just culture and promotes the consistent management of patient safety incidents.

- Staff are able to speak up about and report patient safety incidents without fear of blame.

Effective governance processes are in place to:

  - Monitor and record decision making and agreed responses.
  - Ensure patient safety incidents are managed in a timely manner agreed with those involved.
  - Demonstrate clear accountability and responsibilities.
  - Ensure all staff are aware of the processes of escalation, reporting, review, and management of patient safety incidents via induction and ongoing training.
  - Ensure the requirements of the Being Open and Duty of Candour Policy are met.

- Clear lines of communication are in place for those involved with signposting to support available.
- Learning is identified from reported safety incidents, and appropriate action is taken to avoid recurrence. This may include making changes and improvements to practice, systems and process, and/or the environment to improve patient, staff and public safety.
- Debriefs are undertaken at an appropriate level and learning is shared.
- All relevant internal and external stakeholders, agencies and regulatory bodies are engaged, involved, and informed of safety incidents in line with national legislation and requirements (see Appendix 1 for related policies and procedures).

4. Definitions

Patient safety incident
Any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. This includes known complications which should also be reported to enable further review.

Patient Safety Response (PSR)
A response initiated following a near miss or actual patient safety incident. See Appendix 3 for the types of responses use at the Foundation Trust.

Patient Safety Incident Investigation (PSII)
A commissioned investigation undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation.

See Appendix 2 for further definitions and harm grading.

5. Roles and responsibilities

The leadership and management functions in relation to the PSIRF oversight are wider and

more multifaceted when compared to previous response approaches[4].

5.1 The Chief Executive is the accountable officer for the Foundation Trust and has overall responsibility for ensuring that the Foundation Trust has appropriate policies and robust monitoring arrangements in place.

5.2 The Board of Directors have a responsibility to ensure that it receives assurance that this policy is being implemented, that lessons are being identified, and areas of vulnerability are improving. This will be achieved through systematic and robust governance reporting processes, including receiving assurance via the Quality and patient Safety Academy.

The Board of Directors will follow the PSIRF Oversight 'Mindset' principles to underpin the oversight of patient safety incident responses.

- *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.

[4] Oversight roles and responsibilities specification, NHSE 2022

5.3 The Chief Medical Officer and Chief Nurse have joint Board delegated accountability for ensuring that the Foundation Trust has robust risk management and governance processes in place, including processes for recording and responding to patient safety incidents. They are the Executive leads for PSIRF.

5.4 The Chief Medical Officer has Board delegated accountability for mortality and is responsible for the processes to monitor, review and receive assurance on the effective implementation of national and local strategies targeted at reducing preventable mortality in accordance with patient choice, reducing adverse events, improving outcomes and quality of care for patients. The Chief Medical Officer is also responsible for taking appropriate action to ensure medical and professional standards are maintained.

5.5 The Chief Nurse has Board delegated accountability for patient safety, quality and patient experience across the Foundation Trust; including taking appropriate action to ensure clinical and professional nursing and allied health professional standards are maintained. This includes ensuring services respond to potential and actual risks that may impact adversely on the health and well-being of patients.

5.6 The Associate Director of Corporate Governance / Company Secretary and Associate Director for Quality have joint responsibility to ensure that there are effective risk and governance systems in place across the Foundation Trust and provide specialist risk management and governance advice across the organisation in relation to incidents and risk management. This will be for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical incidents.

5.7 Specialty leads and Clinical Service Unit (CSU) management triumvirates (Clinical Director, General Manager and Lead Nurse/Allied Health Professional (AHP) will encourage the reporting of all patient safety incidents and ensure all staff in their department/speciality/service unit are competent in using the reporting system and have time to record and share information. They will also ensure that incidents are reported and managed in line with internal and external requirements and ensure that they and their staff review the PSIRF and the Foundation Trust's Patient Incident Response Plan (PSIRP) to check that expectations are clearly understood. The are also responsible for making sure local management arrangements are suitable and effective, to allow for all aspects of this policy to be implemented.

The speciality leads and CSU management triumvirates will provide time for staff to attend training in patient safety disciplines to support skill development across the wider staff group. They will also facilitate time for staff to participate in patient safety reviews and investigations and ensure those affected by patient safety incidents are directed to, and have access to the support they need. Clinical leads and senior managers will aid with and support the development and delivery of actions in response to patient safety reviews/ Patient Safety Investigations that relate to their area of responsibility (including taking

corrective action to achieve the desired outcome).

5.8 The Quality Governance Team will develop and maintain the local risk management and clinical governance systems and report to the relevant external systems i.e. Learning from Patient Safety Events (LFPSE), Maternity and Newborn Safety Investigations Special Health Authority (MNSI), Health Services Safety Investigations Body (HSSIB), and CQC to support the recording and sharing of patient safety incidents and monitoring of incident response processes.

The team will provide advice and guidance to wider Trust's CSU's, services, departments and specialty teams on PSIRF principles and aims to ensure that reviews, updates and development of relevant policies, guidelines and procedures align with the fundamental elements of PSIRF. The team will lead on the development and review of the Foundation Trust's PSIRP and PSIRF policy.

The Quality Governance team will collaborate with the Quality Improvement team to establish processes to enable the triangulation of PSII's, thematic review findings and recommendations for improvement, and provide support with identified improvement projects and plans.

5.9 The Patient Safety Specialist under the leadership of the Associate Director for Quality has operational responsibility for the implementation and monitoring of the Foundation Trust's incident reporting and risk management systems and processes. They are the Information Asset Owner for the integrated reporting learning and improvement system and have overall responsibility for the system, managing the Quality Patient Safety Manager for Systems and Learning. As the Patient Safety Specialist, they will provide specialist advice and support to operational teams and to their senior management and are responsible for policy development, implementation, and monitoring.

5.10 The Senior Quality Governance Lead under the leadership of the Associate Director of Quality has the operational responsibility of ensuring that governance monitoring processes are in place to ensure safety actions are completed within expected timeframes and to a high-quality standard. They manage the Quality and Patient Safety Facilitators aligned to the CSU's and the Moving to Outstanding Lead to ensure that all regulatory aspects are complied with.

5.11 Clinicians/Specialist Advisors under the PSIRF will support patient safety investigations co-opting other specialist advisors to assist in reviews (e.g Safeguarding, Non- Clinical Risk / Health and Safety, Biomedical sciences, Pharmacy, Radiology and clinicians with experience in a particular medical or surgical speciality).

