Blackpool Teaching Hospitals
NHS Foundation Trust

Patient Safety Incident Response Policy

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Name	**Designation**	**Date Response Received**
Louise Cheung	Deputy Director of Quality Governance	01/11/2023
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1 Introduction / Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF (1)) and sets out Blackpool Teaching Hospitals NHS Foundation Trust's (BTHFT) 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 patient safety incidents.
- application of a range of system-based approaches to learning from patient safety incidents.
- considered and proportionate responses to patient safety incidents and safety issues.
- supportive oversight focused on strengthening response system functioning and improvement.

2 General Principles / Target Audience

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

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

There are processes which sit outside the scope of a Patient Safety Incident as the focus of the investigations are different in principle from that of a PSI response. It is not the purpose of a PSI response to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

Processes that sit outside the scope of a PSI are as follows:

- Claims.
- Human Resources investigations into employment concerns.
- Professional standards investigations.
- Coronial inquests.
- Criminal investigations.

The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

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

3 Definitions and Abbreviations

AIR	After Incident Review
AHP	Allied Health Professional
BTHFT	Blackpool Teaching Hospitals NHS Foundation Trust
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
ESR	Electronic Staff Record
HSIB	Healthcare Safety Investigation Branch
ICB	Integrated Care Board
LeDeR	Learning Disabilities Mortality Review
NMC	Nursing and Midwifery Council
PSA	Patient Safety Alert
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PSP	Patient Safety Partner
QI	Quality Improvement
SBAR	Situation, Background, Assessment, Recommendation
SJR	Structured Judgement Review
SMART	Specific, measurable, achievable, relevant, and time-bound
SOP	Standard Operating Procedure
StEIS	Strategic Executive Information System
SWARM	Used to identify learning from patient safety incidents. Immediately after an incident

4 Responsibilities (Ownership and Accountability)

This organisation describes clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents.

4.1 Chief Executive and Board of Directors

The Chief Executive and Trust Board have the ultimate responsibility for all aspects of risk management and safety, including the management of incidents. This includes ensuring that suitable arrangements are in place for the systematic investigation, analysis and improvements, both locally and corporately, including ensuring resources are available to comply fully with this policy.

4.2 Medical Director and Director of Nursing and Quality

The Medical Director and Director of Nursing, Midwifery, AHPs and Quality have overarching strategic responsibility for the implementation of PSIRF, ensuring the process is well define, understood, implemented and overseen to provide assurance of delivery and that appropriate action is taken in response.

4.3 Deputy Director of Quality Governance, and Head of Quality Governance

The Deputy Director of Quality Governance, and Head of Quality Governance have operational responsibility for ensuring that the Trust has robust incident management systems and processes in place that meet the requirements of the PSIRF and are effective. They are responsible for ensuring that the processes are utilised effectively to identify learning and change to prevent recurrence, ensuring that appropriate action is taken.

4.4 Divisional / Directorate Managers, Clinical Leads, Matrons/Senior Nurses and Service Managers

Ensure that appropriate experts are available to support the PSII Leads to carry out investigations within the relevant Divisions. They ensure that all investigations are completed in a timely manner by releasing all staff involved within an incident to attend any investigation discussions. The Divisional Directors of Nursing and/or Divisional Director agree risk reduction action plans and ensure that all relevant risks identified from incident reports are included on the Divisional risk registers. They also ensure the completion of any safety improvement action plans arising from incidents and report as necessary to professional bodies e.g., Nursing Midwifery Council (NMC), General Medical Council (GMC) if staff conduct or performance is proven to be deficient.

4.5 Divisional Quality Governance Leads

The Divisional Quality Governance Leads support the Trust's Divisional and Directorate teams in ensuring that the Divisions / Directorates review, manage, investigate and monitor learning from incidents. They work closely with the Incident and Risk team in supporting the timely and appropriate reporting, recording, investigating and co-ordinating of all incidents. The Quality Governance Leads are responsible for ensuring that risks and trends from incidents are escalated through the risk management process. Any learning is included within the Divisional Governance and Quality processes, so learning can be cascaded within the Division/Directorates.

4.6 Incident and Risk Team

The Incident and Risk Team are responsible for reviewing all incidents reported on the Safeguard Risk Management system, obtaining additional information and amending incident details as necessary. They will manage and co-ordinate the triage of all incidents assigning the correct level of investigation in conjunction with the Divisional Quality Governance Leads. The Team is required to report incidents to relevant external Stakeholders in accordance with their reporting requirements and timely submission of investigation reports to the Rapid Review Panel and the Patient Safety Panel for final sign off and onward reporting to other external bodies as required.

4.7 Patient Safety Incident Response Leads

The Patient Safety Incident Response Leads (PSIRL) are responsible for undertaking Patient Safety Incident Investigations (PSIIs) using SEIPS methodology for any Patient Safety Incidents that meet the criteria within the policy and plan. They are responsible for ensuring PSIIs are conducted in accordance with the policy and plan, ensuring that patient/families/carers are engaged in the investigation and that investigations are delivered to timescale.

4.8 All Staff

All staff are required to provide information either/both verbal or written reports for any investigation for an unexpected event or incident in a culture of being open and honest, supporting colleagues with a view to learning in a just culture. Line managers have a responsibility to ensure staff are released from duty to attend debriefings, round table discussions and interviews regarding any incident.

