Patient Safety Incident Response Policy

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What is in this policy?

This policy supports the requirements of NHS England's Patient Safety Incident Response Framework (PSIRF) and sets out University Hospitals Bristol and Weston NHS Foundation Trust's (the Trust) 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. It should be read in conjunction with the Trust's Patient Safety Incident Response Plan.

This policy describes the framework for delivering the Trust's Patient Safety Incident Response Plan and sets out the responsibilities for all staff, individuals in specific roles and designated groups relating to recording, responding to, and learning from patient safety incidents and feeding this into improvement work to reduce risk or address gaps in systems designed to keep people safer.

This policy replaces the previous Serious Incident Policy, Incident Management Policy and associated documents.

Document Change Control				
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March 2023	0.1	Associate Director of Quality and Patient Safety	Major	New Policy. This replaces the previous Serious Incident Policy, Incident Management Policy and associated documents.
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- **Stakeholder Group** can include any group that has been consulted over the content or requirement for this policy.
- **Steering Group** can include any meeting of professionals who has been involved in agreeing specific content relating to this policy.
- **Other Groups** include any meetings consulted over this policy.
- **Policy Assurance Group** must agree this document before it is sent to the **Approval Authority** for final sign off before upload to the DMS.

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Do I need to read this Policy?

1. Introduction

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out University Hospitals Bristol and Weston's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

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

NHS England set out responsibilities for healthcare providers and those in oversight roles under PSIRF in their Patient Safety Incident Response Standards document which are reflected in this policy.

2. Purpose

This policy aims to provide a clear framework for all staff, individuals in specific roles and designated groups relating to recording, responding to and learning from patient safety incidents and feeding this into improvement work to reduce risk or address gaps in systems designed to keep people safer.

The PSIRF recognises that there are a range of recognised learning responses that can be deployed proportionately in relation to identified risk following identification of a patient safety incident. This policy includes the decision-making process for considered and proportionate responses and should be read in conjunction with our Patient Safety Incident Response Plan.

3. Scope

This policy relates to all permanent and temporary employees, volunteers, agencies and agency staff working for and on behalf of the Trust. This includes staff whose role does not involve direct care delivery because staff in such roles will use or be involved with systems that support the delivery of safe care.

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all UHBW services. Information Governance and Health and Safety incidents are also recorded on Datix and undergo a local manager's review. Some Information Governance and Health and Safety incidents also meet the definition of a patient

safety incident. Such incidents should be managed under this policy alongside responses specified in the separate policy documents referenced in section 9.

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 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, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The main 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.

4. Definitions

4.1 Patient safety incident

A patient safety incident is any unintended or unexpected event (including omissions) in healthcare that could have or did harm one or more patients. This includes incidents related to direct care delivery and incidents relating to work systems that support care delivery. The incident may occur due to something that happened, or something that did not happen and may or may not cause harm.

4.2 Manager's local incident review and response

This is the initial review and learning response to all incidents recorded within a manager, clinical specialist or consultant's area of responsibility as designated by divsions via notifications of the incident via the Datix local risk management system. Please see UHBW Incident Recording and Management SOP.

4.3 Work system

A work system comprises various components or inputs that interact with each other during a process for the purpose of delivering an intended outcome e.g., the delivery of safe and effective care with a good patient/family experience. A work system can include tools and technology, people, physical environments, external environments (such as regulation, societal and economic environments) and organisational factors (such as structures, culture, training, work schedules, resource availability).

4.4 Near miss

A near miss is an incident that very nearly happened that could have resulted in harm but did not do so due to chance, corrective action and/or timely intervention.

4.5 Never Event

Never Events are defined in NHS England's policy as certain types of incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. NHS England maintains a list of incidents that are defined as never events on their website.

4.6 Incident of concern

An incident of concern is an incident that does not meet the criteria for an enhanced learning response in the Patient Safety Incident Response Plan but does warrant consideration for an enhanced learning response via a Rapid Incident Review based on the criteria outlined in section 6.7 of this policy.

4.7 Incident leading to death thought more likely than not due to problems in care

An Incident leading to death thought more likely than not due to problems in care is one that meets learning from deaths criteria for a patient safety incident investigation. More details are provided in section 6.8 of this policy and the Learning from Deaths Policy.

4.8 Patient Safety Incident Response Plan

The Trust's Patient Safety Incident Response Plan sets out the priorities for implementing PSIRF. It identifies the key patient safety risks that justify an enhanced learning response as part of a planning a considered and proportionate approach required by PSIRF, as well as outlining learning responses for other types of incidents. The plan is to be refreshed every 18 to 24 months.

4.9 Work as imagined and work as done

The definitions of "work as imagined" and "work as done" are important to consider the gap between how we think work is done (work as imagined) and how work is really done (work as done), recognising that adjustments and trade-offs are a normal part of everyday work.

4.10 Enhanced Learning Response

A learning response is a broad term for a number of ways organisations can respond proportionately to recorded patient safety incidents for the purposes of learning and improvement. Managers/supervisors will still undertake the initial response to incidents recorded in their area, but a small proportion of incidents will be subject to an enhanced learning response as outlined in the Patient Safety Incident Response Plan. There are four nationally recognised enhanced learning responses in PSIRF : a patient safety incident investigation or thematic review, a

Swarm Huddle, an after action review and a multi-disciplinary (MDT) review, which are described in our Patient Safety Incident Response Plan.

4.11 Emerging risk

An emerging risk is a risk not previously recognised that is identified from sources of quality and patient safety data including recorded incidents. These will be responded to as outlined in the Patient Safety Incident Response Plan. The complexity of healthcare systems means emergent properties and risks cannot always be predicted.

4.12 Patient Safety Specialist

The national Patient Safety Strategy for England requires NHS Trusts to have one or more identified Patient Safety Specialists. Patient Safety Specialists are individuals in healthcare organisations who have been designated to provide dynamic senior patient safety leadership. Patient Safety Specialists provide expert support to their organisation through direct access to their executive team, which facilitates the escalation of patient safety issues or concerns. They also play a key role in the development of a patient safety culture, safety systems and improvement activity.

(Further information on the role of Patient Safety Specialists and be found on the NHS England website.)

4.13 Learning Response Lead

Learning response leads are staff with additional PSIRF learning response training in identified patient safety roles. In UHBW learning response leads are:

- Divisional and corporate patient safety team members Band 6 and above
- Doctor patient safety leads in divisions.

4.14 Oversight role

Oversight roles are those in provider organisations and Integrated Care Boards with responsibility for designing systems for patient safety oversight in a way that demonstrates improvement, rather than compliance with prescriptive, centrally mandated measures. To achieve this, organisations must look carefully not only at what they need to improve but also what they need to stop doing. Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control. In UHBW, oversight roles are:

- Chief Medical Officer
- Chief Nurse and Midwife
- Deputy Chief Nurses
- Associate Medical Director for Patient Safety
- Associate Director of Quality and Patient Safety
- Head of Patient Safety

- Non-Executive Director Chair of Quality and Outcomes Committee

4.15 Engagement lead role

Engagement leads are responsible for compassionate engagement and meaningful involvement of those affected by patient safety incidents. This includes those leading learning responses. In UHBW engagement lead roles are:

- Associate Medical Director for Patient Safety
- Associate Director of Quality and Patient Safety
- Head of Patient Safety
- Expert Patient Safety Investigators
- Divisional Patient Safety Team members
- Doctor divisional patient safety leads

4.16 Rapid Incident Review

A Rapid Incident Review is a meeting that takes place within a week after an incident occurs that meets the screening criteria as set out in this policy. The purpose of the meeting is to confirm incidents that meet the criteria for an enhanced learning response set out in the Patient Safety Incident Response Plan, and to consider other incidents of concern escalated from divisions. (See Rapid Incident Review Standard Operating Procedure)

4.17 Patient safety incident investigation (PSII)

A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Patient Safety Incident investigations (PSIIs) are conducted solely for the purpose of systems-based learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected factors that may appear to be precursors to patient safety incidents.

Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

4.18 After Action Review (AAR)

An After Action Review (AAR) is one type of recognised learning response to a patient safety incident under the PSIRF. It should ideally be completed within two weeks of the incident being identified. It is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future. (See After Action Review Standard Operating Procedure)

4.19 Swarm Huddle

Swarm Huddles are another type of recognised learning response to a patient safety incident under the PSIRF. They are used to identify learning from patient safety incidents and are designed to start as soon as possible after a patient safety incident occurs and prior to those involved finishing their shift. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. Swarms enable insights and reflections to be quickly sought and generate prompt learning. (See Swarm Huddle Standard Operating Procedure)

4.20 Mortality and Morbidity meeting

The Trust's existing Mortality and Morbidity meetings are the fora for a Multidisciplinary Team (MDT) incident learning response as defined in PSIRF . This Mortality and Morbidity meeting will include a retrospective review of an incident(s) to support healthcare teams to:

- Identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents)
- Agree, through open discussion, the key factors and system gaps in patient safety incidents for which it is more difficult to collect staff recollections of events either because of the passage of time or staff availability.
- Explore a safety theme, pathway, or process
- Gain insight into 'work as done' in a healthcare system.

(See Mortality and Morbidity Standard Operating Procedure)

Incidents should be reviewed at an existing or specifically convened Mortality and Morbidity meeting within four months of the need being identified.

4.21 Local risk management system (Datix)

UHBW's local risk management system at the time of writing this policy is called Datix. Datix is the system we use for recording incidents and all staff can record incidents on any networked device. Staff that respond to recorded incidents require log-in access and this can be obtained by contacting Datix.support@uhbw.nhs.uk. Training on using the Datix system can be found on the Datix Connect pages.

5. Duties, Roles and Responsibilities

5.1 All staff

All staff are expected to:

(a) Record an incident using the Datix system (or if they do not have access to a networked device inform the person in charge of the work area of the incident) as soon as possible after it has been identified, ideally on the same day or same shift.

(b) Contribute to or participate in learning responses to patient safety incidents in your work area/specialty/field of expertise.

(c) Respond to colleagues involved in incidents with kindness and compassion and in line with a Just and Restorative Culture

(d) Receive offers of well-being support if they have been adversely affected by a patient safety incident.

(e) Participate in patient safety education and development relevant to their role as identified in the patient safety training matrices (Appendix 1)

5.2 Person in charge of a ward or department

In addition to the expectations for all staff, the person in charge of the ward or department at the time an incident happens is expected to:

(a) Ensure the immediate safety of those involved in the incident (patients, family, visitors, staff) and respond to their initial well-being needs

(b) If relevant, ensure any immediate safety actions to reduce the risk of a similar incident are taken

(c) Seek help and support from a senior colleague or clinical site manager if required.

(d) Quarantine any equipment, disposables or items involved in the incident in case required to inform an investigation or learning response.

(e) Lead a Swarm Huddle on shift in the absence of a patient safety team member for certain incidents as specified in the Patient Safety Incident Response Plan (See Swarm Huddle Standard Operating Procedure). In addition, staff can choose to undertake a Swarm Huddle for any patient safety incident as a local initial learning response.

5.3 Ward and department managers and senior clinicians/managers

In addition to the expectations for all staff and the person in charge, ward and department managers in clinical and non-clinical areas and senior clinicians and managers are expected to:

(a) Ensure the manager's local incident review and response is completed within the timescales as set out in the UHBW Incident Recording and Manager's Review SOP

(b) Ensure that acknowledgement, thanks and feedback are given to the person who recorded the incident, ideally in person.

(c) Check in with those involved in the incident and ensure access to any further well-being support is provided, including any local de-briefing sessions.

(d) Ensure that initial learning from the incident is shared with the ward/department team e.g., at the daily safety brief/team brief and the incident is closed within 30 days of it being recorded on Datix; unless there is to be a more structured

investigation or learning response that will take longer in line with this policy and the Patient Safety Incident Response Plan.

(e) Support team members to lead Swarm Huddles in the absence of a patient safety team member and ensure they are an embedded learning response within their ward/department and provide leadership and support to ensure these are carried out effectively immediately after a relevant incident.

(f) Where relevant, facilitate team members to participate in a Rapid Incident Review screening process.

(g) When relevant, facilitate team members to participate in a more structured investigation or local learning response (if there is to be one) such as:

- Holding an After Action Review in the work area
- Participating in incident reviews at Mortality and Morbidity meetings
- Contributing to a patient safety incident investigation

5.4 Consultant medical staff, Staff Grade, Associate Specialist and Specialty Doctor, senior doctors in training (ST3 upwards)

In addition to the expectations for all staff, consultant medical staff and Staff Grade, Associate Specialist and Specialty Doctor, senior doctors in training (ST3 upwards) are expected to:

(a) Ensure that acknowledgement, thanks and feedback are given to the person who recorded the incident, ideally in person.

(b) Check in with those involved in the incident and ensure access to any further well-being support is provided, including any local de-briefing sessions.

(c) Ensure that initial learning from the incident is shared with the specialist team pending a more structured investigation or learning response if there is to be one.

(d) Where relevant, facilitate team members to participate in a Rapid Incident Review screening process.

(e) When relevant, facilitate team members to participate in a more structured investigation or local learning response (if there is to be one) such as:

- Holding an After Action Review in the work area
- Lead or participate in a Swarm Huddle
- Lead or participate in incident reviews at Mortality and Morbidity meetings
- Contributing to a patient safety incident investigation

5.5 Trust wide subject matter experts and specialist leads

(e.g. leads for falls, dementia, tissue viability, safeguarding, learning disabilities and autism, infection prevention and control, medicines, medical equipment, digital specialists, clinical specialists etc)

In addition to expectations for all staff, Trust wide subject matter experts and specialist leads are expected to:

(a) Support learning responses by provision of expert specialist advice and participation in After Action Reviews and incident reviews at Mortality and Morbidity meetings and contributing to patient safety incident investigations.

(b) Undertake thematic analysis of recorded incidents and other forms of quality intelligence related to their specialist area of expertise and identify and take forward quality improvement work in their specialist area.

(c) Ensure incidents are reported to external bodies relevant to their scope of practice as shown in Appendix 3.

5.6 Divisional patient safety teams/Weston General Hospital patient safety team

In addition to expectations for all staff, divisional patient safety team members are expected to:

(a) Act as learning response leads as defined in PSIRF for the services provided by the division.

(b) Review recorded incidents in their division each working day and be responsible for escalating any incidents of concern to the central patient safety team that do not meet the automatic criteria for a Rapid Incident Review (see section 6)

(c) Be responsible for ensuring the Rapid Incident Review screening process is operated effectively and within one week of a recorded incident for incidents within their division.

(d) Be responsible for ensuring that local learning responses (Swarm Huddles, After Action Reviews, incident reviews at Mortality and Morbidity meetings) occur in their division in accordance with this policy and the Patient Safety Incident Response Plan and that learning and improvement actions are captured and recorded on Datix.

(e) Liaise with the corporate patient safety team in supporting patients, families, and staff involved in incidents undergoing a patient safety incident investigation to ensure a joined-up approach for patients, families and staff involved in incidents subject to a patient safety incident investigation.