5.12 Patient Safety Incident Investigators will have attended the Foundation Trust's patient safety investigation training and investigators undertaking PSII's will have

completed the Foundation Trust's systems-based patient safety incident investigation training provided by our external provider or NHS England. This is to ensure that all PSII's and related PSII duties are undertaken in-line with the national PSII standards in relation to liaising with patients and families if an independent nominated member of staff has not been allocated to act as a family liaison officer.

5.13 Patient Safety Incident Reviewers (This includes Matrons/ Lead Allied Healthcare Professionals/ Ward and department managers). Incidents must be investigated and reported using the appropriate tools and techniques for the type of Patient Safety Review (PSR) required. The reviewer(s) should have completed the appropriate training for the review technique to be used. The review should be fair and thorough using the methods taught on the appropriate training course.

They are responsible for ensuring that staff within their area of responsibility are made aware of this policy and comply with it. They will lead and co-ordinate the duty of candour process in line with Policy RM75 Being Open and Duty of Candour and encourage staff to be open with patients and/or their carers. They will escalate any concerns and seek support as required to ensure that the process of disclosure is well managed.
Matrons will have a responsibility to:

- Support the MDT assessment of the incident to determine the level of immediate response.
- Support the MDT in deciding on the most appropriate members of staff from the clinical team to discuss the incident with the patient and/or their carers. This decision should consider seniority, relationship to the patient, and the experience and expertise in the type of patient safety incident that has occurred.
- Consider the appropriateness of engaging patient support at this early stage. This includes the use of a facilitator, a patient advocate or a healthcare professional that will be responsible for identifying the patient's needs and communicating them back to the healthcare team.
- Identify immediate support needs for the healthcare staff involved and offer access to the staff counselling service if appropriate.
- Ensure that the patient safety incident has been reported onto the Foundation Trust's Incident reporting, learning and improvement system (IRLIS).
- Share the outcome of the investigation with the patient, their family or carer if they are the nominated individual leading the disclosure with the patient/relevant person.

All Staff have a responsibility to highlight any risk issues and patient safety incidents which would warrant further investigation or may have the potential for learning and improvement. Staff should be fully open and co-operative with any patient safety review process. All staff are required to be aware of and comply with this policy and the associated Patient Safety Incident Response Plan.

Information regarding the reporting and management of incidents is provided for new staff at corporate induction. Information for existing staff is available on the Quality Governance pages of the Foundation Trusts intranet.

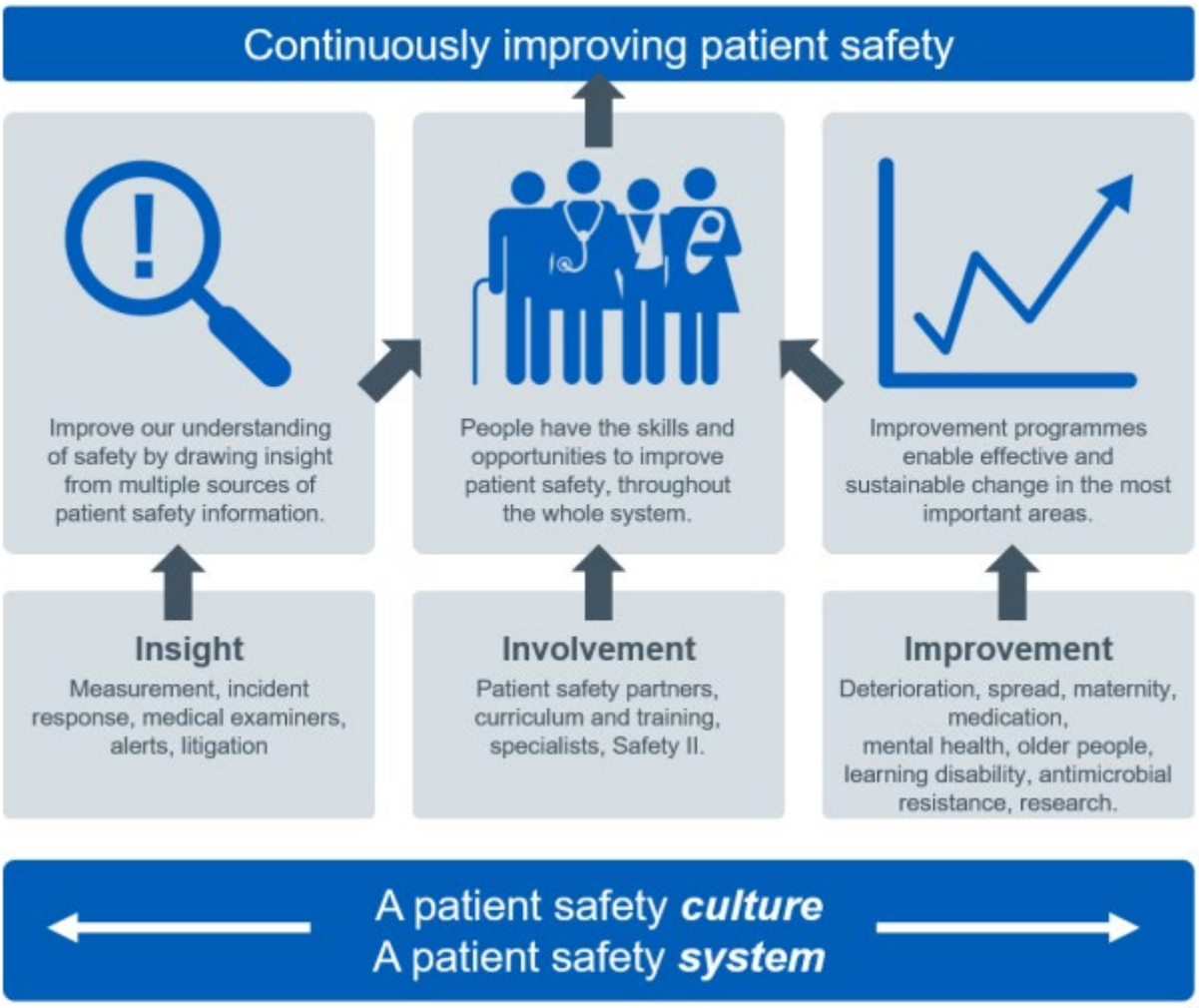
6. Our Patient Safety Culture

The NHS Patient Safety Strategy[5] acknowledges that too often people fear blame and close ranks which makes them lose sight of the need to improve when patient safety incidents occur. The strategy aims to build on the foundations of a patient safety culture and a patient safety system to ensure that the NHS can achieve its safety vision to continuously improve patient safety (See Figure 2).