5 Our Patient Safety Culture

The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

A significant amount of work has been undertaken at BTH in 2022 / 2023 and 2023 / 2024 to understand and improve the Trust's safety culture. A number of wards and teams have participated in the Trust's Patient Safety Culture Quality Improvement Collaborative, which involved working closely with selected ward teams to understand their safety data and empower them to make change locally. The QI collaboratives have been well received and the Trust will continue to build on this work, ensuring that the outputs from Patient Safety Incident data and Patient Safety Incident Investigations are fed into this work to empower teams to make improvements at a local level. In this way the Trust will embed a healthy patient safety culture which touches all areas of the Trust.

Blackpool Teaching Hospitals Trust has promoted the use of the NHS's 'Just Culture' guide (2) as a tool to be used in our patient safety investigation process. The guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate as most patient safety issues have deeper causes and require wider action.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoidability or cause of death.

The Trust has a culture of open and transparent reporting of incidents and concerns and continues to demonstrate a very positive and proactive culture of patient safety incident

reporting and being open with patients, visitors and staff when things go wrong. Staff utilise the Trust's Safeguard Risk Management system for incident reporting, registering risks, managing complaints and concerns and monitoring coronial and legal issues.

To enhance our safety culture, we encourage the use of safety huddles at all levels of the organisation which consider risks emerging or known and the insight offered from incidents that have occurred and an opportunity to share learning.

The Trust promotes and encourages openness, transparency and candour (3) between staff and patients / service users throughout the organisation. This is an integral part of the Trust's safety culture which supports organisational and personal learning.

In addition to incident reporting, we also have a Freedom to Speak Up Service (FTSU (4)) in place since 2017 and the Trust remains committed to listening and encouraging all our staff to have a voice to speak up.

6 Patient Safety Partners

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

At BTHFT, we are excited to recruit PSPs who will offer support alongside our staff, patients, families / carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

This exciting new role across the NHS will evolve over time and in our Trust, the main purpose of the role is to be a voice for the patients and community who utilise our services and ensure that patient safety is at the forefront of all that we do.

PSPs will communicate rational and objective feedback focused on ensuring that patient safety is maintained and improved, this may include attendance at governance meetings reviewing patient safety, risk and quality and being involved with contributing to documentation including policies, investigations, and reports. This information may be complex, and the PSPs will provide feedback to ensure that patient safety is our priority. As the role evolves, we may ask PSPs to participate in the investigation of patient safety events, assist in the implementation of patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support specific to this new role in collaboration with the patient safety team to ensure PSPs have the essential tools and advice they need.

The PSPs will be supported in their honorary role by the Patient Safety Specialist for the Trust who will provide expectations and guidance.

6.1 Oversight

National oversight for patient safety incident responses will be through NHS England, providing support for the activity of regional teams. They will provide strategic direction and leadership and monitor the effectiveness of PSIRF.

Regional teams will:

- Support local Integrated Care Board (ICB) PSIRF leads.
- Collaborate with NHS England commissioned services as required.
- Support a learning system.
- Support co-ordination of cross-system responses to patient safety incidents.
- Identify incidents that may require centrally coordinated and independent patient safety incident investigation (PSII).

Our local Integrated Care Board will:

- Collaborate with the Trust in the development, maintenance and review of provider patient safety incident response policies and plans.
- Agree our patient safety incident response policies and plans.
- Oversee and support effectiveness of our systems to achieve improvement following patient safety incidents.
- Support coordination of cross-system learning responses.
- Share insights and information across organisations/services to improve safety.

The Trust will ensure that:

- The organisation meets national patient safety incident response standards.
- Ensure PSIRF is central to overarching safety governance arrangements.
- Quality assure learning response output.

Local organisational oversight of PSIRF will be through the Trust's Safety Panel, Clinical Governance and Quality Assurance Committees, with assurance provided through to Trust Board.

Oversight from partners such as Patient Groups, local Healthwatch organisations and local Councils' Health Scrutiny Committees will also be actively encouraged.

7 Addressing Health Inequalities

The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust, as a public authority, is committed to delivering on its statutory obligations under the Equality Act (2010 (5)) and will use data intelligently to assess for any disproportionate safety risk to patients from across the range of protected characteristics. The Trust's Safeguard Risk Management system (6) will allow for the details of patients to be directly drawn from the healthcare record and incidents will be analysed by protected characteristics to give insight into any apparent inequalities.

Within our patient safety response toolkit,, which can be located on the Trust's Risk Management SharePoint site (7), we will directly address if there are any particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to incidents we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

We will also address apparent health inequalities as part of our safety improvement work. In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy. We consider this as an integral part of the future development process.

It is critical to engage with patients, families and staff when responding to patient safety incidents. We will ensure that we use available tools, such as, easy read, translation and interpretation services and other methods as appropriate, to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response (8).

The Trust is supportive of the NHS England led Core20PLUS5 work-streams (9) which aim to tackle health inequalities at a national and system level. The Trust will continue to work with national and regional system partners to ensure that our services continue to close the gap on health inequalities.

Further to this, the Trust has affirmed that it endorses a zero tolerance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/service users, carers and families. As part of this, discrimination of any kind including racism will be dealt with by using a 'Support, Educate, Challenge' approach. With explicit role modelling led by the Trust Board, we will use these principles to underpin patient safety training and implement the system-based approach to patient safety responses which is at the heart of PSIRF best practice.