(f) Act as After Action Review conductors across all divisions after receipt of training in this role

(g) Be responsible for providing advice relating to this policy and the Patient Safety Incident Response Plan to clinical and operational teams.

(h) Be responsible for ensuring that divisional thematic analysis of incidents and assurance reporting is carried out in line with the standards in this policy and required by the PSIRF.

(i) Ensure new risks identified from recorded incidents are managed in accordance with the Risk Management Policy.

5.7 Divisional Boards/Weston General Hospital (WGH) Management Team

In addition to expectations for all staff, divisional board/WGH management team members are expected to:

(a) Formulate and deliver action plans in response to recommendations from (internal or external) patient safety incident investigations that are systems focussed, effective, realistic and resourced.

(b) Be responsible for ensuring quality improvement work to improve systems for keeping people safer is risk assessed and taken forward within the division in accordance with local prioritisation.

(c) Risk assess any actions/improvement work that cannot be prioritised and enter the risk on the divisional/hospital risk register.

(d) Ensure outcomes of investigations relevant to the division/hospital undertaken by external bodies under PISRF are responded to in a timely manner and learning is fed into divisional patient safety governance reporting and learning mechanisms.

(e) Be responsible for the effective operation of systems for sharing local learning from incidents within the division/hospital.

(f) Seek assurance that adherence to the standards outlined in this policy are being met with the division/hospital and take improvement action if required.

(g) Ensure collaboration with other divisions, system partners and external bodies by contributing to investigations or learning responses and working to improve safety systems.

(h) Undertake Essentials of Patient Safety for Boards and Senior Leaders e-learning as required by the national patient safety syllabus.

5.8 Corporate Patient Safety Team

In addition to expectations for all staff, the corporate patient safety team are expected to:

(a) Act as learning response leads and engagement leads as defined in PSIRF. This includes:

  (i) Conducting in-depth, systems-focussed patient safety investigations or thematic reviews in accordance with the Trust's Patient Safety Incident Response Plan and PSIRF standards and make recommendations to those with authority to act in response to the recommendations.

  (ii) Liaising with the divisional/hospital patient safety teams and in supporting patients, families, and staff involved in incidents undergoing a patient safety incident investigation to ensure a joined-up approach for patients, families and staff involved in incidents subject to a patient safety incident investigation.

  (iii) Ensuring NHS England's guidance for Engaging and involving patients, families and staff following a patient safety incident is effectively and

inclusively operated for the duration of each patient safety investigation or thematic review.

(iv) Collaborating with system partners and external bodies where patient safety incident investigations and learning responses involve other healthcare providers and/or external bodies.

(v) Liaising with UHBW teams responsible for other investigatory processes in accordance with the Standard Operating Procedure for Identifying Incidents from Complaints and the Link Between Incident Investigations and other Investigatory Procedures to ensure clarity of purpose and a joined-up approach for patients, families and staff involved in incidents subject to a patient safety incident investigation (see Appendix 2).

(vi) Acting as After Action Review conductors after receipt of training in this role

(vii) Providing patient safety advice and support about this policy and the Patient Safety Incident Response Plan

(viii) Being responsible for Trust level thematic analysis of incidents and assurance reporting in line with the standards in this policy and required by the PSIRF.

(ix) Escalating specific incidents of concern and significant new or emerging patient safety risks to the Associate Directors for Patient Safety (and Chief Nurse and Midwife and Chief Medical Officer if appropriate).

5.9 Head of Patient Safety

In addition to the expectations of all staff and the corporate patient safety team, the Head of Patient Safety is expected to:

(a) Ensure Patient Safety Partners are supported to carry out their role in full in accordance with the Patient Safety Partner Policy and are provided with training and development opportunities relevant to their role

(b) Ensure NHS England's guidance for Engaging and involving patients, families and staff following a patient safety incident is effectively and inclusively implemented across the Trust

(c) Act as a Patient Safety Specialist for the Trust. Please see section (5.10)

(d) Undertake Essentials of Patient Safety for Boards and Senior Leaders e-learning as required by PSIRF standards and the national patient safety syllabus

(e) Undertake patient safety training for those in learning response oversight roles as required in the PSIRF.

5.10 Associate Director for Quality and Patient Safety and Associate Medical Director for Patient Safety

In addition to the expectations for all staff and the corporate patient safety team, the Associate Director for Quality and Patient Safety and Associate Medical Director for Patient Safety are expected to:

(a) Act as Patient Safety Specialists for the Trust. This includes (but is not limited to):

(i) Developing a Just and Restorative Culture (see section 6.1)

(ii) Responsibility implementation of PSIRF and continuous improvement of the Trust's learning response mechanisms

(iii) Consistent and effective delivery of patient safety education and training in line with PSIRF and the national patient safety syllabus

(iv) Delivery of the Trust Patient Safety Improvement Programmes

(v) Working in the West of England Patient Safety Collaborative and with system partners to support system wide learning and improvement under PSIRF.

(b) Undertake Level 1 Essentials of Patient Safety and Essentials of Patient Safety for Boards and Senior Leaders e-learning as required by PSIRF standards and the national patient safety syllabus

(c) Undertake patient safety training for those in learning response oversight roles as required in the PSIRF shown in Appendix 1

(d) Take responsibility as delegated by the Chief Nurse and Midwife and Chief Medical Officer for provider oversight of PSIRF in NHS England's Oversight Roles and Responsibilities Specification (see section 5.10).

5.11 Chief Nurse & Midwife and Chief Medical Officer

The Chief Medical Officer is the appointed executive lead for patient safety and PSIRF. They, along with the Chief Nurse and Midwife, are responsible for provider oversight of PSIRF in NHS England's Oversight Roles and Responsibilities Specification This includes:

(a) Ensuring the Trust meets national patient safety incident response standards.

(b) Ensuring PSIRF is central to overarching safety governance arrangements.

(c) Quality assuring learning response outputs including signing off patient safety incident investigations.

They are also expected to:

(d) Undertake Level 1 Essentials of Patient Safety and Essentials of Patient Safety for Boards and Senior Leaders e-learning as required by PSIRF standards and the national patient safety syllabus

(e) Undertake patient safety training for those in learning response oversight roles as required in the PSIRF shown in Appendix 1.

5.12 Chair of the Quality and Outcomes Committee

The Chair of the Quality and Outcomes Committee is the identified Non-executive Director for patient safety and PSIRF and has an oversight role under PSIRF. They are responsible for seeking and receiving assurance that:

(a) The Trust meets national Patient Safety Incident Response Standards.

They are also expected to:

(b) Be familiar with the requirements for provider oversight of PSIRF in NHS England's Oversight Roles and Responsibilities Specification

(c) Undertake Level 1 Essentials of Patient Safety and Essentials of Patient Safety for Boards and Senior Leaders e-learning as required by PSIRF standards and the national patient safety syllabus

(d) Undertake patient safety training for those in learning response oversight roles as required in the PSIRF shown in Appendix 1

6. Policy Statement and Provisions

6.1 Our Patient Safety Culture

(a) Open and transparent recording of incidents

(i) Incident recording is actively encouraged in UHBW. It is expected that all staff will record incidents and near misses using the Datix system. Datix allows for incidents to be recorded anonymously if necessary.

(ii) The purpose of recording incidents is solely for learning and making system improvements to reduce risk (not for accountability, liability, avoidability or cause of death.)

(iii) Staff will be supported to raise patient safety concerns by any route they feel comfortable to do so, including via our Freedom to Speak Up Guardian. Patient safety concerns should initially be raised internally, in line with our Freedom to Speak Up Policy. If necessary, concerns can be raised with an external body such as the National Patient Safety Team at NHS England, HM Coroner, NHS Resolution, the CQC and the Medicines and Healthcare products Regulatory Agency.