To embed the national Patient Safety Strategy and the PSIRF we are working towards embedding the shift from focusing on the level of harm caused by a patient safety incident, to the potential for learning and improving the safety of our systems.

[5] https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

Figure 2 Summary of the Patient Safety Strategy[5]



The key features for healthcare organisations that want to be safe are, staff who feel psychologically safe; valuing and respecting diversity; a compelling vision; good leadership at all levels; a sense of teamwork; openness and support for learning. These features are underpinned by the essential elements of:

- A 'Just culture', where psychological safety means we will hear more, learn more, and can act more to improve care.
- Positivity, kindness, and civility, as when these are missing safety is compromised.

PSIRF recognises the need to establish psychologically safe cultures and practices before approaches such as Just Culture can work in practice. The implementation of PSIRF necessitates the development of a culture that fosters psychological safety throughout the organisation. PSIRF recognises the need to ensure we have support structures for staff and patients involved in the investigation and review of patient safety incidents. Part of which is the fostering of a psychologically safe culture shown in our leaders, and our reporting systems.

Central to this is supporting a culture in which people feel safe to talk. Having conversations with people relating to a patient safety incident can be difficult, and we will continue to explore how we can equip and support our colleagues to best hear the voice of those involved. In doing so, we will support our core ambition of working in partnership with our people to improve safety.

We recognise that it is vitally important to actively engage and involve patients and families[6] in our learning responses to seek their input and develop a shared understanding of what happened. Engaging well and meeting people's needs can alleviate the harm experienced and avoid compounding harm. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing the learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

The Foundation Trust is clear that patient safety incident investigations are conducted for the sole purpose of learning and identifying system improvements to reduce risk. The safety culture within the Foundation Trust has progressed in a positive way with reporting of patient safety incidents improving over time, and we want to make reporting as easy as possible for staff.

To support our safety culture, we have established safety huddles at all levels within the Foundation Trust which consider known, or emerging risks and the insight offered from incidents that have occurred with an opportunity to share learning. The Foundation Trust will utilise findings from the NHS staff and patient surveys from the specific safety questions to assess if we are sustaining our ongoing progress in improving our safety culture. We will also utilise the responses to the Patient Measure of Safety questionnaire to help us understand our patients perspective of safety as they experience it.

Based on the Mersey Care Model the Foundation Trust is developing an approach towards a restorative just and learning culture through developing curiosity in our work. We recognise the need for assurance not reassurance and facilitating a coaching culture will enable this. Engaging with our people and working collaboratively to involve staff, patients, families, friends, and carers in the Foundation Trust's response to patient safety incidents will enable their full participation and demonstrate our openness and transparency in order to learn and improve. This will lead to a restorative culture and be a catalyst for embracing diversity and collective wisdom.

A confidential service for staff is also available via the Freedom to Speak Up (FTSU) Guardian and FTSU champions if they have any concerns in relation to our response to incidents and events. For further information see the Foundation Trust's FTSU raising concerns (whistleblowing) Policy.

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

6.1 Patient Safety Partners

Working in partnership with patients is not a new concept, however the Patient Safety Partner (PSP) role is a new and evolving role and is a key priority of the NHS Patient Safety Strategy (2019). The Framework for involving patients in patient safety[7] (2021) describes the role of the Patient Safety Partner (PSP) and elaborates on their involvement in organisational safety.

The Foundation Trust aims to include at least one PSP as a member of the Quality and Patient Safety Academy, a sub-committee to the Board of Directors, as well as our Patient Safety Group, which is the operational group. The Foundation Trust also intends to prepare our PSPs by ensuring they have received the required training during 2023/24 in readiness for the national priority areas for PSP involvement across the next 2-3 years. PSPs will also be involved in developing and delivering PSIRF oversight processes and they will be invited to other patient groups such as, the local Healthwatch and Maternity Voice Partnerships to provide insight into the strength of our patient safety incident response systems.

Our PSP's will be supported in their role by the Quality Governance Team who will provide training and guidance.

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

We recognise and acknowledge the significant impact that patient safety incidents can have on patients, their families, carers, and staff, and we are fully committed to ensuring our responses have the right level of involvement to support us to improve the services we provide. As a Foundation Trust we have participated in the Learn Together[8] pilot, funded by the National Institute for Health and Care Research, supporting involvement after safety events in healthcare and we will continue to embed the principles involving those involved in our responses to patient safety incidents from the outset.

We are committed to being open, honest, and transparent with patients, their families, and carers whenever there is a concern about the care provided, regardless of the level of any harm caused, or where a patient safety incident has occurred as we know it is the right thing to do. Being open, honest, and transparent will also ensure that we meet our

[7] The Framework for involving patients in patient safety (2021)

[8] https://learn-together.org.uk/

professional and regulatory requirements under Duty of Candour. Our Being Open and Duty of Candour Policy[9] sets out the Trusts expectations and standards.

The Foundation Trust's Patient Experience team listen to any compliments, enquiries and concerns regarding our hospitals and services. They support patients, families, and carers to identify how best to address concerns and will make sure any enquiry goes to the correct person to address it. They also advise on how to make a formal complaint and who should be contacted if advice or support is needed to do this. As part of our work to involve patients, families, carers, and staff, we will engage with them to identify whether there are any other forms of support that can help at a time when they have been affected by a patient safety incident and signpost them to their preferred source. Within the Foundation Trust we have a Patient Advice and Liaison Service (PALS) which ensures that we listen to patients, their relatives, carers and friends, answer their questions and resolve their concerns as quickly as possible. PALS also helps us to improve services by listening to what matters to patients and their loved ones, and making changes, when appropriate.

8. Training and resources to support patient safety Incident responses

The Trust is committed to fully implementing PSIRF ensuring all requirements are met. We have used the patient safety incident response standards[10] which describe how patient safety incident responses should be resourced, including the training and competencies those undertaking these responses require. We have made human factors and patient safety syllabus level one training mandatory for all staff. Learning response leads required to conduct patient safety incident investigations (PSIIs) have undertaken training on the systems approach to learning from patient safety events and involving those affected by patient safety incidents in the learning process.

All other training is being delivered to staff in line with the NHS England Patient Safety Incident Response Standards and includes training with the Board of Directors. For those delivering learning responses there are two cohorts planned to receive training on conducting the required responses and a review of the training provision is ongoing. We will be developing an ongoing training plan to describe the training and competencies required for all staff within the Trust and those with oversight roles.