8 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.

The Trust is committed to continuously improving the care and services we provide. As an organisation, we must learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence and 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 improving 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.

As well as meeting our regulatory and professional requirements for Duty of Candour (3), the Trust will be open and transparent with our patients, families, and carers, to ensure those concerned are well informed.

8.1 How we will engage and involve patients and families:

In line with our current Duty of Candour process (3), where moderate harm (or above) has occurred all patients and families will be informed as close to the incident occurring that they have been involved in a Patient Safety Incident. Where an PSI progresses to investigation, the patient and family will be invited to participate in the investigation process, with the completed investigation shared with them and an explanation of the action being taken. Patient and family engagement will be more enhanced when it comes to full Patient Safety Incident Investigations using SEIPS, where the investigation will put the patient and family at the heart of the investigation, inviting them to interview to gain their recollection of care and to feed in any questions which they would like to investigate as part of the PSII. A follow up meeting will take place following the completed investigation to share the findings of the report and the action being taken with the patient and/or family.

8.2 How we will engage and involve our staff:

At BTH we recognise that staff involved in incidents can become a 'second victim' of the incident. The Trust will ensure that following a Patient Safety Incident, that any member of staff involved in an incident receive a welfare check from their line manager.

Staff will be approached to participate in a PSI response to offer their recollection of events and to share the findings of the investigation with them for learning.

More detail regarding how we will engage with patients, families and staff following a Patient Safety Incident will be set out as part of the Trust's new policy framework which will be based on our existing Being Open and Duty of Candour Policy (CORP/POL/538 (3)).

9 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.

The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our patient safety incident response plan 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.

9.1 Resources and training to support patient safety incident responses

The Trust has committed to ensuring that we fully embed the PSIRF and meet its requirements. We have therefore used NHS England's patient safety response standards (2022 (1)) to frame the resources and training required to allow for this to happen.

A review of the PSII resource and activity (associated with PSII) for the two-year period April 2021 to March 2023 has been undertaken to determine how many PSIIs can be supported during the next 18 months, October 2023 to March 2025. This review has been undertaken alongside the Patient Safety Investigation Standards, to ensure that all future PSIIs are compliant with these standards.

The following table captures the analysis of categories of incidents investigated as serious incidents over a two-year period, including the response type and average annual number of responses undertaken.

Table of serious incident analysis:

Response type	Category	Average annual number of responses
National priorities requiring patient safety incident investigation	PSII into Never Events	2
	PSII into deaths thought more likely than not to be due to problems in care.	7
	PSII into Maternity patient safety incidents	4
	All other StEIS incidents. Pressure ulcer incidents in brackets ( ).	24 (13)
Patient safety incident investigations conducted locally (After Incident Review)	Manage within Division full incident investigation (including moderate harm incidents meeting the requirement for statutory Duty of Candour.)	100
Patient safety reviews	Learning Disabilities Mortality Review (LeDeR)	11
	Structured Judgement Review (SJR) 1	66
	SJR 2	61

In addition, two data review workshops were undertaken in early 2023 utilising quantitative analysis on data pulled over the last five years, from incidents, complaints, mortality, audit, claims and clinical pathway data. Qualitative analysis utilised thematic information from serious incidents, complaints, national patient surveys, Freedom to Speak Up concerns and CQC action plan responses. This review was undertaken by a range of Trust professionals to identify the Trust's local priorities.

As Trusts were advised that PSIRF implementation was to be undertaken on a cost neutral basis, the Trust has sought to cover the new investigation requirements within the resource currently in place.

To undertake Patient Safety Incident Investigations, the Trust has established a Learning Response Pool. Based on the projected numbers of investigations listed above, the Trust asked for a minimum of 4 Learning Response Leads per clinical Division to be added to the pool and who were to undergo the relevant level of training to support them in delivering this expectation. Nominations were also requested from corporate teams for members to be added to the Learning Response Pool. To date the Trust has identified 47

members of staff who have been added to the pool. A minimum of 20 members of staff nominated are expected to complete the relevant levels of training in advance of PSIRF transition. The remaining members of staff will complete training in advance of 31 March 2024.

PSIs which do not meet the criteria of a Patient Safety Incident Investigation i.e., that will be investigated using After Incident Reviews, SWARM Huddles, Hot Debriefs etc. will be led by key members of staff as nominated by the Division as detailed in the Trust's Incident SOP documents.

9.2 Understanding patient safety incident response activity

In summary, BTHFT has identified that there will be approximately 20 – 25 cases a year that will require investigation as a full PSII. Each lead investigator will be supported by the PSII team administrator and subject matter experts as appropriate. Further support in terms of a family support lead will be provided by clinical staff within Divisions to ensure patient / family / carers are involved and kept informed of progress.

To improve our ability to deliver against PSIIs, the Trust plans to:

- Assign a team of appropriately trained patient safety incident (PSI) investigators who have received systems-based training on incident investigation methodologies. Four leads will be identified per Division are to be added to a pool of Learning Response Leads.
- Assign an appropriately trained board member to oversee delivery of PSIIs and support the sign off for all PSIIs.
- Develop an incident investigation toolkit to support other Trust staff so they can review PSIs where a PSII is not indicated but learning can still be identified.