(iv) We will develop our systems and process to record good care for the purposes of learning and sharing enabling factors that support good outcomes and good experiences of care.

(b) Openness with patients and families and Duty of Candour

(i) We will be open and transparent with patients and families when incidents have occurred leading to harm and offer a meaningful apology for what happened as set out in our Being Open (Duty of Candour) Policy.

(c) Responding to patient safety incidents. We will:

(i) Ensure the immediate safety and care needs of patients, families, staff and others are identified and met, including the offer of well-being support.

(ii) Respond to colleagues involved in incidents with kindness and compassion and in line with a Just and Restorative Culture is an expectation for all staff. This includes a default position of good intention unless proven otherwise.

(iii) Ensure responses to incidents do not undermine a just culture by requiring inappropriate automatic suspension of staff involved in patient safety incidents or their removal from business-as-usual activities.

(iv) Ensure that language, behaviours and processes used in learning responses remain systems focussed.

(v) Develop psychologically safe spaces for people to contribute their insights and experiences and to share their account of what happened for the purpose of learning and improvement.

(vi) Provide access to well-being support for those affected by patient safety incidents as outlined in the Trust's Respecting Everyone Policy and associated resources.

6.2 Patient Safety Partners

(a) The Trust has Patient Safety Partners who will be supported to work alongside staff, volunteers and patients, influencing and shaping the patient safety agenda both strategically and locally.

(b) Patient Safety Partners will be actively involved in the design of safer healthcare at all levels in the organisation. This includes roles in safety governance e.g., sitting on the Trust Patient Safety Group to support compliance monitoring and how safety issues should be addressed. This includes providing appropriate challenge to ensure learning and change and to contribute to the development and implementation of relevant strategy and policy.

(c) They also assist in the design and development of processes for engagement and involvement with those affected by patient safety incidents as part of a learning response.

(d) Further information about the role of Patient Safety Partners is in the Trust Patient Safety Partner Policy.

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

(a) 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).

(b) This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and ensure they are offered support as required.

(c) Our Being Open (Duty of Candour) Policy describes how we will be open and transparent with patients and families when an incident has happened and offer a meaningful apology.

(d) We will include staff and patients in development and testing of actions recommended in response to patient safety incidents

(e) Additional information about building on our existing mechanisms to engage and involve patients, families and staff following a patient safety incident, including with consideration of their different needs, will be in our "Patient, Family and Staff Engagement and Support Framework" which is being developed with our Patient Safety Partners and other stakeholders.

6.4 Patient safety incident response planning

(a) 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.

(b) Our Patient Safety Incident Response Plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. Developing the plan involves a detailed analysis to identify key patient safety risks, understand existing insights and improvement work as part of a considered and proportionate approach to responding to incidents.

(c) We will review the plan every 18 to 24 months to ensure our focus remains up to date. With ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 18 to 24 months.

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

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

(f) The corporate patient safety team includes expert patient safety incident investigators who meet the training and competence requirements set out in the national Patient Safety Incident Response Standards. Please see section 5.7.

(g) Divisional patient safety teams include people with the role of learning response leads as defined in PSIRF . Please see section 5.5.

(h) An initial cohort of After Actions Review (AAR) conductors in divisional and corporate patient safety teams have been trained to facilitate AARs in accordance with our Patient Safety Incident Response Plan. Training is being arranged for further cohorts of AAR conductors to enable wider adoption of this as a learning response. Trained AAR conductors are expected to work collaboratively and support AARs across all divisions. Please see sections 5.5 and 5.7.

(i) How we will demonstrate we are meeting the Patient Safety Incident Response standards is set out in Section 7.

6.5 Addressing health inequalities

Our patient safety incident response processes support health equality and reduce inequalities in a number of ways:

(a) Applying a more flexible approach and intelligent use of data to inform response planning can help identify any disproportionate risk to patients with specific characteristics which can be addresses in our Patient Safety Incident Response Plan. We are further developing the completeness and reliability of recording protected characteristics of people who use our services to enable valid and meaningful conclusions to be drawn to reduce risk for specific groups of people.

(b) The tools we use to respond to patient safety incidents prompt the consideration of inequalities e.g. where our insights reveal that training, equipment and processes impact differently on people with different characteristics

(c) Upholding a system-based approach (not a 'person focused' approach) and ensuring staff have the relevant training and skills development to support this approach will support the development of a just culture and reduce the ethnicity disparity in rates of disciplinary action across the NHS workforce. This is supported by our Respecting Everyone Policy.

6.6 Patient safety incident recording arrangements

(a) Internal incidents

(i) UHBW incidents will be recorded using the Datix Risk Management System. Please see section 6.1.a

(ii) National Patient Safety Training Level 1 Essentials of Patient Safety is mandatory for all new staff and includes how recording incidents helps improve patient safety.

(iii) If required, e learning about using Datix is available on the risk management pages of the Trust intranet.

(b) Incidents which involve other healthcare providers

(i) Recorded patient safety incidents which solely relate to care provided by another provider will be shared with that provider to enable them to undertake a learning response and closed on UHBW Datix system.

(ii) Recorded patient safety incidents which relate to care provide by UHBW and another provider will trigger a collaborative and joint learning response overseen and supported by the patient safety specialists in BNSSG Integrated Care Board.

(c) Externally reportable incidents

(i) All patient safety incidents will be reported to NHS England via NHS England's national reporting system

(ii) All incidents will be reported to the Care Quality Commission under Regulation 18. This requirement is discharged through reporting as outline in section (i) above.

(iii) Certain incidents will be required to be reported to external bodies. A table of external bodies and relevant incidents found in Appendix 3.

6.7 Patient safety incident response decision-making

(a) A Rapid Incident Review process is how decisions are made as to whether an enhanced learning response is triggered for certain incidents as identified in our Patient Safety Incident Response Plan.

(b) An incident of concern can be raised by anyone as potentially requiring a rapid incident review. Decision making regarding an enhanced learning response will be made under PSIRF requirements for considered and proportionate response. Consideration for an enhanced learning response will take into account:

(i) the views of those affected, including patients and their families

(ii) capacity available to undertake a learning response

(iii) what is known about the factors that lead to the incident(s)

(iv) whether improvement work is underway to address the identified contributory factors

(v) whether there is evidence that improvement work is having the intended effect/benefit

(vi) if UHBW and/or BNSSG ICB are satisfied risks are being appropriately managed.

(c) Appendix 4 contains a flow chart showing the incident response decision-making process.

(d) The Rapid Incident Review Standard Operating Procedure provides more detail on how the Rapid Incident Review screening process works. The process and SOP will

be kept under review and be developed as we learn following initial transfer to PSIRF.

6.8 *Identifying deaths that are more likely than not to have been contributed to by problems in healthcare delivery*

(a) PSIRF requires that deaths that are more likely than not have been contributed to by problems in healthcare delivery are subject to a patient safety incident investigation. These are identified via the existing Learning From Deaths process.

(b) Appendix 5 contains a flow chart showing how deaths that are more likely than not have been contributed to by problems in healthcare delivery are fed into the PSIRF process.

(c) The Learning From Deaths Policy contains further detail.

6.9 *Responding to patient safety incidents*

(a) Internal learning responses will include:

(i) a manager's local review and learning response to the incident within 72 hours

(ii) the divisional patient safety team's review as to whether the incident meets the national or local requirement for an enhanced learning response in accordance with our Patient Safety Incident Response Plan.

(b) Responses to cross-system incidents/issues

(i) Staff in UHBW will collaborate with colleagues in Integrated Care Boards and other healthcare providers when it is identified that there is value in a shared learning response to a patient safety incident or incidents. This will capture a wider learning and support system-wide quality improvement interventions.

