FAIRFIELD INDEPENDENT HOSPITAL

Patient Safety Incident Response Policy

June 2023

Contents

Version control

AUTHOR	VERSION NO.	DATE	CHANGES FROM PREVIOUS VERSION
C Nolan	1	Sept 2023	New policy
S Smith	1.1	Feb 2024	Minor grammatical corrections

1. Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Fairfield Independent Hospital (the Hospital) will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of

PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds PSIRF 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:

• inclusive and 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.

This policy should read in conjunction with our current patient safety incident response plan,

2. Scope of Policy

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

Responses under this policy follow a systems-based approach. 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.

The processes listed below are outside of the scope of this policy.

- claims handling,
- human resources,
- professional standards
- information governance
- estates and facilities
- financial investigations and audits
- safeguarding concerns

- criminal investigations
- complaints (except where a significant patient safety concern is highlighted)

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, for example, complaints, claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

3. FIH patient safety culture

The Hospital has worked hard over the years to embed a patient safety culture across the organisation. Moving away from a perceived blame culture to one of doing things right, leaning from mistakes and cascading the learning. We feel we have a 'just culture' within our organisation.

The Hospital is committed to:

- promoting a fair, open, inclusive and just culture that abandons blame as a tool and promotes the belief that incidents cannot simply be linked to the actions of individual staff but also focuses on the system in which they were working in order to learn lessons.

- improving communication and the development of a mature safety culture, encouraging a positive approach to the reporting and investigation of patient safety incidents.

- openness in the handling of patient safety incidents and the application of the Being Open Policy and Duty of Candour.

- justifiable accountability and a zero tolerance for inappropriate blame. The NHS Improvement just culture guide should be used to determine a fair and consistent course of action towards staff.

PSIRF will create much stronger links between a patient safety incident and learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers.

We feel we are a transparent organisation but we will strive to enhance this further by demonstrating transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

4. Patient safety partners.

The introduction of patient safety partners will be considered as part of the Hospital's commitment to patient involvement and engagement in the local implementation of the principles of PSIRF

5. Addressing health inequalities.

The Hospital will apply a flexible approach and intelligent use of data to help identify any disproportionate risk to patients.

The Hospital will respond to any issues related to health inequalities as part of the implementation of this policy.

Within our patient safety response toolkit, 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 any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

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

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. We are well aware the impact a patient safety incident can have on patients, 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. We have always regarded Duty of Candour as the right thing to do and we are open and transparent and act with integrity at all times.

We want to be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident.

As part of our new policy framework, we will be outlining procedures that support patients, families, and carers – based on our existing Being Open Policy (Duty of Candour). This will be underpinned by the involvement and action of the Director of Clinical Services and the Heads of our Clinical Departments and other members of the governance team who are able to guide patients, families and carers through any investigation or learning review.

For every incident requiring a PSII and incidents meeting the Duty of Candour Statutory requirement, a Being Open and Honest Lead will be allocated.

The Being Open and Honest Lead at FIH may be the Lead Investigator for the PSII or PSR or the lead Director for the incident. The Being Open and Honest Lead will be the key contact for communication with patients, families and carers during an investigation.

The Being Open and Honest Lead is responsible for:

- Meeting with patient, families and carers involved in a patient safety incident to explain what has happened, the investigation taking place and the process surrounding that and provision of contact details. The lead may include other people in the discussion with the family if appropriate and if acceptable to the patient/family.
- Hearing the patient/family account of the incident from their perspective and gathering any questions that they would like the review to answer
- Ensuring that the patient has been provided the appropriate ongoing support and follow up.
- Arranging for the transfer of care where the patient (and/or carer) requests this
- Documenting the details of all discussions with the patient (and/or carer), copies of letters relating to the patient safety review ensuring that this documentation is uploaded to the relevant incident record on Vantage
- Keeping close communication with the patient, family and/or carer as per their wishes. Contact will also take place following the conclusion of the investigation to share the findings, lessons learned and actions being taken

There is help and support available. (Although not an NHS Trust we have included this information as it is a valuable resource).

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

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 patients, families and carers deem not to have been resolved fairly 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.