9.3 Competence and Capacity

Learning response leads, those leading engagement and involvement and those in PSIRF oversight roles require specific knowledge and experience. PSI investigators:

- Must not be involved in the patient safety incident itself, or by those who directly manage those staff.
- Should have an appropriate level of seniority and influence within an organisation and should be employed where possible at a Band 8a and above.
- Should not work in isolation - a learning response team should be established to support wherever possible.
- Should involve subject matter experts with relevant knowledge and skills where necessary, to provide expertise, advice and proof-reading.
- Should have dedicated staff resource to support engagement and involvement of those affected.

9.4 Training Requirements

In preparation for transition to the PSIRF, it has been identified that there is a significant training need for the organisation.

All Trust staff are required to access Levels 1 and 2 patient safety training which are provided through the National Patient Safety Syllabus (10). Whilst it is desirable that all staff complete this training by 31st October 2023, it is acknowledged nationally that training will extend beyond this date.

These courses are available via the Trust's Electronic Staff Record (ESR) system (11) and are available for staff to access. Oversight of training compliance figures will be maintained.

For those staff that are to play a lead role in undertaking PSIIs and those that have a responsibility for oversight of the PSIRF, i.e., executive directors and senior leaders, there is further training required which is more intensive. Staff within this cohort are required to access the following:

- Systems approach to learning from patient safety Incidents - 2-day (12 hour) course
- Oversight of learning from patient safety Incidents – 1- day (6 hour) course
- Involving those affected by patient safety incidents in the learning process – 1-day (6 hour) course.

In addition, key staff within the organisation were contacted in November 2022, to alert them to the availability of enhanced training provision, meeting the requirement of the intensive training listed above which is delivered by the Healthcare Safety Investigation Branch (HSIB (12)).

Other options for training delivery are being explored, such as securing training at a cost via the NHS procurement framework, or the development of in-house training packages (although these are not accredited courses). The option for outsourced 'train the trainer' courses for oversight governance training is also being considered within the local network.

10 Our patient safety incident response plan

Our plan sets out how the 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. 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.

11 Reviewing our Patient Safety Incident Response Policy and Plan

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

Updated plans will be published on our website, replacing the previous version.

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

12 Responding to patient safety incidents

12.1 Patient safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incidents on the Trust's Safeguard Incident Reporting system (Ulysses (6)) and will record the level of harm they know has been experienced by the person affected (see Appendix 1).

Divisions will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where Duty of Candour applies (see our Trust Being Open and Duty of Candour policy - CORP/POL/538 (3)). Most incidents will only require local review within the service, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated within the Division (see **section 12.** Patient safety incident response decision-making).

Divisions will highlight to the Quality Governance team any incident which appears to meet the requirement for reporting externally. This will allow the Trust to work in a transparent and collaborative way with our ICB or regional NHS teams if an incident meets the national criteria for a PSII or if supportive coordination of a cross system learning response is required.

The Quality Governance team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust.

13 Patient safety incident response decision-making

The Trust will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require a mandatory PSII, others will require review by, or referral to, another body or team depending on the event. These are set out in our PSIRF plan,

The PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. The Trust has developed its own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work. In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for a PSII and our toolkit for responding to other patient safety incidents.

13.1 Process for identifying patient safety incidents

The Trust utilises the Ulysses (Safeguard) Risk Management system (6) for recording patient safety incidents. Staff are encouraged to report incidents within 24 hours of any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving healthcare within the Trust. Reporting incidents supports the organisation to learn from mistakes and to take action to keep patients safe.

Managers of all service areas must have arrangements in place to ensure that incidents can be reported and responded to within their area. Incident responses should include immediate actions taken to ensure safety of patients, public and staff, as well as 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. Any response to an incident should be fed back to those involved or affected and appropriate support offered. Where Duty of Candour applies this must be carried out according to Trust policy - Being Open and Duty of Candour policy (CORP/POL/538 (3)).

13.2 Method for agreeing an investigation response

Incidents reported with a harm category of moderate or above require a Rapid Review to be completed by the division(s) / relevant team involved. An automatic notification is sent through the Safeguard system to the relevant staff informing them of the requirement for a Rapid Review. All Rapid Reviews are reviewed and monitored through the Trust's twice weekly Rapid Review panel where a decision will be made by the panel as to whether an incident meets the national or local priority criteria for a PSII.

The Rapid Review panel will consider any mitigation identified by the Rapid Review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met. The panel will define terms of reference for a PSII to be undertaken by an appropriate member of the Patient Safety Investigation team. The panel will also designate subject matter expert input required for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared, i.e., through an SBAR or Safety Alert.

Once the PSII has been concluded, the investigation report will be presented to the Trust's Safety Panel and representation from the division(s) involved will be invited to attend. The Safety Panel will review the report, request any further clarification or changes and then sign off prior to Executive Director / Chief Executive approval.

For incidents that do not meet the criteria for a national or local priority PSII, a decision will be made at the Rapid Review panel for an appropriate level of investigation, i.e., a local After Incident Review, Patient Safety Audit, Thematic Review, Structured Judgement Review, Multidisciplinary team review, SWARM huddle etc, or for closure with actions identified within the Rapid Review.