9. Addressing Health Inequalities

Health inequalities are unfair and avoidable differences in health across the population and between different groups in society. Factors driving inequalities are complex and interlink

[9] https://intranet.bradfordhospitals.nhs.uk/download/133/risk-management/21074/rm75-2021-d-2-being-open-and-duty-of-candour-policy.pdf

[10] Patient safety incident response standards (NHSE 2022)

through various systems such as education, housing, employment, cultural, communities and health.

The Foundation Trust has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. It has a legal obligation under the Equality Act 2010 to ensure that no one is disproportionately impacted on the grounds of their specific characteristics. We believe that, if we improve equality, value diversity, and create an inclusive organisation, this will ultimately lead to better patient care and patient experienced for everyone and this commitment to is captured within the Foundation Trust's Equality, Diversity and Inclusion strategy[11].

Deeper analysis of our patient safety incident data has already commenced to identify any disproportionate risk to patients. We will work on improving our approach to collecting patient data with particular focus on capturing protected characteristic data of the patients and wider communities we serve. We will use this information proactively to inform our patient safety incident response, address any themes or identified variation. This will be enabled by development of our Integrated reporting, learning and improvement system (IRLIS) at the Foundation Trust that will help us to further understand our patient safety incident data and triangulate it with other sources of intelligence. Any emerging risks or themes identified related to health inequalities will be fed into our quality governance processes to inform the ongoing review and maintenance of the Foundation Trust's patient safety incident response plan.

We will ensure that when we respond to patient safety incidents our tools will enable us to engage and involve patients, families and staff following a patient safety incident with consideration of their different needs. They will help us to identify and address any elements which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including those with protected characteristics. Post incident response we will ensure that we consider inequalities when developing our safety actions to ensure they prevent recurrence, facilitate the sharing of identified learning, and do not put anyone at a disadvantage.

The training that is available for staff involved in conducting patient safety incident investigations ensures that the Foundation Trust adopts and upholds a system-based approach (not a 'person focused' approach). This supports the development of a just culture and helps the Foundation Trust to reduce any locally identified ethnicity disparity in rates of disciplinary action across our workforce or any disproportionate risk to patients.

We will also use our local mortality Structured Judgement Reviews (SJR's) and LeDeR review processes (see Learning from Deaths policy) to identify and address any features of an incident that indicates health inequalities may have contributed to harm or demonstrates

[11] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2023/05/22100504-EDI-Strategy-2023-2025-IWEB.pdf

a risk to a particular population group, including all protected characteristics (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation).

10. The procedure / implementation

10.1 Patient safety incident response planning

The 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.

10.2 Our patient safety incident response plan

Our patient safety incident response plan sets out how the Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed, it serves as a roadmap, guiding our teams to respond effectively and efficiently to any unforeseen circumstances or adverse events that may arise.

To develop our plan, we used a systematic process to identify and agree the most important emerging patient safety issues for the Foundation Trust. This process involved, a review of all reported patient safety incidents from the Foundation Trust's incident reporting and patient safety management system from 1 January 2019 to 31 December 2022, triangulated with patient experience (Friends and Family Test (FFT), complaints, compliments, Patient Advisory Liaison Service), Claims and Litigation, and Learning from Deaths data.

This policy should be read alongside the Patient Safety Incident Response Plan (PSIRP).

10.3 Patient safety incident reporting arrangements

All incidents must be recorded on the Foundation Trust's Integrated reporting, learning and improvement system (IRLIS). This is accessible via the Bradford Teaching Hospitals Intranet and desk top application. All staff are responsible for reporting any potential or actual safety incident. When recording the incident on the system they will record the level of harm as they know has been experienced by the person affected at that time. If unsure they should refer to the definitions section of this policy. In the NHS, degree of harm recording relates to the actual impact of the incident at the time of recording. The harm grading can be reviewed and updated as more information becomes available, but should

not be used to speculate about, for example more severe 'potential harm' if that does not appear to have been caused.

The immediate safety or well-being of the patient(s), staff member(s) or visitor(s) affected or involved in an incident is paramount. Any remedial first aid or emergency treatment must be given and the relevant medical, surgical, nursing and Allied Health Professional staff contacted and made aware of the incident. Safety actions must be immediately instigated for any environmental issues that have contributed to or caused an incident where significant risk to harm to people remains, while appropriate risk assessments are undertaken to enable resolution activities to be identified and commenced safely (for example utilising appropriate equipment to support the movement of a patient following a fall). Any equipment involved in the incident and is suspected of contributing towards the incident occurring, must be made safe and retained for the purposes of any further investigation by the Medical Devices Safety Officer who will notify The Medicines and Healthcare Products Regulatory Agency (MHRA) if required. The member of staff in charge of an area or department is responsible for ensuring that appropriate action has been taken to ensure the immediate safety of staff, patients, visitors and contractors is secured. They are also responsible for ensuring the incident is escalated appropriately via their specialty / CSU escalation process.

10.3 The Process

The process for the management of patient safety incidents is summarised in a flowchart (See Figure 3).

10.4.1 All staff should report any potential or actual patient safety incident on to the Foundation Trust's Integrated reporting, learning and improvement system (IRLIS) as soon as possible.

10.4.2 A system generated email sent from IRLIS will notify the Quality Governance Team, Ward Manager/Matron, CSU Lead, and subject matter expert, for example, infection prevention and control lead, of the reported patient safety incident.

10.4.3 The reported patient safety incident should be discussed at the Clinical Service Unit (CSU) daily huddle to ensure that responses are proportionate and timely.

10.4.4 The initial level of harm identified by the reporter may change following review by the CSU and Specialty. Immediate actions should be reviewed to ensure the safety of patients, public and staff, as well as an indication of any measures needed to mitigate a problem until further review is possible. This may include, for example, withdrawing equipment or monitoring a procedure. Duty of Candour criteria should be considered and the requirements of the Being Open and Duty of Candour Policy should be met.

10.4.5 A local review and learning response should take place within the CSU with involvement of the Specialty Lead/Subject matter expert as indicated. Most patient safety incident learning responses will be conducted and closed at CSU level. All documentation and evidence should be uploaded to the IRLIS. See Appendix 3 for Patient Safety Response methods.

10.4.6 Further action and escalation to the Safety Event Group (SEG) maybe required (see table 1). The aligned Quality and Patient Safety Facilitator will support the CSU in this process and the SBAR should be fully completed in IRLIS as this is reviewed at SEG to inform decision making.