7. Patient Safety Incident Response Planning

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

The Hospital 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 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 Hospital will meet both national and local focus for patient safety incident responses. The plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change.

a) Patient safety incident reporting arrangements

It is the responsibility of the Hospital to ensure that all incidents and near misses are reported, investigated and actioned to prevent or minimise similar instances in the future. Any incident or near miss can be defined as:

"*An unintended/unexpected event which has the potential to cause harm"*
Staff should use the Hospitals approved incident reporting system to report all patient safety incidents".

All staff are responsible for reporting any potential or actual patient safety incident on a Hospital incident reporting system and will record the level of harm they know has been experienced by the person affected. Appendix B shows the internal reporting arrangements using the Vantage System.

Departments 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. 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 Hospital (see Patient safety incident response decision-making below).

The Departmental Manager will highlight to the Director of Clinical Services and Quality any incident which appears to meet the requirement for reporting externally. This may be to allow the Hospital to work in a transparent and collaborative way with the ICB or regional NHS teams

b) Patient safety incident response decision making

Any patient safety incident meeting the criteria for a patient safety incident investigation (PSII) as defined in the agreed patient safety incident response plan will be escalated and reported to the Hospitals Patient Safety Panel – this panel will be a re-formed adverse events committee which will need to meet more frequently, on a needs must basis in order to respond. The membership will need to be reviewed to reflect the incident The co-ordination of this meeting will be undertaken by the Clinical Governance Co-ordinator who will confirm if the incident fulfils the PSII criteria. The Hospitals Patient Safety Panel is chaired by the Director of Clinical Services and Quality and the Medical Director (MAC Chair).

In circumstances when it is not immediately clear if the incident meets the criteria for a patient safety incident investigation (PSII), as defined in the agreed patient safety incident response plan, the Patient Safety /Clinical Governance team. The Patient Safety /Governance team will undertake an initial review of the incident, liaise with the relevant clinical staff, gather further information and complete an incident review and escalation form (Appendix C) to be presented at the Patient Safety Panel.

When potential patient safety incidents are identified through the complaints, clinical negligence or inquest process the Director of Clinical services and Quality will complete an incident review and escalation form for discussion and consideration at the Patient Safety Panel.

The Patient Safety Panel will be responsible for identifying any themes and emergent issues in relation to patient safety matters.

Any incident highlighted will follow the process outlined below which can be seen in diagram form in on Page 14.

Local level incidents – 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. or. 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 Hospital policy.

Incidents with positive or unclear potential for 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 practicable after the event via the Hospital's emergency cascade process to include safety huddle, log of incident etc. Duty of Candour disclosure should take place according to Hospital guidance. Where it is clear that a PSII is required (for example, for a Never Event) the Director of Clinical Services and Quality should notify as soon as possible the Exec Team and the Patient Safety/Governance team as soon as practicable so that the incident can be shared. The incident will be escalated to the Hospital Patient Safety Panel. A rapid review will be undertaken to inform decision making.

Other incidents with unclear potential for PSII, must also be reported to the Patient Safety team. Decision making with regard to escalation to the Hospital Patient Safety Team. A rapid review will be undertaken to inform this decision making. Significant incidents which may require consideration for ad-hoc PSII due to an unexpected level of risk and/or potential for learning should be included in this category.

The Hospital Patient Safety panel will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), 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 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.

Where an incident does not meet the requirement for PSII, the Hospital Patient Safety panel may request a patient safety review (PSR) or closure of the incident at a local level, with due consideration of any Duty of Candour requirement being met. It will be at the panel's discretion in such circumstances to specify a particular tool is used to complete a PSR. The Hospital Patient Safety panel will also indicate how immediate learning is to be shared. All incidents will be reviewed by the Incident Review Group which is inter-departmental and multi-disciplinary group. This group will be re-named the Patient Safety Group.

Incidents requiring possible patient safety review (PSR) – all staff (directly or through their line manager) must ensure notification of incidents that may require a patient safety review response as soon as practicable after the event through the hospitals escalation processes and this must include the Patient Safety/Governance team. A rapid review will be undertaken to inform decision making following this.

The Patient Safety Panel will meet at the earliest opportunity to discuss the nature of the incident, immediate learning (which should share via an appropriate platform), any mitigation that is needed to prevent recurrence and whether the Duty of Candour requirement has been met.