(c) Timeframes for learning responses.

(i) Swarm Huddles will take place as soon as the immediate safety and wellbeing needs of those affected by the incident have been met, ideally prior to the shift end so those involved can contribute.

(ii) Rapid incident reviews will take place within a week of the incident being identified

(iii) After Action Reviews should ideally be completed within two weeks of the incident being identified

(iv) Mortality and Morbidity meetings to review incidents should take place within four months of the need being identified

(v) Patient Safety Incident Investigations will aim to be completed within 6 months of incident being identified as requiring a PSII as an enhanced

learning response. Specific timeframes for a PSII will be agreed as part of the development of the Terms of Reference of the PSII with the patient/family, commissioning executive director and lead investigator.

(d) Safety action development and monitoring improvement:

(i) Formal safety actions will be developed by divisions in response to learning arising from enhanced learning responses including AARs/Mortality and Morbidity meeting , and recommendations from formal patient safety incident investigations.

(ii) Development of safety actions will include:

(A) involvement of those who do the work, including staff and patients, in development and testing of actions in response to patient safety incidents

(B) ensuring actions will effectively address identified weaknesses in safety systems

(C) consideration of unintended consequences of proposed safety actions on other parts of the work system

(D) consideration of introducing unnecessary "safety clutter" that inadvertently introduces new patient safety risk.

(E) a sense check: Who benefits from this action?

(F) a risk benefit analysis and prioritisation of actions with the most effective impact that are feasible and practical to deliver, with any resulting risk being identified in Trust risk registers.

6.10 Safety Improvement Plans

Broader organisation wide safety improvement plans will be developed in response to recommendations arising from formal patient safety incident investigations.

(a) Development of safety improvement plans will include:

(i) Identification of a divisional lead for formulating and delivering the plan

(ii) involvement of those who do the work in their development

(iii) improvement actions that will effectively address identified weaknesses in safety systems

(iv) collaborative work with the ICB and other providers where wider systemic improvements are required across patient -pathways

(v) involvement of patient safety partners or service users to inform systems redesign

(vi) a risk benefit analysis and prioritisation of actions with the most effective impact that is feasible, with resulting risk being identified in Trust risk registers

(vii) an organisational prioritisation process that is part of the Trust's management operating system of Patient First.

6.11 Oversight roles and responsibilities

(a) The Chief Medical Officer and Chief Nurse and Midwife have executive director responsibility for PSIRF. They are supported in this role by their deputies and the Trust Patient Safety Specialists: the Associate Medical Director for Patient Safety, the Associate Director for Quality and Patient Safety and the Head of Patient Safety.

(b) Their oversight responsibilities are:

(i) Ensuring the Trust meets national patient safety incident response standards.

(ii) Ensuring PSIRF is central to overarching safety governance arrangements.

(iii) Quality assuring learning response outputs including signing off patient safety incident investigations.

(c) The Chair of the Quality and Outcomes Committee has a non-executive director oversight role (see section 5.12)

(d) Bristol, North Somerset, South Gloucestershire Integrated Care Board and other external bodies have oversight responsibilities as set out in NHS England's Oversight Roles and Responsibilities Specification

6.12 Training requirements

(a) National Patient Safety Syllabus training for all staff

(i) UHBW staff will be expected to undertake national patient safety training in line in the training matrices at Appendix 1.

(ii) As a minimum, all new UHBW staff must undertake Health Education England Level 1 Essentials of Patient Safety as an essential training requirement as part of their induction programme.

(b) PSIRF training for those in patient safety roles

(i) The three roles identified under PSIRF are: learning response lead, engagement lead and oversight lead.

(ii) Staff with specific responsibilities for patient safety will undertake additional specific to role training as required by the PSIRF in accordance with the training matrices in Appendix 1.

(c) Additional department specific or specialist training

(i) Additional department specific or specialist training about learning responses to incidents may be required e.g. regulatory requirements required by IRMER (Ionising Radiation Medical Exposure Regulations).

7. Standards and Key Performance Indicators

7.1 Patient Safety Incident Response Framework Standards

Assurance of the impact of our Patient Safety Incident Response Policy and Plan will include:

(a) Progress against the national Patient Safety Incident Response Framework Standards

(b) Feedback from those affected by patient safety incidents of their experience in being involved in enhanced learning responses

(c) Progress of safety improvement actions and programmes arising from patient safety incident learning response

7.2 Measurement and Key Performance Indicators

These will comprise:

(a) Process measures

(i) Number and type of incidents subject to enhanced learning responses in accordance with the key patient safety risks identified in our Patient Safety Incident Response Plan

(ii) Compliance with Patient Safety Incident Response Standards for those incidents subject to a Patient Safety Incident Investigation, target is 100% compliance

(iii) Formal feedback surveys on completion of every patient safety incident investigation about patient, family and staff experience of being involved in the investigation and improvements made in practice/process as a result. Baseline to be established in Year 1 after transfer to PSIRF

(b) Outcome measures

(i) Conversion of themes and outcomes of enhanced learning responses into system focussed improvement actions, risk mitigation actions or existing workplans or improvement work

(ii) Delivery and impact of above improvement work as measured within improvement workstreams' measurement strategies

(iii) Year on year improvement in annual NHS staff survey questions about patient safety culture

(iv) Quarterly "temperature check" safety climate staff surveys. Baseline to be established in Year 1 after transfer to PSIRF

8. References

NHS England Patient Safety Incident Response Framework

9. Associated Internal Documentation

Patient Safety Incident Response Plan

Learning From Deaths Policy

Patient, Family and Staff Engagement and Support Framework

Risk Management Policy

Being Open (Duty of Candour) Policy

Respecting Everyone Policy

Rapid Incident Review Standard Operating Procedure

After Action Review Standard Operating Procedure

Swarm Huddle Standard Operating Procedure

Mortality and Morbidity Review Standard Operating Procedure

Patient Safety Incident Investigation Standard Operating Procedure

Health and Safety Incident SOP

Information Governance Incident SOP

Post Infection Review Procedure

UHBW Incident Recording and Management SOP

10. Appendix 1 Patient safety training matrices

National Patient Safety Syllabus training for NHS staff provided by Health Education England and local patient safety training.

Accreditation will be given for completion of national Patient Safety Syllabus training in a previous role on provision of evidence.

Training	Content	Target audience	Update required	Method	How to access
Level 1 Essentials of Patient Safety	• Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety and is open to learning about risk and safety	Mandatory for all new UHBW staff and PSIRF engagement leads, Patient Safety Partners and those leading learning responses and those in oversight roles as defined in this policy.	No	E learning	Via Kallidus
Level 1 Essentials of Patient Safety for Boards and Senior Leaders		Mandatory for Trust Board members, Divisional Board members, Senior Leadership Team members including PSIRF engagement leads, those leading	No	E learning	Via Kallidus

Training	Content	Target audience	Update required	Method	How to access
		learning responses and those in oversight roles as defined in this policy.			
Level 2 Access to practice	• Introduction to systems thinking and risk expertise. • Human factors • Safety culture	Mandatory for clinical staff Band 5 and above Mandatory for medical consultants, SAS grades and doctors in training Mandatory for corporate and divisional patient safety team members. Mandatory for PSIRF engagement leads, those leading learning responses and those in oversight roles as defined in this policy. Specific to role for other relevant senior and operational managers.	No	E learning	Via Kallidus
Levels 3-5 under development by Health Education England	TBC	TBC	TBC	TBC	TBC
UHBW patient safety update	Human factors awareness Safety culture New and emerging patient safety risks	Currently mandatory for all clinical staff every 3 years. Under review.	Under review	Face to Face	Via Kallidus