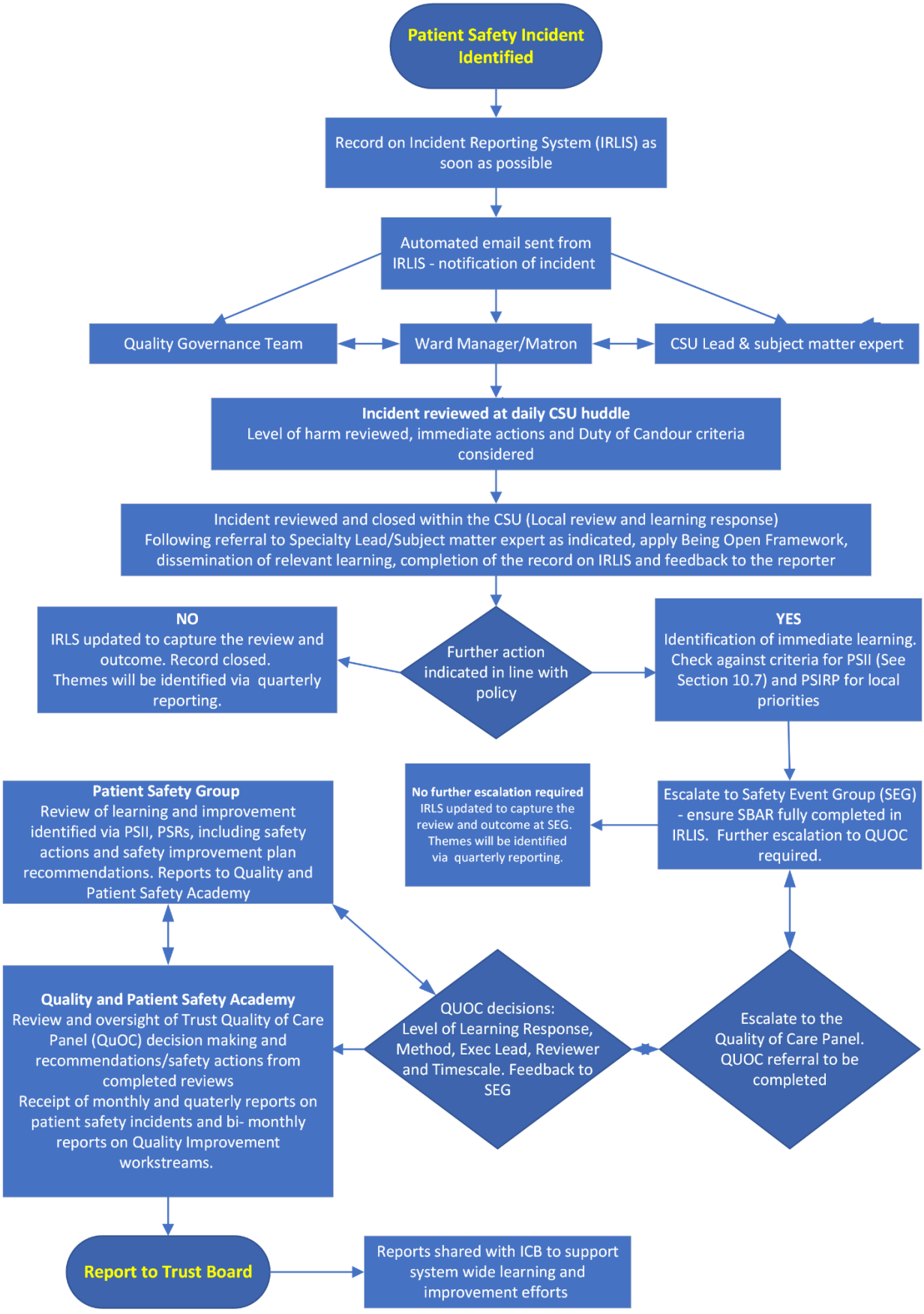
10.4.7 The Safety Event Group (SEG) will meet weekly to discuss any escalated patient safety incident. SEG may recommend that the patient safety incident does not need further escalation and can continue with a local response or that it requires escalation to the weekly Quality of Care Panel.

10.4.8 The IRLIS will be updated with the outcome of SEG. This will allow closure if no further action is required.

10.4.9 If SEG recommend escalation to QuOC panel, a QuOC referral will need to be completed by the CSU. The referral should include the findings of the local learning response to inform decision making and any external notifications required.

10.4.10 The QuOC panel will decide on the level of response required, the method, Exec Lead, Reviewer, and timescales. This information will be reported back to the SEG and CSU. Consideration will be made of whether it meets the national event response requirements (See Appendix 4).

Figure 3 - Process for the management and monitoring of Patient Safety Incidents


Patient Safety Incident Identified
Record on Incident Reporting System (IRLIS) as soon as possible
Automated email sent from IRLIS - notification of incident
Quality Governance Team
Ward Manager/Matron
CSU Lead & subject matter expert
Incident reviewed at daily CSU huddle
Level of harm reviewed, immediate actions and Duty of Candour criteria considered
Incident reviewed and closed within the CSU (Local review and learning response)
Following referral to Specialty Lead/Subject matter expert as indicated, apply Being Open Framework, dissemination of relevant learning, completion of the record on IRLIS and feedback to the reporter
NO
IRLS updated to capture the review and outcome. Record closed.
Themes will be identified via quarterly reporting.
Further action indicated in line with policy
YES
Identification of immediate learning. Check against criteria for PSII (See Section 10.7) and PSIRP for local priorities
No further escalation required
IRLS updated to capture the review and outcome at SEG. Themes will be identified via quarterly reporting.
Escalate to Safety Event Group (SEG) - ensure SBAR fully completed in IRLIS. Further escalation to QUOC required.
Patient Safety Group
Review of learning and improvement identified via PSII, PSRs, including safety actions and safety improvement plan recommendations. Reports to Quality and Patient Safety Academy
QUOC decisions: Level of Learning Response, Method, Exec Lead, Reviewer and Timescale. Feedback to SEG
Escalate to the Quality of Care Panel. QUOC referral to be completed
Quality and Patient Safety Academy
Review and oversight of Trust Quality of Care Panel (QuOC) decision making and recommendations/safety actions from completed reviews
Receipt of monthly and quaterly reports on patient safety incidents and bi- monthly reports on Quality Improvement workstreams.
Report to Trust Board
Reports shared with ICB to support system wide learning and improvement efforts

10.4.11 The QuOC Panel reports to the Patient Safety Group who will review the learning and improvement identified via learning responses conducted.