Where it is clear that a PSII is not required, the Patient Safety Panel will consider any incident as having potential for PSR. The tool to be utilised for the review will be specified and a suitable member of the Patient Safety/Governance team will undertake the review. This will not be any staff involved in the incident or by those who directly manage the staff. There will be clear records maintained regarding this decision-making process.

All safety panel arrangements will include the recording of safety action arising from any PSR or other learning response and these details will be used to inform potential safety improvement plans

The Patient Safety Team will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the CQC according to accepted reporting requirements. Whilst this will include some incidents escalated as PSII, the Patient Safety team will work with the departments to have effective processes in place to ensure that any incidents meeting external reporting needs are appropriately escalated.

c) Responding to cross-system incidents/issues

If more than one organisation is involved in the care and service delivery in which a patient safety incident has occurred, the organisation that identifies the incident is responsible for recognising the need to alert relevant stakeholders to initiate discussions about subsequent investigation and action. All relevant stakeholders involved should work together to undertake one single investigation wherever this is possible and appropriate. The integrated care system should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process.

d) Timeframes for learning responses

The Hospital will aim to complete all PSII within 60 working days of the PSII being confirmed. No PSII take longer than six months to complete (in line with national guidance.

Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the PSII leads should work with all the information they have to complete the response

to the best of their ability; it may be revisited later should new information indicate the need for further investigative activity.

In rare and exceptional circumstances where there is an external investigation into a patient safety incident; for example, police or Healthcare Safety Investigation Branch, the Hospital's PSII will not commence until permission from the external agency has been granted.

e) Safety improvement plans

All learning from PSII will be recorded on a safety action summary table in the PSII report.

A SMART approach to action planning is essential. That is, the actions should be: Specific, Measurable, Attainable, Relevant and Time-bound.

f) Safety action development and monitoring improvement

Where the learning from patient safety incident responses identifies the need for safety improvements these will be recorded on the Hospital's patient safety software and monitored through the Hospital's governance framework for implementation, sustainability and effectiveness.

All safety improvements will consider health inequalities and any disproportionate risk to patients with specific characteristics.

g) Complaints and appeals

Any patient/carer/family member complaints related to the Hospital's patient safety incident response process should be made through the Hospital's formal complaints process.

8. Roles and responsibilities

Medical Director (MAC Chair) and Director of Clinical Services and Quality

- To provide Executive lead and oversight
- To ensure that the hospital meets the national requirements
- To ensure that PSIRF is central to the Hospitals governance arrangements and framework
- To provide quality assurance and oversight of learning response outputs
- To be compliant with PSIRF training requirements

Heads of Departments

- To ensure this policy and the plan are implemented within their areas of responsibility
- To report and escalate patient safety incidents
- To share the leaning form response output
- To ensure action is taken to implement recommendations
- To ensure staff are compliant 8 with all training requirements

9. Training and resource

The Hospital has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.
Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses

- Induction – all staff will be made aware of how to access policies and how to report patient safety incidents
- Departmental induction - On their detailed induction into their department all staff will receive induction on the incident reporting process . it is the responsibility of managers to make sure this happens and that there is compliance with this policy.