13.3 Allocation of resources to support responses to incidents not included in our Patient Safety Incident Response Plan

All Divisions must have daily / weekly review and escalation arrangements in place for the monitoring of patient safety incidents to ensure recorded levels of harm are appropriate and that learning from incidents is identified and shared.

Incidents requiring possible investigation – all staff (directly or through their line manager) must ensure notification of incidents that may require investigation, are escalated as soon as practicable after the event, through Divisional escalation processes. A rapid review will be undertaken by the Division to inform decision making by the Rapid Review panel.

Incidents that are recorded and validated as low or no harm, are investigated locally by the division(s) involved and closed with appropriate actions and learning recorded.

Where it has been identified that there has been a cluster of similar type low or no harm incidents reported, the division should undertake a rapid review to escalate the concerns. The Rapid Review panel will then consider whether further investigation through a Thematic Review or Patient Safety Audit is required.

14 Responding to cross-system incidents / issues

The Incident and Risk team will forward those 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 the relevant 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 and system colleagues, including the ICB and other regional providers have in place an agreed set of shared principles to which it will adhere throughout the PSIRF Transition as follows:

1. We will all commit to 1 patient 1 learning response rather than silo working for cross organisational incidents. We will agree collaboratively through an MDT approach how

to allocate defined roles and responsibilities across all organisations involved including leadership/oversight, co-ordination and will agree a method of escalation.

2. We will ensure patient, family and staff involvement as part of cross trust delivery of PSIRF, ensuring co-design of a jointly owned safety culture within a well-functioning safety system
3. We will promote openness and transparency to share concerns and allow for growth with clearly defined roles/leads for each area to promote consistency and adapt as required. We will be flexible and adapt our communication methods to ensure that everyone in included and has access and will encourage sharing of information and ideas, promoting kind provocation.
4. We will create a safe space where we can have open and honest discussions and we will demonstrate mutual respect focussing on the collective goal embracing what other organisations can bring.
5. We will provide a safe environment for all to be open/transparent to share learning from events.
6. Compassion and empathy will underpin our approach, ensuring we provide support with kindness when interacting with patients, families, staff and colleagues.
7. We will commit to being honest and disclose all relevant information. We will be upfront about challenges we have faced and what we have learned and make our goals and outcomes visible to all who are affected.
8. We will agree our shared goals and the principles and values we need in place to make these happen and we will adapt as we learn and progress.
9. We will actively connect and collaborate on these shared goals. To help us achieve this we will collectively create a safe, responsive space where a culture of civility and constructive feedback is the norm.
10. We will continue to reflect on and respond to the lessons we learn to ensure we are continuously improving our health system at scale.

Learning responses should be managed as locally as possible to facilitate the involvement of those affected by and those responsible for delivery of the service in which the incident or issue relates to. However, where a response involving multiple providers and/or services across a care pathway is too complex for a single provider to manage, ICBs should support the co-ordination of cross-system response.

The ICB lead will liaise with relevant providers (and other ICBs if necessary) to 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. ICB leads appointed to support cross system learning responses must have the required time and training (as described in the Patient safety incident response standards).

As expected, the Trust will work together with the ICB to establish and undertake cross system learning responses, but where issues arise, these will be supported by NHS England regional teams to ensure such responses are delivered as required.

15 Timeframes for learning responses

15.1 Timescales for PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within three months of the start date. No PSII should take longer than six months to complete.

The timeframe for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. 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 investigative activity once this is received. This would require a decision by the Trust's Patient Safety panel.

In exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

15.2 Timescales for other forms of learning response

A learning response must be started as soon after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months.

16 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 required.

The Trust will have 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 or 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. Following this, the Trust will have measures to monitor any safety action and set out review steps.

Learning responses should avoid actions that attempt to devise a solution - safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development this will be completed in a collaborative way with a flexible approach from

Divisions and with support from the Quality Governance team and where possible the Quality Improvement Team.

16.1 Safety Action development

The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022 (13)) as follows:

1. Agree areas for improvement – specify where improvement is needed, without defining solutions.
2. Define the context – this will allow agreement on the approach to be taken to safety action development.
3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved.
4. Prioritise safety actions to decide on testing for implementation.
5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics.
6. Safety actions will be clearly written and follow SMART principles and have a designated owner.
7. The completion of safety actions will be overseen and monitored by a combination of the Quality Governance team and the Divisions, supported by Clinical Governance Committee oversight.

16.2 Safety Action Monitoring

Safety actions must continue to be monitored within the Divisions' governance arrangements to ensure that any actions put in place remain impactful and sustainable. Divisional reporting on the progress with safety actions including the outcomes of any measurements will be made through Divisional Quality Governance meetings.

For some safety actions with wider significance, these may require oversight by the Clinical Governance Committee and Quality Assurance Committee.

17 Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The Trust has a number of overarching safety improvement 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 the Commissioning for Quality and Innovation (CQUIN).

The Trust's Patient Safety Incident Response Plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there may be no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

The Trust will use the outcomes from existing patient safety incident reviews where present and any relevant learning response conducted under the PSIRF, to create related safety improvement plans to help to focus our improvement work. The Divisions will work collaboratively with the Quality Governance and Quality Improvement teams to ensure there is an aligned approach to development of plans and resultant improvement efforts.