10.4.12 The PSG and QuOC Panel report to the Quality and Patient Safety Academy who have oversight of the decision making at QuOC and the learning and improvements actions identified through the learning responses conducted.

10.4.13 The Quality and Patient Safety Academy reports to the Trust Board of Directors who in turn share learning with the Integrated Care Board to support system wide learning and improvement efforts.

10.4.14 The Quality Governance team (patient safety incidents) and Non-Clinical Risk team will act as liaisons with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

10.5 Incidents that meet national or local priorities or unclear for PSR or PSII

All staff (directly or through their line manager must ensure notification of incidents that may require a higher level of response as soon as practicably possible after the event to their CSU triumvirate management team (out of hours to the on-call site manager) and the Quality Governance team. Where it is clear that a PSII is required (for example a Never Event) Duty of Candour discussions should take place according to trust policy. The Quality Governance team may also identify incidents that meet national or local priorities or unclear potential incidents that may require PSR or PSII. Significant events which require consideration for ad-hoc PSII due to an unexpected or emergent level of risk and/or potential for learning should be escalated through the weekly Safety Event Group.

Where it is clear that a PSII is required (for example, for a Never Event) the CSU should notify the aligned Quality and Patient Safety Facilitator (or Q&PSF team via quality.facilitator@bthft.nhs.uk) and the Quality Governance Team (quality.governance@bthft.nhs.uk) as soon as practicable so that the incident can be shared with Trust executives.

Some patient safety incidents will meet the criteria for nationally mandated responses as described by NHS England[12] and will require to be reported to external agencies (See Appendix 4).

Some incidents will require to be reported to the Health and Safety Executive (HSE) by the Trust under the Reporting of Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). The HSE will normally investigate all fatal accidents/incidents reported under RIDDOR, but not patient incidents that arise from medical treatment or diagnosis. The Non-

[12] Guide to responding proportionately to patient safety incidents, NHSE (2022)

Clinical Risk team and the Quality Governance Team will give advice and guidance on which incidents meet RIDDOR reporting criteria.

An incident may need to be reported to the police if there is a suspicion that a crime has been committed such as knife crime, theft, or suspicion that harm or death to patients has been caused with deliberate intent or where there is a legal duty to disclose, further guidance can be found at : http://transform.england.nhs.uk/information-governance/guidance/sharing-information-with-the-police/

Some maternity incidents may also require reporting to MBRACE-UK or the Maternity and Newborn Safety Investigations Special Health Authority (MNSI) or the Health Services Safety Investigations Body (HSSIB).

10.6 Responding to Cross System Incidents

The Quality Governance team will forward incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

The Trust will work with partner providers and relevant Place/ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Quality Governance team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

The Trust will defer to the Place/ICB for co-ordination where a cross system incident is felt to be too complex to be managed as a single provider. The Trust anticipates that the ICB will provide support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

10.7 Timeframes for Learning Responses

A learning response (PSR or PSII) must be started as soon as possible after the patient safety incident has been identified. PSR's should primarily be completed within one to 3 months of their start date and PSII's due to their depth of review will take on average 3 months to complete. No learning response should take no longer than six months to complete.

Timescales for response should be agreed with patients and family and regular updates provided in order to ensure transparency and inclusion. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

In exceptional circumstances (e.g. when a partner organisation requests an investigation is

paused, or the processes of an external body delays access to information) the Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigation once this is received. This would require a decision by the Chief Medical Officer or Chief Nurse. In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In these cases, any extended timeframe should be agreed between the Trust and those affected. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our Patient Safety Incident Response Plan (PSIRP).

The PSIRF does not set out further guidance or thresholds to determine what method of response should be used to support learning and improvement. The Trust has used the PSIRF guidance documents to develop its own response mechanisms using what we already know from our incident data. The 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 contributary 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)[13]. A decision to conduct a patient safety incident review or investigation should be based on the following:

Criteria	Considerations
Potential for harm	• People: physical, psychological, loss of trust (patients, family, caregivers) • Service delivery: impact on quality and delivery of healthcare services; impact on capacity • Public confidence: including political attention and media coverage
Likelihood of occurrence	• Persistence of risk • Frequency • Potential to escalate
Potential for learning and improvement	• Increased knowledge: potential to generate new information, novel insights, or bridge a gap in current understanding • Likelihood of influencing: healthcare system, professional practice, safety culture • Feasibility: practicality of conducting an appropriate rigorous PSII • Value: extent of overlap with other improvement work, adequacy of past actions • New emergent area of risk
Systematic risk	• Complexity of interactions between different parts of the healthcare system

Table 1 Criteria and Considerations for patient safety incident reviews or investigations

[13] Guide to responding proportionately to patient safety incidents, page 15

10.8 Oversight

The Trust's Safety Event Group (SEG) will review patient safety incidents added to the agenda for discussion with reference to the national and local priorities, learning and improvement potential and emerging risk. SEG will escalate to the executive led Quality of Care panel (QuOC) any patient safety incident which requires a formal patient safety response to be commissioned. The group will also confirm any statutory Duty of Candour or external reporting requirements. Clinical Service Units (CSUs) will be expected to report on their patient safety incident learning responses and outcomes at the Safety Event Group (SEG).

The Trust's Quality of Care Panel (QuOC) will have delegated responsibility for commissioning investigations that meet the national or local criteria for PSII. QuOC is also responsible for oversight and review of the learning and outcomes of investigations. QuOC will ensure that investigations are conducted using a systems-based approach from which the recommendations are founded with valid safety actions that will contribute to existing safety improvement plans, or where necessary ensure that such plans are established when they are required. The panel will also have oversight of the Duty of Candour, external reporting requirements and timescales of investigations agreed with those involved.

The Trust's Patient Safety Group (PSG) a sub-group of the Quality and Patient Safety Academy will have overall oversight of the learning and improvement from patient safety responses and PSIIs to ensure the Foundation Trust continually learns and improves following patient safety incidents. The Patient Safety Group will provide assurance to the Quality and Patient Safety Academy that PSIRF and related workstreams are being implemented to the highest standards. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.

The Trust's Quality and Patient Safety Academy (QPSA) a sub-committee to the Board will have overall oversight of the above processes and is able to constructively challenge the decision making of QuOC. This will ensure that the Board of Directors can be assured that the true intent of PSIRF is being implemented within our organisation, and we are meeting the national patient safety incident response standards.