The following training will need to be undertaken

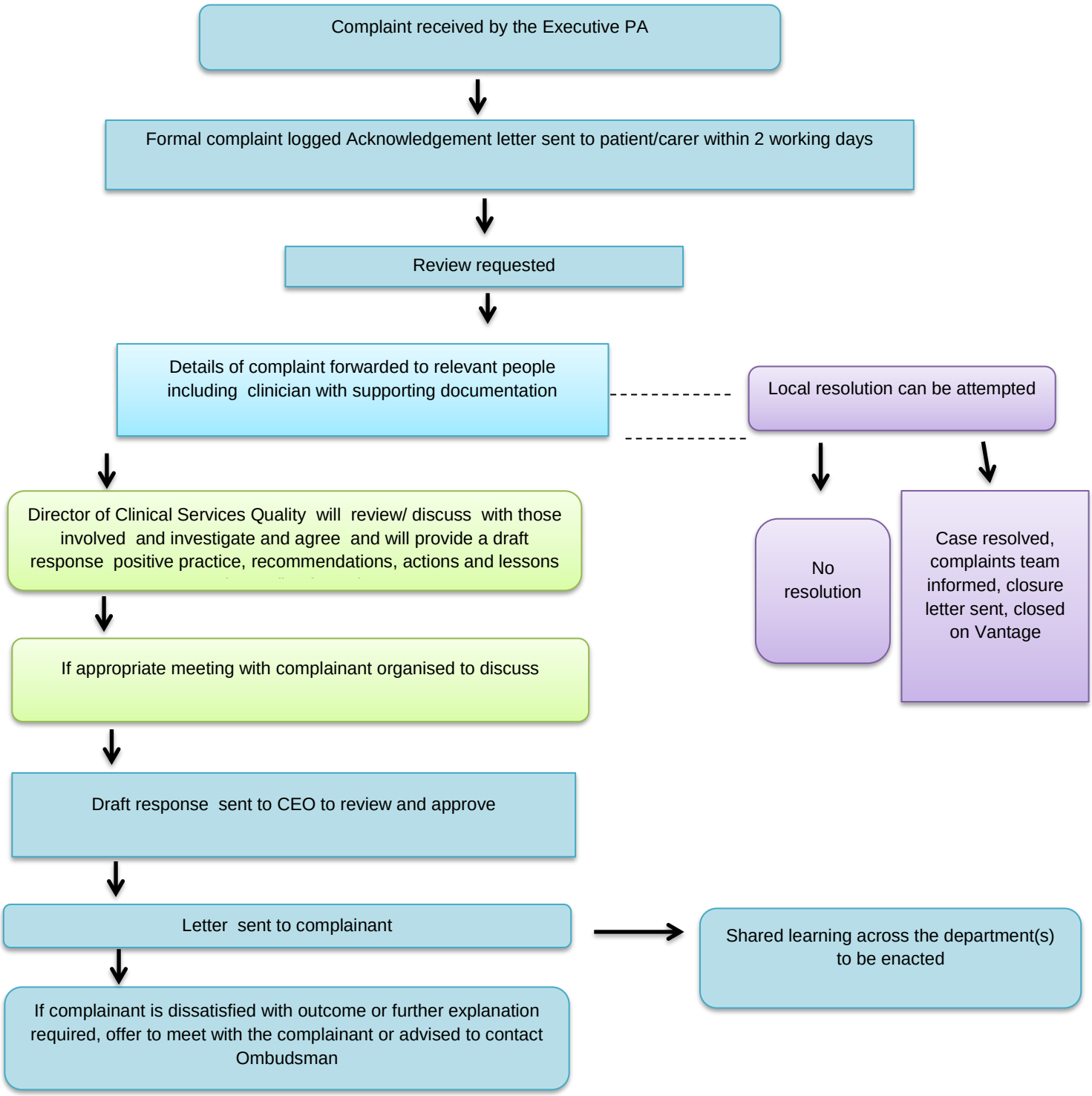
PSIRF Training Requirement	FIH roles
Completion of Level 1 and 2 patient safety syllabus	CEO Director of Hospital Services Director of Clinical Services and Quality MAC Chair
At least two days formal training	MAC chair Director of Hospital Services Director of Clinical Services and Quality

	Clinical governance assistant
Completion of level 1 training (will become mandatory)	All managers All clinical staff

10. Monitoring and Audit

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individual/ group/committee	Frequency of monitoring	Responsible individual/group /committee for review of results	Responsible individual /group for development of action plan	Responsible individual/ group for monitoring action plan
PS11 are completed with 60 days	audit	Patient Safety team	Quarterly	Patient Safety Panel	Patient Safety Team	IGC
PSIRP reviewed in line with policy	Report to IGC /Board	Director of Clinical Services and Quality	12-18 months	IGC	IGC	IGC
Review of PSIRF	Review and audit	Patient Safety Panel	4 yearly	Patient Safety Panel	Patient Safety Panel	Patient Safety Panel

The flow chart below outlines the process for the management of a clinical complaint.



11. Learning From Patient Safety Events

The Learn from Patient Safety Events (LFPSE) service is a 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.