Where overarching systems issues are identified by learning responses outside of the Trust's local priorities, a safety improvement plan will be developed. These will be identified and approved through Divisional governance processes and reported to the Deputy Director of Quality Governance for approval. The Divisions will work collaboratively with the Quality Governance team, Quality Improvement team, stakeholders and others to ensure there is an aligned approach to the development of the plan and resultant improvement efforts.

18 Oversight roles and responsibilities

National oversight for patient safety incident responses will be through NHS England, providing support for the activity of regional teams. They will provide strategic direction and leadership and monitor the effectiveness of PSIRF.

Regional teams will:

- Support local Integrated Care Board (ICB) PSIRF leads.
- Collaborate with NHS England commissioned services as required.
- Support a learning system.
- Support co-ordination of cross-system responses to patient safety incidents.
- Identify incidents that may require centrally coordinated and independent patient safety incident investigation (PSII).

Our local Integrated Care Board will:

- Collaborate with the Trust in the development, maintenance and review of provider patient safety incident response policies and plans.
- Agree our patient safety incident response policies and plans.
- Oversee and support effectiveness of our systems to achieve improvement following patient safety incidents.
- Support coordination of cross-system learning responses.
- Share insights and information across organisations/services to improve safety.

The Trust will ensure that:

- The organisation meets national patient safety incident response standards.
- Ensure PSIRF is central to overarching safety governance arrangements.
- Quality assure learning response output.

Local organisational oversight of PSIRF will be through the Trust's Safety Panel, Clinical Governance and Quality Assurance Committees, with assurance provided through to Trust Board.

Oversight from partners such as Patient Groups, local Healthwatch organisations and local Councils' Health Scrutiny Committees will also be actively encouraged.

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

A mixture of both qualitative and quantitative measures have been triangulated in order to get a clear understanding of the effectiveness of patient safety incident response systems and processes in place. Both outcome and process-based data has been reviewed and the Trust will continue to review different approaches to gathering and monitoring data, in order to continue to design and improve our metrics and tools for monitoring patient safety incident response systems and processes.

Patients, families, and staff affected by patient safety incidents can provide some of the best and most pertinent warnings of poorly functioning patient safety incident response systems. The Trust will be giving priority to capturing meaningful patient, family and staff-centred metrics for learning and improvement.

The Trust will continue to involve our patient safety partners and stakeholders in the development and delivery of the PSIRF oversight processes. Patient groups such as Lancashire Healthwatch, Maternity and Neonatal Voice Partnerships and our local Patient Influence panel, have and will continue to be involved to provide insight into the strength of our patient safety incident response systems.

Development of our safety metrics will also feature strongly in our collaborative working with both our local Integrated Care Board (ICB) and the Care Quality Commission (CQC). Regular oversight meetings with both the ICB and the CQC are already well established with the Trust.

19 Complaints and appeals

Blackpool Teaching Hospitals NHS Foundation Trust recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided by the Trust.

The first point of contact with the Trust is the Patient Relations Team, who will support the resolution of any concerns raised –

Telephone 01253 955588/89 –

email address - bfwh.patientexperienceteam@nhs.net and

web page: https://www.bfwh.nhs.uk/patients-and-visitors/patient-experience/. Comments can also be shared publicly on the Care Opinion website (14): careopinion.org.uk.

The Patient Relations Team provide free, confidential advice to help patients and their carers who have raised a concern. The team liaise with Trust staff and refer the patient to the most appropriate person in the clinical area to seek early resolution, provide them with information on services and direct patients to an independent advocate to support and advise people on how to make a formal complaint.

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 as long as this is with the agreement of the person raising the concern.

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 a formal review.

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 (15).

Advice and support is available from the Trust and independent organisations:

Blackpool Advocacy Hub at: blackpooladvocacyhub.org.uk/contact

Email: info@blackpooladvocacyhub.org.uk

Telephone: 0300 323 0251

Advocacy Focus at: advocacyfocus.org.uk.

Email: admin@advocacyfocus.org.uk

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. The written response that is sent to every complainant with the investigation report clearly informs the person raising the complaint that if they are not happy with the outcome of our investigation, they can take their complaint to the Parliamentary and Health Service Ombudsman (16).

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

If a concern cannot be resolved and the complaints team are undertaking a formal review the complaints team will contact the complainant and can be contacted directly on 01253 955588 / 89 bfwh.complaints@nhs.net.

20 References and Associated Documents

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3. **BTHFT - Policy.** Being Open and Duty of Candour Policy. [Online] 21 03 2022. [Cited: 15 09 2023.] http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-POL-538.docx. CORP/POL/538.

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9. **NHS England.** Core20PLUS5 (adults) – an approach to reducing healthcare inequalities. [Online] [Cited: 01 11 2023.] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/.

10. —. NHS Patient Safety Syllabus training programme. [Online] 2023. [Cited: 15 09 2023.] https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/.

11. **NHS Business Services Authority.** Electronic Staff Record (ESR). [Online] [Cited: 15 09 2023.] https://my.esr.nhs.uk/dashboard/web/esrweb.

12. **HSIB.** Healthcare Safety Investigation Branch. [Online] [Cited: 15 09 2023.] https://www.hsib.org.uk/.

13. **NHS England.** Patient safety learning response toolkit. [Online] Page updated 17/08/2023. [Cited: 15 09 2023.] https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/.

14. **Care Opinion.** [Online] [Cited: 15 09 2023.] https://www.careopinion.org.uk/.