Training	Content	Target audience	Update required	Method	How to access
	Examples improvements made because of learning from recorded patient safety incidents				
Additional human factors training (under development)	TBC	TBC	TBC	TBC	TBC

NHS
University Hospitals Bristol and Weston
NHS Foundation Trust

PSIRF training for engagement leads, those leading learning responses and those in oversight roles

Training	Duration/ method	Content	Target audience	UHBW target audience	How to access
Systems approach to learning from patient safety incidents	2 days/12 hours Programme of recorded webinars	• Introduction to complex systems, systems thinking and human factors • Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after action reviews • Safety action development, measurement, and monitoring	Learning response leads	Divisional and corporate patient safety team members. Divisional patient safety team members specific to role. Doctor patient safety leads in divisions.	HSIB education Level 2 investigation training
			Those in PSIRF oversight roles	Chief Medical Officer Chief Nurse and Midwife Deputy Chief Nurses Associate Medical Director for Patient Safety Associate Director of Quality and Patient Safety Head of Patient Safety Non-Executive Director Chair of Quality and Outcomes Committee	

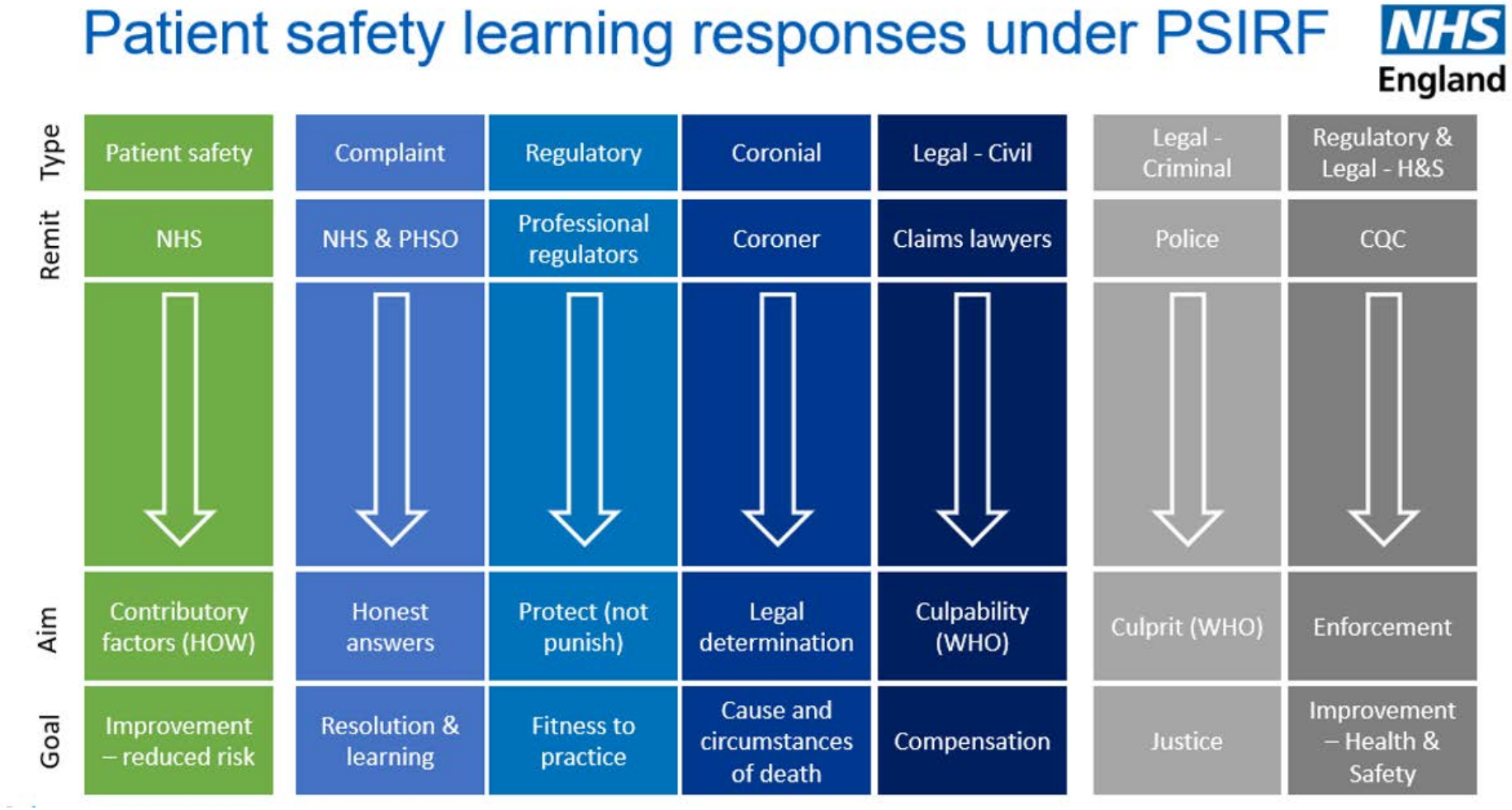
Training	Duration/ method	Content	Target audience	UHBW target audience	How to access
Oversight of learning from patient safety incidents	6 hours (2 x 3 hour interactive live webinars)	• NHS PSIRF and associated documents Effective oversight and supporting processes. • Maintaining an open, transparent and improvement focused culture • PSII commissioning and planning	Those in PSIRF oversight roles	Chief Medical Officer Chief Nurse and Midwife Deputy Chief Nurses Associate Medical Director for Patient Safety Associate Director of Quality and Patient Safety Head of Patient Safety Non-Executive Director Chair of Quality and Outcomes Committee	HSIB education PSIRF oversight training
Involving those affected by patient safety incidents in the learning process	6 hours	• Duty of Candour • Just culture • Being open and apologising • Effective communication • Effective involvement • Sharing findings • Signposting and support	Engagement leads	Associate Medical Director for Patient Safety Associate Director of Quality and Patient Safety Head of Patient Safety Expert Patient Safety Investigators Divisional Patient Safety Team members specific to role. Doctor divisional patient safety leads	HSIB education Training for engagement leads

Training	Duration/ method	Content	Target audience	UHBW target audience	How to access
			Those in PSIRF oversight roles	Chief Medical Officer Chief Nurse and Midwife Deputy Chief Nurses Associate Medical Director for Patient Safety Associate Director of Quality and Patient Safety Head of Patient Safety Non-Executive Director Chair of Quality and Outcomes Committee	
Continuing professional development (CPD)	At least annually	• To stay up to date with best practice (e.g. through conferences, webinars, etc) • Contribute to a minimum of two learning responses	Learning response leads	Divisional and corporate patient safety team members. Divisional patient safety team members specific to role. Doctor patient safety leads in divisions.	Personal development

Training	Duration/ method	Content	Target audience	UHBW target audience	How to access
			Those in PSIRF oversight roles	Chief Medical Officer Chief Nurse and Midwife Deputy Chief Nurses Associate Medical Director for Patient Safety Associate Director of Quality and Patient Safety Head of Patient Safety Non-Executive Director Chair of Quality and Outcomes Committee	
			Engagement leads	Associate Medical Director for Patient Safety Associate Director of Quality and Patient Safety Head of Patient Safety Expert Patient Safety Investigators Divisional Patient Safety Team members Band 6 and above Doctor divisional patient safety leads	

Training	Duration/ method	Content	Target audience	UHBW target audience	How to access