LFPSE initially provides two main services:

- **Record a patient safety event** – organisations, staff and patients will be able to record the details of patient safety events, contributing to a national NHS wide data source to support learning and improvement.

- **Access data about recorded patient safety events** – providers can access data that has been submitted by their teams, in order to better understand their local recording practices and culture, and to support local safety improvement work.

Recording patient safety events, whether they result in harm or not, provides vital insight into what can go wrong in healthcare and the reasons why.

At a national level, this allows for new or under-recognised safety issues to be quickly identified and acted upon on an NHS-wide scale, ensuring providers across the country take action to reduce the risk.

It also provides a wealth of data offering essential insight to support ongoing national patient safety improvement programmes, as well as improvement work at a more local or speciality-specific level.

It is very important, in a small organisation like Fairfield, that a range of staff involved in patient safety issues have access to the LFPSE portal in order to inform learning and to see what other safety improvement measures other 'like' organisations are putting in place. Sharing patient safety information across the health community is vital.

Executive Directors will have access to the LFPSE portal and will be responsible for reporting all Patient Safety Events.

Appendix A

Level 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.

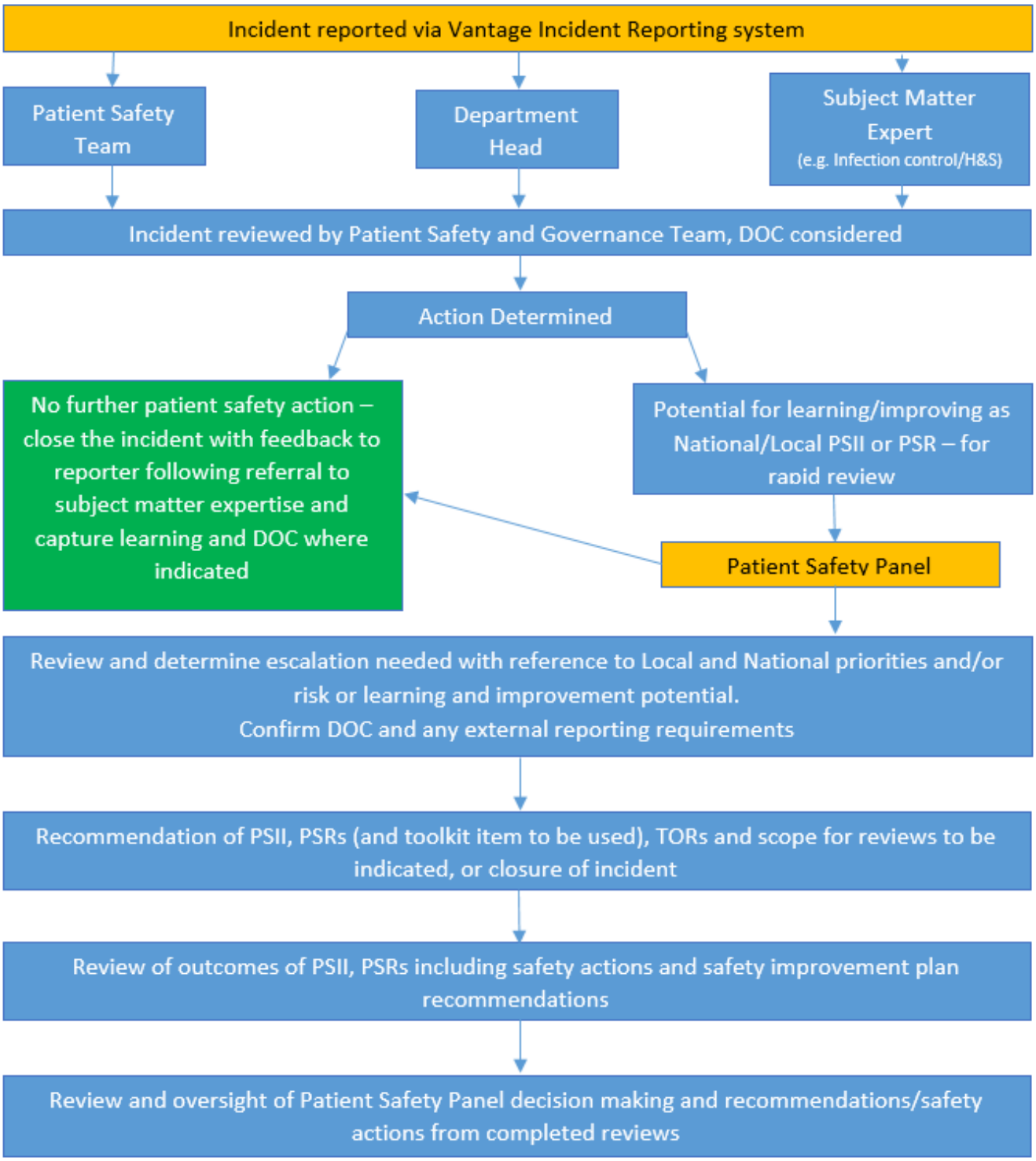
Low harm - Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care.