15. **Crown.** The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. [Online] 2009. [Cited: 15 09 2023.] http://www.legislation.gov.uk/uksi/2009/309/contents/made.

16. **Parliamentary and Health Service Ombudsman.** [Online] [Cited: 15 09 2023.] https://www.ombudsman.org.uk/.

Appendix 1: Levels of Harm

Levels of harm were previously set out in the National Reporting and Learning Service guidance on reporting patient safety incidents.

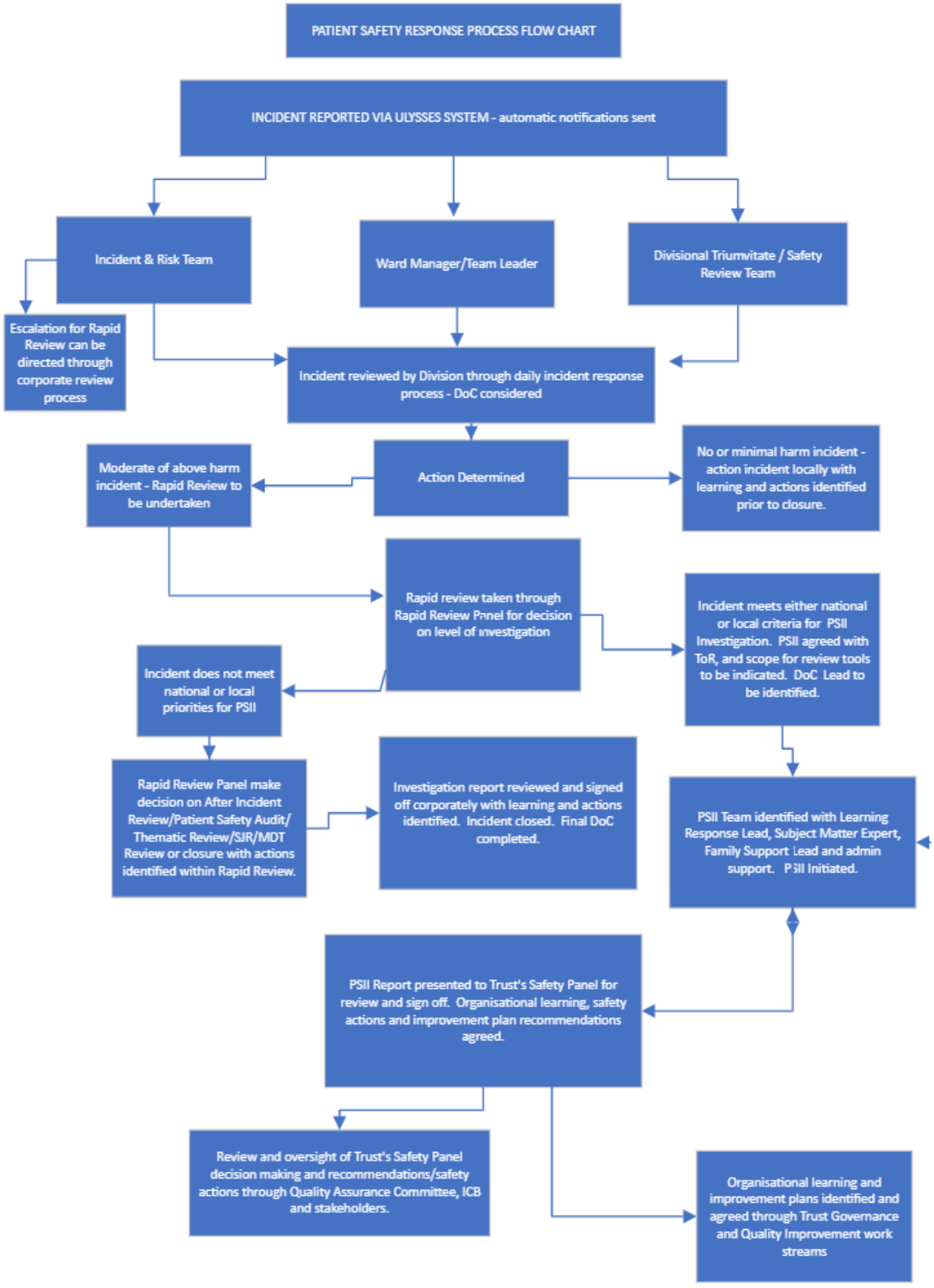
In summary harm is defined as follows:

No harm

This has two sub-categories:

- **No harm (Impact prevented)** –
  Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. This may be locally termed a 'near miss'.
- **No harm (impact not prevented)** -
  Any patient safety incident that ran to completion, but no harm occurred to people receiving NHS funded care. Ensure that the
  - **Low harm** -
    Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care.
  - **Moderate harm** -
    Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.
  - **Severe harm** -
    Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.
  - **Death** –
    Any unexpected or unintended incident that directly resulted in the death of one or more persons.