11. Appendix 2 Comparison of aim and outputs of related investigatory processes



12. Appendix 3 Incidents reportable to external bodies

Patient safety incident type	Required response	Lead body for response	Responsible UHBW role to report to external body
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place.	Refer to Healthcare Safety Investigation Branch for independent patient safety incident investigation	HSIB	Head of Midwifery Patient Safety Manager for maternity services
Maternal and neonatal deaths	MMBRACE: Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK	As outlined in UHBW Patient Safety Incident Response Plan	Head of Midwifery Patient Safety Manager for maternity services
Maternity/ Neonatal Incidents meeting criteria for Early Notification Scheme	NHS Resolution	As outlined in UHBW Patient Safety Incident Response Plan	Legal Team
Deaths of persons with learning disability	Refer to Learning Disability Mortality Review Programme (LeDeR) for independent review of events leading up to the death	LeDeR programme	Learning Disabilities Lead Nurse
Child death (patients aged under 18)	Refer to Child Death Review process. If incident meets the learning from deaths criteria, incident requires UHBW Patient Safety Incident Investigation required (see section 6.8 and appendices 4 and 5).	Child Death Overview Panel/UHBW	Lead Doctor for Child Death Relevant divisional Patient Safety Team

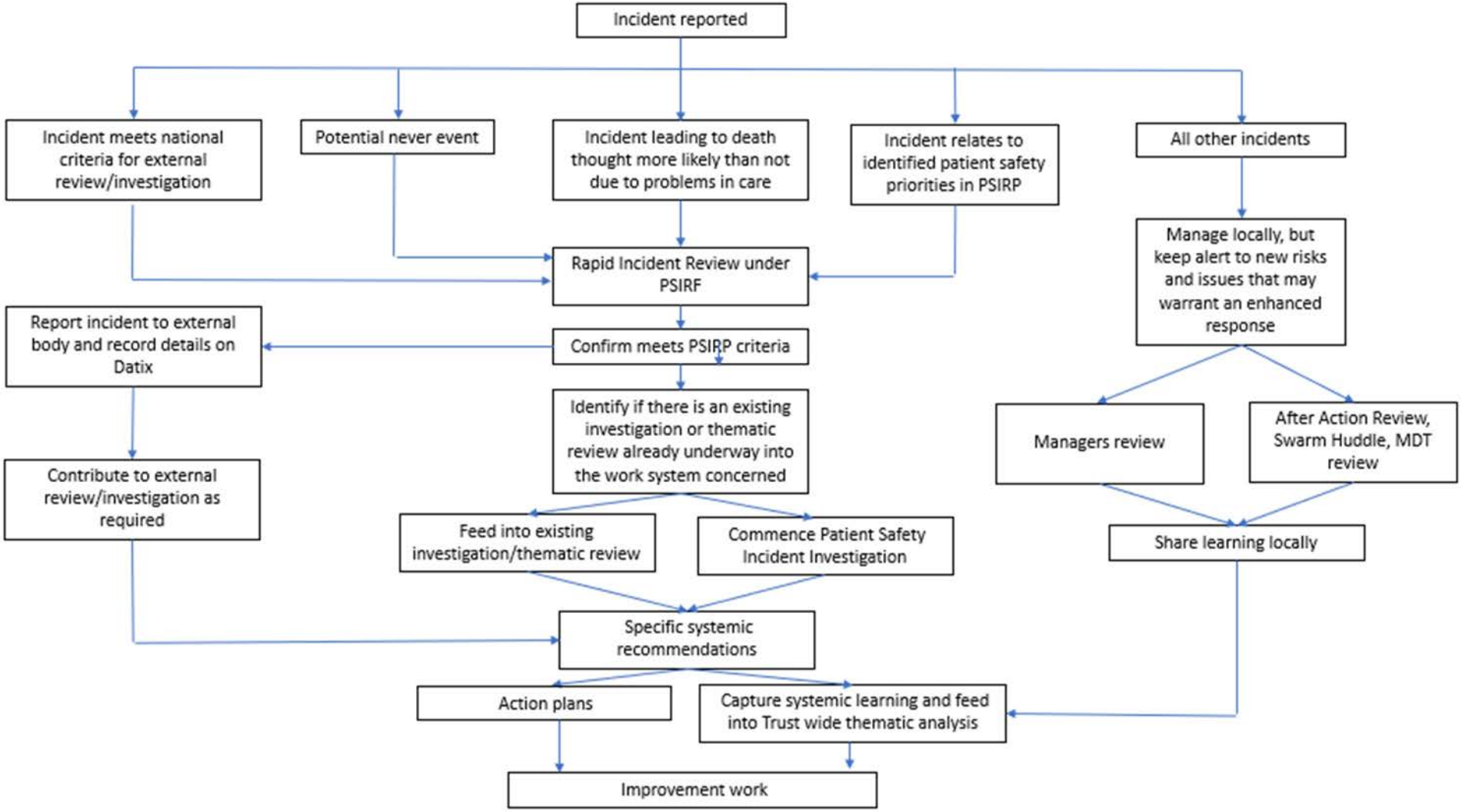
Patient safety incident type	Required response	Lead body for response	Responsible UHBW role to report to external body
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII	As decided by the RIIT	Associate Medical Director for Patient Safety/ Associate Director of Quality and Patient Safety
Other unexpected deaths	Referral to HM Coroner	HM Coroner	Responsible consultant or delegated team member Legal Services
Safeguarding incidents in which: **1) babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence** **2) adults (over 18 years old) are in receipt of care and support needs from their local authority** **3) the incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence**	Refer to local authority safeguarding lead. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Local designated professionals for child and adult safeguarding	Safeguarding Team
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response	NHSE Regional Team/UHBW	Relevant divisional Patient Safety Team

Patient safety incident type	Required response	Lead body for response	Responsible UHBW role to report to external body
Domestic Homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	Community Safety Partnership	Safeguarding Team
Incidents which involve medical devices **Incidents which involve medicines**	Refer to Medicines and Healthcare Products Regulatory Agency (MHRA)	As outlined in UHBW Patient Safety Incident Response Plan	Medical Devices: Medical Device Safety Officer Medicines: Medicines Safety Officer
Blood transfusion incidents **Guidance for what is reportable:**	Refer to MHRA and Serious Hazards of Transfusion	As outlined in UHBW Patient Safety	Transfusion Practitioner or