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 B


Incident reported via Vantage Incident Reporting system
Patient Safety Team
Department Head
Subject Matter Expert
(e.g. Infection control/H&S)
Incident reviewed by Patient Safety and Governance Team, DOC considered
Action Determined
No further patient safety action – close the incident with feedback to reporter following referral to subject matter expertise and capture learning and DOC where indicated
Potential for learning/improving as National/Local PSII or PSR – for rapid review
Patient Safety Panel
Review and determine escalation needed with reference to Local and National priorities and/or risk or learning and improvement potential.
Confirm DOC and any external reporting requirements
Recommendation of PSII, PSRs (and toolkit item to be used), TORs and scope for reviews to be indicated, or closure of incident
Review of outcomes of PSII, PSRs including safety actions and safety improvement plan recommendations
Review and oversight of Patient Safety Panel decision making and recommendations/safety actions from completed reviews

Appendix C

PSII Rapid Review Document

Guidance notes

1. In all cases, sections 1, 2 and 3 **MUST** be completed for the purposes of review of patient safety incidents potentially requiring PSII. For any fields that are not applicable/relevant for the division or incident please have a clear audit trail of the rationale to support N/A response.

2. For purpose of anonymity/to assist external reporting, name of patient, relative or staff is not to be included in the report. Initials should be used, or job titles for staff members (role and grade).

3. The completed report must be uploaded to the corresponding Vantage incident report.

4. Any acronyms should be explained, and report should be easy to read/understand; in exceptional circumstances the report may be disclosed externally, with prior approval.

5. Do not include unnecessary text, always summarise, particularly in relation to details of the incident, service user profile and chronology.

6. Retain any additional documents/appendices.

NB: Sections 1 to 3 must be fully completed for the Rapid Review

SECTION 1 – Incident details					
Vantage Incident No.		Division/Team:			
Incident location:		Team Leader:		Incident type:	
Incident date:		Date reported:		Patient Safety Panel review date:	
Incident Description:	.				

Completed by:					
Name:		Designation:			
Tel:		E-mail:		Date:	

SECTION 2 - Service user/patient profile			
FIH No.		Service:	
Date of birth:		Gender:	
Ethnicity:			
Diagnosis:		Medications/Allergies	
Current treatment:		Responsible clinician:	
Level of harm to patient:		Near miss:	Yes / No
Mental state (if applicable):		Level of harm to "other":	

SECTION 3 – Incident Summary: situation/background/assessment/recommendations (SBAR)

Situation information - examples/required:

- Current status of patient / management plan
- Age, significant past medical history
- Synopsis of history on caseload

Details:

Background information - example/required:

- Description of circumstances leading to detection of the incident.

Details:

Assessment information - examples/required:

- Details of care plans implemented with review dates.
- Immediate actions put in place to ensure safety.
- Confirm safety plan and risk assessment in place.
- Risk assessment - date completed, reviewed, outcome.
- Specific assessments required or undertaken
- Summary of equipment used – category, date ordered, delivered, compliance.
- Clinical observations such as NEWS2 / investigations.