10.9 Safety action development and monitoring improvement

The Trust acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed. NHS England's Safety Action Development Guide[14] promotes a move from the term

[14] Safety Action Development Guide (NHSE 2022)

'recommendations' to 'areas for improvement' to reduce the likelihood of 'solutionising' (jumping to a solution) at an early stage of the safety action development process.

The Trust has systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – 'areas for improvement'. The Trust will generate safety actions in relation to each of these defined areas for improvement. To achieve successful improvement, safety actions will be identified and completed in a collaborative way in conjunction with the CSU representatives and if necessary with the support of the Quality Improvement team utilising their improvement expertise. The Trust will use the process for development of safety actions as outlined by NHS England[7] (See Figure 4).

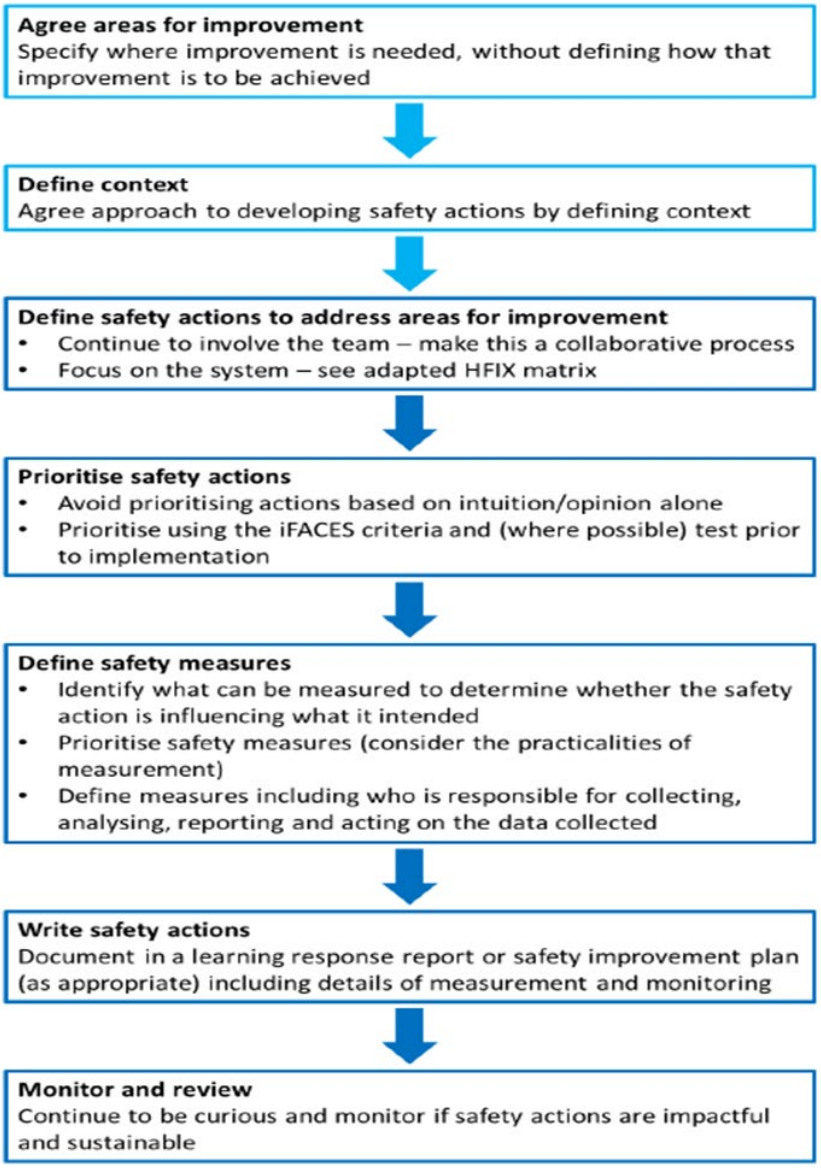


Figure 4 Process for development of safety actions

10.10 Safety Action Monitoring

Safety actions will be recorded in the incident record on the Integrated reporting, learning and improvement system (IRLIS) to enable monitoring of progress made in completing the actions within the specified timeframes.

Safety actions will be monitored within the CSU governance arrangements to ensure that any actions put in place remain impactful and sustainable. CSU reporting on the progress of safety actions including the outcomes of any measurements will be submitted to the Safety Event Group (SEG).

For some safety actions with wider significance, this may require oversight by the Patient Safety Group (PSG). When a PSII or PSR has been commissioned by the QuOC panel they will monitor the safety actions.

10.11 Safety improvement plans

Safety improvement plans bring together findings from the various responses to patient safety incidents and issues. The Trust has several overarching safety improvement programmes and plans in place which are adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes or CQUINs.

The Trust's patient safety incident response plan (PSIRP) has outlined the local priorities for our investigation priorities under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed with oversight from the Patient Safety Group (PSG). The CSUs will work collaboratively with the Quality and Patient Safety Facilitators and others to ensure there is an aligned approach to development of the plans and resultant improvement efforts.

Monitoring of progress regarding trust wide safety improvement plans will be overseen by reports submitted from the CSUs or other Trust lead to the Patient Safety Group (PSG) and subsequently to the Quality and Patient Safety Academy and up to the Board of Directors.

11. Impact assessments

11.1 Equality implications

This Policy was assessed on 03 August 2023 and is subject to an in-depth Equality Impact Assessment to confirm any disproportionate impact on protected groups affecting our services users, employees, or the wider community.

11.2 Privacy implications – Assessment completed. No privacy implications.

11.3 Financial implications

Whilst it is acknowledged that there will be organisational costs associated with implementing this policy and ensuring robust investigations, in addition to the potential costs associated with implementing action plans, reducing harm to patients in this way has important quality of care implications for patients, the Foundation Trust's reputation and cost benefits to the organisation (for instance in reduced litigation).

12. 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 months to ensure our focus remains up to date as 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. The policy will also be initially reviewed in line with review of the plan to ensure we capture any revisions required. Updated plans will be published on our website, replacing the previous version.

13. Monitoring and review arrangements

13.1 The implementation and effectiveness of this policy will be monitored by:

• Quarterly and annual reports to the Quality and Patient Safety Academy.

14. Acknowledgements

This policy has been developed by expanding upon the national policy template mandated by NHS England. The policies published by other NHS provider organisations have been reviewed to ensure that this Bradford Teaching Hospitals NHS Foundation Trust (the Foundation Trust) policy represents current best practice.

Appendix 1 - Policies and procedures related to externally reportable incidents.

Please note, this is not an exhaustive list.