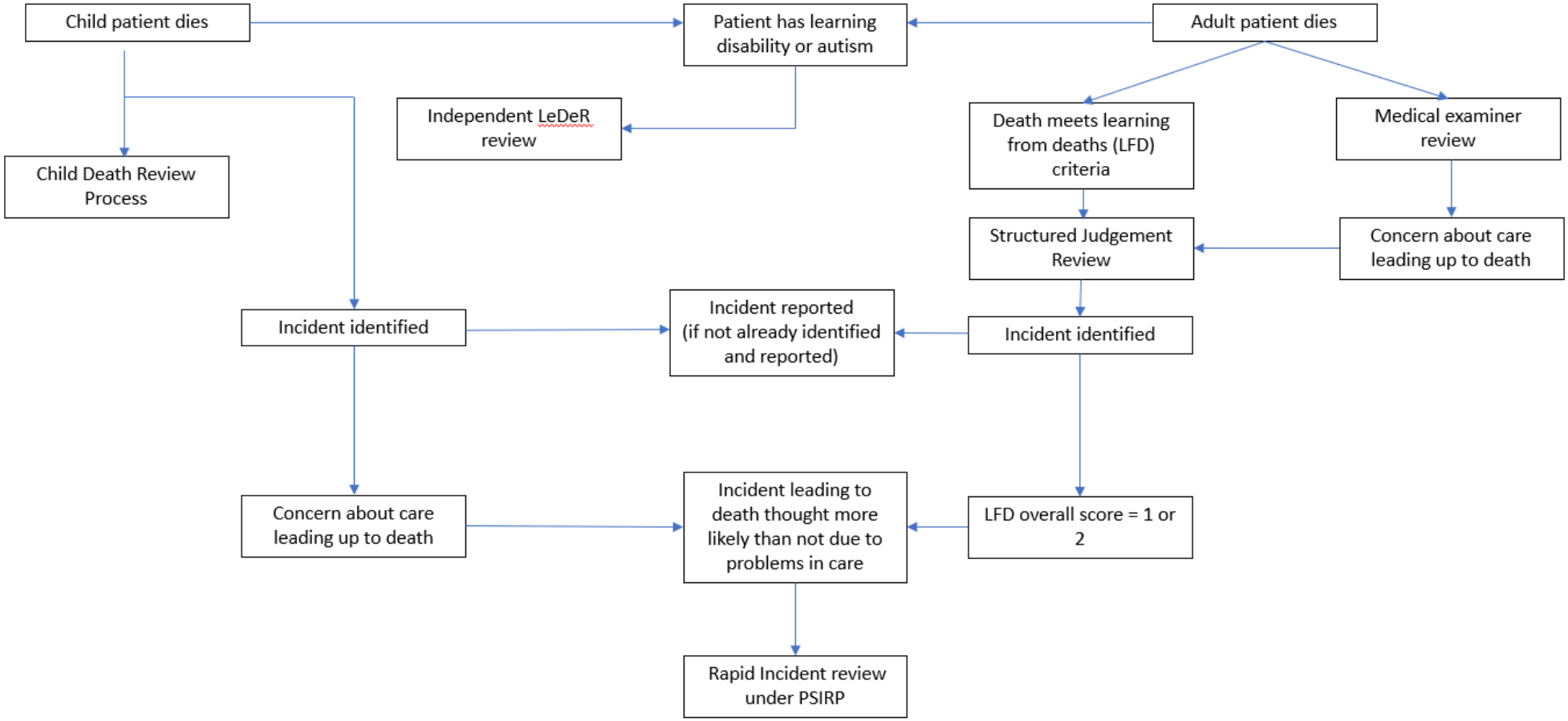
Patient safety incident type	Required response	Lead body for response	Responsible UHBW role to report to external body
Serious Hazards of Transfusion web portal (SHOT) and SABRE – Serious Adverse Blood Reactions and Events		Incident Response Plan	Haematology Department
Serious adverse event or reaction resulting from the procurement, testing, transport or infusion of stem cells	Refer to Human Tissue Authority within 24 hours	As outlined in UHBW Patient Safety Incident Response Plan	Stem Cell Transplant Quality and Service Manager
Post mortem incidents **https://www.hta.gov.uk/reporting-incident-or-concern**	Refer to Human Tissue Authority	As outlined in UHBW Patient Safety Incident Response Plan	Human Tissue Authority Designated Individual
Radiation incidents involving patients meeting CQC IRMER criteria for incident notification	Refer to IRMER Inspectorate of the Care Quality Commission	As outlined in UHBW Patient Safety Incident Response Plan	Local Radiation Protection Supervisor and Trust Radiation Protection Team
Incidents likely to form the basis of a negligence claim	Refer to NHS Resolution	As outlined in UHBW Patient Safety Incident Response Plan	Legal Team
Major communicable disease outbreaks and MRSA bacteraemia incidents	Refer to UK Health Security Agency	As outlined in UHBW Patient Safety Incident	Infection Control Team

Patient safety incident type	Required response	Lead body for response	Responsible UHBW role to report to external body
		Response Plan	
Notifiable Infection related incidents	Refer to UK Health Security Agency	As outlined in UHBW Patient Safety Incident Response Plan	Infection Control Team
Incidents where press enquiries are anticipated	N/A	As outlined in UHBW Patient Safety Incident Response Plan	Communication Team

13. Appendix 4 Flowchart showing patient safety incident response decision-making



14. Appendix 5 Flow chart showing how we will identify incidents leading to death thought more likely than not due to problems in healthcare.



15. Appendix A – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this policy. Please ensure any possible means of monitoring this policy to ensure all parts are fulfilled are included in this table.

Objective	Evidence	Method	Frequency	Responsible	Committee
Compliance with PSIRF investigation standards	Routine monitoring after completion of every PSII	Reports to Patient Safety Group	Quarterly	Head of Patient Safety	Patient Safety Group
Patient, family and staff experience of PSII	Routine feedback mechanism after completion of every PSII	As above	To baseline in Year 1	As above	Patient Safety Group
Safety culture development	NHS staff survey questions about patient safety culture	Scores for patient safety culture questions	Annual	Organisational Development Team. Head of Patient Safety to include in patient safety reports	Patient Safety Group
Safety climate	Local "temperature check" safety climate staff surveys	Reports to Patient Safety Group	Quarterly	Head of Patient Safety	Patient Safety Group

16. Appendix B – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Anne Reader, Associate Director of Quality and Patient Safety
Is this document: A – replacing the same titled, expired policy, B – replacing an alternative policy, C – a new policy:	B

Plan Elements	Plan Details
If answer above is B: Alternative documentation this policy will replace (if applicable):	Incident Management Policy Serious Incident Policy
This document is to be disseminated to:	All staff
Method of dissemination:	Briefings to Managers Newsbeat articles with Links to Connect pages Staff drop-in sessions and walk abouts to clinical areas Posters/Screen savers/Wallpaper Staff Information Leaflets and PAQs Patient and Family Information leaflets Information videos
Is Training required:	[DITP - Training is required]
The Training Lead is: Anne Reader, Associate Director of Quality and Patient Safety and corporate/divisional patient safety team members	Please also see dissemination list above Resources on Connect pages. After Action Review Training commissioned and completed Swarm Huddle educational video E learning

Additional Comments

17. Appendix C – Equality Impact Assessment (EIA) Screening Tool

Further information and guidance about Equality Impact Assessments is available here:
http://nww.avon.nhs.uk/dms/download.aspx?did=17833

Query	Response
What is the main purpose of the document?	To describe how we will record and respond to patient safety incidents for the purpose of learning and improvement
Who is the target audience of the document? Who is it likely to impact on?	UHBW staff including agency and locum staff **Staff √ Patients √ Visitors √ Carers √ Agency and locum staff and volunteers√**

Could the document have a significant negative impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment in relation to your response.
Age (including younger and older people)		√	This policy applies to all patients and staff regardless of their protected characteristics
Disability (including physical and sensory impairments, learning disabilities, mental health)		√	
Gender reassignment		√	
Pregnancy and maternity		√	
Race (includes ethnicity as well as gypsy travelers)		√	
Religion and belief (includes non-belief)		√	
Sex (male and female)		√	
Sexual Orientation (lesbian, gay, bisexual, other)		√	
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		√	
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		√	

Could the document have a significant positive impact on inclusion by reducing inequalities?	YES	NO	If yes, please explain why, and what evidence supports this assessment.
Will it promote equal opportunities for people from all groups?	√		Please see section 6.5
Will it help to get rid of discrimination?	√		
Will it help to get rid of harassment?	√		Please see sections 5.1 and 6.1
Will it promote good relations between people from all groups?	√		
Will it promote and protect human rights?		√	

On the basis of the information/evidence so far, do you believe that the document will have a positive or negative impact on equality? (Please rate by circling the level of impact, below.)

Positive impact				Negative Impact		
Significant	Some √	Very Little	NONE	Very Little √	Some	Significant

Will the document create any problems or barriers to any community or group? NO

Will any group be excluded because of this document? NO

Will the document result in discrimination against any group? NO

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment.

Is a full equality impact assessment required? NO

Date assessment completed: 11/05/2023

Person completing the assessment: Anne Reader, Associate Director of Quality and Patient Safety