Details:

Recommendation information - examples/required:

- Immediate actions taken to maintain safety and manage the incident
- Advice given to patient

Details:

RETURN COMPLETED REPORT TO DIRECTOR OF CLINICAL SERVICES AND QUALITY IN PREPARATION FOR PATIENT SAFETY PANEL (SEE SECTIONS 4 & 5 BELOW)

<table>
<tr><td colspan="3">SECTION 4 – Outcome from Patient Safety panel meeting

COMPLETE AT PANEL MEETING</td></tr>
<tr><td>Present at Panel meeting:</td><td colspan="2">Please include nominated Chair for the meeting</td></tr>
<tr><td>Summary of discussion at Panel meeting
Key question
Is this incident suitable for PSII ?</td><td colspan="2"></td></tr>
<tr><td rowspan="3">Check if DOC disclosure required / completed?
(when/how/by whom)</td><td rowspan="3"><u>Notifiable incident?</u>
Unintended or Unexpected arising in the course of a regulated activity (care or treatment provided) ☒
Occurred during provision of regulated activity ☒
Has (or might) result in moderate or greater harm (including prolonged psychological harm) ☒</td><td><u>DOC disclosure completed?</u>
Yes/No

Give Date: dd/mm/yyyy</td></tr>
<tr><td>How DOC Disclosure completed?</td></tr>
<tr><td>Who completed DOC disclosure?
Name:
Designation:</td></tr>
<tr><td>Patient/s/family/carers informed</td><td colspan="2">Give details:</td></tr>
</table>

Decision Making

Refer to Hospital Patient Safety Panel			Patient Safety Review	Incident closure
1. Incident meets national priority for escalation as PSII	**2. Incident meets local priority for escalation as PSII**	**3. Incident may meet criteria for ad-hoc PSII**	**4. Incident meets PSR criteria**	**5. Incident may be approved with local response**
☐ ***National*** priority to be referred for PSII/review by **another team**, please specify: ☐ ***National*** priority incident requiring local PSII, please specify: (eg 'Never Event')	☐ ***Local*** priority incident requiring local PSII, please specify:	☐ ***Emergent*** patient safety risk or incident with learning and improvement potential possibly requiring ad-hoc local PSII, please specify	☐ Learning and improvement to be captured by PSR Select toolkit item to be used: ☐ **Swarm (Huddle)** specify team/s to be involved: ☐ **After Action Review**, specify teams/s to be involved: ☐ **Thematic review**, please specify scope:	☐ Incident not for further review, give rationale:

Incident for closure Please capture any relevant learning and refer to relevant improvement plan holder	Immediate and short-term actions / learning - Medium to long term actions / learning –
Incident meets PSR criteria	Please suggest any key lines of enquiry to be added to the toolkit item selected:
Incident meets national priority for escalation as PSII (1)	Please indicate other agency to be referred to and whether this has been completed – enter details in external links section

Incident meets national priority for escalation as PSII (2)	Please consider if specific notification outside of organisation is required and whether this has been completed – enter details in external links section
Incident meets local priority for escalation as PSII (3)	
Incident may meet local priority for escalation as PSII (4)	
Designated family liaison officer identified for duration of incident investigation:	
Confirm, is family liaison support required and in place?	

Internal links

Internally reportable to another Department?	Yes / No	**Internally reported to:**	
Patient Safety team alerted	Yes / No		
Other Internal Links:			
Necessity to remove/ restrict staff from normal tasks and details? Workforce aware?			

External links

Externally reportable?	Yes / No	**Externally reported to:**	
Media Interest?	Yes / No	**Board informed?**	Yes / No
Other External Links: e.g. multiagency, Police and/or HSE, Coroners Inquest, CQC involvement			

References

NHS England (2021) Core20PLUS5: An Approach to Reducing Health Inequalities

core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)

NHS England (2022) Patient safety incident response standards

B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)

NHS England (2022) Safety action development guide

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Equality Impact Assessment (EIA) Screening Tool
(Towards an Equality and Recovery Focused Organisation)

A. Name of policy/procedure/strategy/plan/function etc. being assessed:	Patient Safety Incident Response Framework Policy
B. Brief description of policy/procedure/strategy/plan/function etc. and reason for EIA:	Supports the requirements of the PSIRF and sets out how we will approach the development and maintenance of effective systems and processes for responding to patient safety incidents
C. Names and designation of author / reviewer	Stephen Smith Director of Hospital Services
D. List of key groups/organisations consulted:	Heads of Departments, Board of Trustees, ICB and approved at IGC
E. Data, Intelligence and Evidence used to conduct the screening exercise.	None based on previous policy in place