Local Policies

- Health and Safety Policy
- Infection Prevention and Control Policy
- Policy for the Management and Governance of Research
- Information Governance Policy

External Agencies

- Serious Hazards of Transfusion (SHOT) scheme

Any incidents that involve blood transfusions could be reportable to SHOT (Serious Hazards of Transfusion). All blood transfusion incidents are notified to the Blood Transfusion Team who will report to SHOT if required. Information on SHOT can be found at http://shotuk.org.reporting/sabre/.

- Reporting of Adverse Events: Reporting Human Tissue Authority Reportable Incidents (HTARIs) to the Human Tissue Authority (HTA)

- Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 2013 (RIDDOR)

- Employer's Procedures for the use of Diagnostic X-Rays

- Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)

If a patient receives a radiation dose 'much greater than intended' then this is reportable to the Care Quality Commission (CQC) Ionising Radiation (Medical Exposure) Reulations (IRMER) incident reporting guidance can be found at Notify us about an exposure – Care Quality Commission (cqc.org.uk).

- Screening Incidents - Screening incident assessment form (SIAF)

The screening quality assurance service (SQAS)

- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)

- Suspected serious breach reporting

Appendix 2 Definitions and harm grading

Where practical, it is good practice to discuss the level of harm with the patient affected and to consider the patient's perspective on the harm definitions stated below.

Previous harm grades	New physical harm grades	New psychological harm grades
No Harm	No physical harm	No psychological harm
Low harm	Low physical harm	Low psychological harm
Moderate harm	Moderate physical harm	Moderate psychological harm
Severe harm	Severe physical harm	Severe psychological harm
Death	Fatal	n/a

Term	**Definition**
Near miss	Any event that could have caused harm.
Being Open	Being Open involves apologising, explaining what has happened and takes place as soon as possible following the identification of a patient safety incident.
Duty of Candour	The statutory and regulatory requirement of the Being Open process which applies when a patient safety incident results in moderate harm, major (severe) harm or death.
No physical harm	No physical harm
Low physical harm	Low physical harm is when all of the following apply: • minimal harm occurred – patient(s) required extra observation or minor treatment • did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit • did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication • did not or is unlikely to affect that patient's independence • did not or is unlikely to affect the success of treatment for existing health conditions.
Moderate harm	Moderate harm is when at least one of the following apply: • has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention • has limited or is likely to limit the patient's independence, but for less than 6 months

	• has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.
Severe harm	Severe harm is when at least one of the following apply: • permanent harm/permanent alteration of the physiology • needed immediate life-saving clinical intervention • is likely to have reduced the patient's life expectancy • needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment • has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions • has limited or is likely to limit the patient's independence for 6 months or more.
Fatal	Fatal (previously documented as 'Death' in NRLS).
Never Event	Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
Compounded Harm	The harm that some people – particularly patients and families – can experience when investigations following safety incidents are handled in ways they feel are closed and defensive (even if that is not the intention of those leading the process).
Learn from Patient Safety Events (LFPSE)	Learn from Patient Safety Events (LFPSE) service is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare. The service introduces a range of innovations to support the NHS to improve learning from the over 2.5 million patient safety events recorded each year, to help make care safer
No psychological harm	Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.
Low psychological harm	Low psychological harm is when **at least one** of the following apply: • distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit • distress that did not or is unlikely to affect the patient's normal activities for more than a few days • distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition
Moderate psychological harm	Moderate psychological harm is when **at least one** of the following apply: • distress that did or is likely to need a course of treatment that extends for less than six months • distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect

	the patient's ability to live independently for more than six months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months
Severe psychological harm	Severe psychological harm is when **at least one** of the following apply: • distress that did or is likely to need a course of treatment that continues for more than six months • distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

Appendix 3 - Patient Safety Responses (PSRs)

AAR – After action review
A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

Deaths thought more likely than not due to problems in care
Incidents that meet the 'Learning from Deaths' criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.
https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Multidisciplinary Team (MDT)
An in-depth process of review, with input from different disciplines to identify learning from multiple patient safety incidents and to explore a safety theme, pathway or process. To understand how care is delivered in the real world i.e., work as done.

PMRT - Perinatal Mortality Review Tool
Developed through a collaboration led by MBRRACE-UK with user and parent involvement, the PMRT ensures systematic, multidisciplinary, high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
Perinatal Mortality Review Tool | NPEU (ox.ac.uk)

PSA – Patient safety audit
A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g., in a policy or guideline).

PSII - Patient Safety Incident Investigation
PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors to help deliver safer care for our patients.

SJR - Structured judgement review
Developed by the Royal College of Physicians as part of the National quality board national guidance on learning from deaths; the SJR blends traditional, clinical- judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.
nqb-national-guidance-learning-from-deaths.pdf

Appendix 4: National event response requirements

Patient safety incident type	Required response	Anticipated improvement route
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)[5]	Patient Safety Incident Investigation	Create local organisational recommendations and actions and feed these into the quality strategy
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)		
Incidents meeting the Never Events criteria 2018, or its replacement.		
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII	
Child deaths Refer for Child Death Overview Panel review	Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	
Deaths of persons with learning disabilities Refer for Learning Disability Mortality Review (LeDeR)	Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding	

• adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults s	
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes	
Deaths in custody (e.g. police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so	
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	

Appendix 5 Resources and national documents

As a Trust we have utilised the following guidance to inform our approach:

Learn Together Investigation Resources
https://learn-together.org.uk/investigation-resources/

National guidance for NHS trusts engaging with bereaved families
https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

Learning from deaths – Information for families
https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/ explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Help is at Hand – for those bereaved by suicide
https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf specifically for those bereaved by suicide this booklet offers practical support and guidance who have suffered loss in this way.

Mental Health Homicide support
https://www.england.nhs.uk/london/our-work/mental-health-support/homicide-support/ for staff and families. This information has been developed by the London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

Child death support
https://www.childbereavementuk.org/grieving-for-a-child-of-any-age
https://www.lullabytrust.org.uk/bereavement-support/
Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

Complaint's advocacy
https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy
The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints process.

Healthwatch
https://www.healthwatch.co.uk/ Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters.
You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site.
https://www.healthwatch.co.uk/your-local-healthwatch/list

Parliamentary and Health Service Ombudsman
https://www.ombudsman.org.uk/ makes the final decisions on complaints that patients, families and carers deem not to have been resolved faIRLISy by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau
https://www.citizensadvice.org.uk/ provides UK citizens with information about healthcare rights, including how to make a complaint about care received.