Appendix 2: Flowchart



Appendix 3: Incident Grading Process

Incident Grading Process

Choose the most appropriate description of the identified risk from the table below

Level of harm and examples

Impact on:	No harm / near miss	Minimal harm	Moderate harm	Severe harm	Death
Patients, staff or other persons (physical / psychological harm)	No harm (impact prevented): any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. This may be locally termed a 'near miss'. No harm (impact not prevented) - Any patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care.	Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care.	Moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.	Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.	Any unexpected or unintended incident that directly resulted in the death of one or more persons.
Post-Partum Haemorrhage (PPH)	Minor PPH (500mls-1000mls)	Moderate PPH (1000mls-2000mls)	Significant PPH(>2000mls)	PPH which leads to major harm	PPH which leads to death of the patient
Rapid Tranquilisation All incidents where a Rapid Tranquilisation has occurred should be reported on Ulysses as soon as clinically safe to do so following the event.	A Rapid Tranquilisation has occurred safely with no unintended harm to the patient	A Rapid Tranquilisation has occurred with minimal unintended harm to the patient	A Rapid Tranquilisation has occurred which has caused significant but not permanent harm to the patient.	A Rapid Tranquilisation has occurred that has resulted in permanent harm to one or more persons.	A Rapid Tranquilisation has occurred that has resulted in the death of one or more persons.

Appendix 3: Incident Grading Process

Quality / complaints / audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources /organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty / inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours	Local media coverage – short-term reduction in	Local media coverage – long-term reduction in	National media coverage with <3 days	National media coverage with >3 days service well below

Appendix 3: Incident Grading Process

	Potential for public concern	public confidence Elements of public expectation not being met	public confidence	service well below reasonable public expectation	reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Appendix 4: Equality Impact Assessment Form

Department	Quality Governance	Service or Policy	CORP/POL 663	Date Completed:	02/11/2023

GROUPS TO BE CONSIDERED

Deprived communities, homeless, substance misusers, people who have a disability, learning disability, older people, children and families, young people, Lesbian Gay Bi-sexual or Transgender, minority ethnic communities, Gypsy/Roma/Travellers, women/men, parents, carers, staff, wider community, offenders.

EQUALITY PROTECTED CHARACTERISTICS TO BE CONSIDERED

Age, gender, disability, race, sexual orientation, gender identity (or reassignment), religion and belief, carers, Human Rights and social economic / deprivation.

QUESTION	RESPONSE		IMPACT	
	Issue	Action	Positive	Negative
What is the service, leaflet or policy development? What are its aims, who are the target audience?	This policy details the Trust's process for the reporting of and investigation of all untoward incidents and serious incidents occurring within the Trust, under the new PSIRF Framework.		Yes – compliance with this policy will ensure the reporting and investigation of all untoward incidents and the sharing of learning from these safety events.	
Does the service, leaflet or policy/ development impact on community safety • Crime • Community cohesion	The policy is relevant to the safety of all in-patients, community patients and staff.		Yes	
Is there any evidence that groups who should benefit do not? i.e. equal opportunity monitoring of service users and/or staff. If none/insufficient local or national data available consider what information you need.	No, this policy should ensure a positive impact across all groups of staff and patients.		Yes	
Does the service, leaflet or development/ policy have a negative impact on any geographical or sub group of the population?	No		Yes	
How does the service, leaflet or policy/ development promote equality and diversity?	The policy defines the standardised process and approach to be followed in the event of an untoward incident.		Yes	
Does the service, leaflet or policy/ development explicitly include a commitment to equality and diversity and meeting needs? How does it demonstrate its impact?	The policy includes a completed EA which provides the opportunity to highlight any potential for a negative/adverse impact.		Yes	
Does the Organisation or service workforce reflect the local population? Do we employ people from disadvantaged groups	Our workforce is reflective of the local population.		Yes	
Will the service, leaflet or policy/ development i. Improve economic social conditions in deprived areas ii. Use brown field sites iii. Improve public spaces including creation of green spaces?	No	N/A	N/A	
Does the service, leaflet or policy/ development promote equity of lifelong learning?	No	N.A	N/A	
Does the service, leaflet or policy/ development encourage healthy lifestyles and reduce risks to health?	The procedure identifies the process in relation to reporting, investigating and learning from incidents which occur within the Trust which will result in improving the safety of our patients and staff.	Persons working within the Trust are provided with adequate training in order to ensure understanding of the process to be followed.	Yes	
Does the service, leaflet or policy/ development impact on transport? What are the implications of this?	No	N/A	N/A	

Appendix 4: Equality Impact Assessment Form

Does the service, leaflet or policy/development impact on housing, housing needs, homelessness, or a person's ability to remain at home?	This policy will have an impact on all members of staff working in the Trust and patients in their care.		Yes	
Are there any groups for whom this policy/ service/leaflet would have an impact? Is it an adverse/negative impact? Does it or could it (or is the perception that it could exclude disadvantaged or marginalised groups?	The Policy promotes access to information for all members of staff in the Trust.	N/A	Yes	
Does the policy/development promote access to services and facilities for any group in particular?	No	N/A	N/A	
Does the service, leaflet or policy/development impact on the environment • During development • At implementation?	No			

ACTION:			
Please identify if you are now required to carry out a Full Equality Analysis		**No**	**(Please delete as appropriate)**
Name of Author: **Signature of Author:**	**Helena Lee, Quality Governance Manager**	**Date Signed:**	**02/11/2023**
Name of Lead Person: **Signature of Lead Person:**	Stuart Logan, Head of Quality Governance	**Date Signed:**	02/11/2023
Name of Manager: **Signature of Manager**	Louise Cheung, Deputy Director of Quality Governance	**Date Signed:**	02/11/2023