F. Equality Strand	**Does the proposed policy/procedure/strategy/plan/function etc. have a positive or negative (adverse) impact on people from these key equality groups? Please describe**	**Are there any changes that could be made to the proposals which would minimise any adverse impact identified? What changes can be made to ensure that a positive impact is achieved? Please describe**	**Have any mitigating circumstances been identified? Please describe**	**Areas for Review/Actions Taken (with timescales and name of responsible officer)**
Race	There is no impact on Race as the policy applies to all employees and clinicians who have practising rights at FIH	N/A	N/A	N/A
Gender Include Transgender and Pregnancy and Maternity	As Race	N/A	N/A	N/A
Disability	As Race	N/A	N/A	N/A
Religion/Belief	As Race	N/A	N/A	N/A

Sexual Orientation Include Marriage & Civil Partnership	As Race	N/A	N/A	N/A
Age	As Race	N/A	N/A	N/A
Social Inclusion[*1]	As Race	N/A	N/A	N/A
Community Cohesion[*2]	As Race	N/A	N/A	N/A
Human Rights[*3]	As Race	N/A	N/A	N/A

[*1] **for Social Inclusion** please consider any issues which contribute to or act as barriers, resulting in people being excluded from society e.g. homelessness, unemployment, poor educational outcomes, health inequalities, poverty etc.

[*2] **Community Cohesion** essential means ensuring that people from different groups and communities interact with each other and do not exclusively live parallel lives. Actions which you may consider, where appropriate, could include ensuring that people with disabilities and non-disabled people interact, or that people from different areas of the City or County have the chance to meet, discuss issues and are given the opportunity to learn from and understand each other.

[*3] **The Human Rights Act 1998** prevents discrimination in the enjoyment of a set of fundamental human rights including: The Right to a Fair Trial; Freedom of Thought, Conscience and Religion; Freedom of Expression; Freedom of Assembly and Association; and the Right to Education.

Conclusions and Further Action (including whether a full EIA is deemed necessary and agreed date for completion)	Based on the Hospitals EIA screening tool there is no further action required for this policy

Project/Policy/Procedure Title: Patient Safety Incident Response Framework Policy

Project Lead: CEO Date: 06/10/2023

Question		Yes	No	Unsure	Comments
1	Are privacy-intrusive[1] technologies being used?		NO		
2	Are new and untested technologies being used?		NO		
3	Are the purposes of data processing unclear?		NO		
4	What is the lawful basis for processing data?				N/A
5	Are new or substantially different identification authentication requirements needed?		NO		
6	Will there be a significant amount of new data about each person, or a significant change in the current data-holdings?		NO		
7	Will there be new data about a significant number of people?		NO		
8	Will there be a new link of personal data with another data-holding?		NO		
9	Are the data collection procedures new, changed, unclear or intrusive?		NO		

[1] Intrusion can come in the form of collection of excessive personal information, disclosure of personal information without consent and misuse of such information. It can include the collection of information through surveillance or monitoring of how people act in public or private spaces and through the monitoring of communications whether by post, phone or online and extends to monitoring the records of senders and recipients as well as the content of messages.

10	Will there be a new or changed data quality process?		NO		
11	Will there be new or changed data security arrangements?		NO		
12	Are there new or changed data access or disclosure arrangements?		NO		
13	Are there new or changed data retention arrangements?		NO		
14	Has any external data sharing been identified on the departments data flow map?		NO		
15	Is the personal data likely to raise privacy concerns with the individuals? e.g. health records, criminal records		NO		
16	Is there any use of highly sensitive or biometric data? e.g. protected characteristics or finger print recognition		NO		
17	Will personal data be disclosed to organisations or people who have not previously had access to the data?		NO		
18	Will data collection and processing result in automated decision making which will have a significant impact on the individuals concerned?		NO		
19	Will individuals be compelled to provide information about themselves?		NO		
20	Is there a contract or data sharing agreement in place with all third parties?		NO		