NHS
Barnsley Hospital
NHS Foundation Trust

Patient Safety Incident Response Policy

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Equality Impact Assessment	June 2023	
Version	1.6	
Status	Final	
Publication date	20/12/2024	
Review date	31 October 2026	
Approval recommended by	Patient Safety and Harm Group	Date: 19 December 2024
Approved by	Patient Safety and Harm Group	Date: 19 December 2024
Distribution	Barnsley Hospital NHS Foundation Trust – intranet Please note that the intranet version of this document is the only version that is maintained. Any printed copies must therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments	

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1.0 Introduction

Barnsley Hospital NHS Foundation Trust (BHNFT/the Trust) is committed to making patient safety its first priority and will adhere to the principles of Duty of Candour in line with the Trust's Being Open and Duty of Candour policy. The Trust will co-operate and support the investigation of cross organisation safety events.

2.0 Objective

This policy supports the requirements of the Patient Safety Incident Response Framework, 2022 (PSIRF) as per the NHS standard contract and sets out the Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

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

- 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.

3.0 Scope

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

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

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.

4.0 Our patient safety culture

The Trust 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.

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

4.2 Addressing health inequalities
The Trust will apply a flexible approach and intelligent use of data to help identify any disproportionate risk to patients.

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

4.3 Engaging and involving patients, families and staff following a patient safety incident
The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises timely inclusive and compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff) and considers individual and specific needs. This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

The Duty of Candour is a legal duty requiring NHS trusts to ensure that patients and their families are informed when things go wrong resulting in moderate harm, severe harm or death. This includes receiving an apology, and sharing the investigation findings and actions to prevent recurrence.

Please see the Duty of Candour Policy for further information.

It is important to recognise that patient safety incidents can have a significant impact on staff who were involved in or who may have witnessed the incident. Like patients and families they will want to know what happened and why and what can be done to prevent the incident happening again. Staff involved in patient safety incidents should have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services.

All learning response standard operating procedures as listed in section six include guidance on how to engage with patients, families and staff involved in patient safety incidents.

4.4 Patient safety incident response planning
PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, the Trust will explore patient safety incidents relevant to local context and the population we serve.

Resources and training to support patient safety incident response

In line with PSIRF the Trust has identified key roles and responsibilities to ensure the local and effective implementation of the national patient safety incident response standards. Please refer to the section covering *Roles and Responsibilities*.

Our patient safety incident response plan

Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

In developing and reviewing the plan the Trust will engage with key internal and external stakeholders, identify our patient safety incident profile and consider the Trust's patient safety and quality improvement priorities.

Reviewing our patient safety incident response policy and plan

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

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

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

4.5 Responding to patient safety incidents

Patient safety incident reporting arrangements

It is the responsibility of all the employees of the Trust 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 Trust's approved incident reporting system to report all patient safety incidents.

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 Trust's Patient Safety Panel who will confirm if the incident fulfils the PSII criteria. The Trust's Patient Safety Panel is jointly chaired by the Director of Nursing, Midwifery and AHPs and the Medical Director.

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 Clinical 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 (see Appendix 2) to be presented at the Patient Safety Panel.

When potential patient safety incidents are identified through the complaints, clinical negligence or inquest process the Patient Advice and Complaints or Legal Services teams 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.

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 learning response and action. All relevant stakeholders involved should work together to undertake one single learning response 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. This can be supported by the Barnsley Place Quality and Safety Committee and other System Committees.

Timeframes for learning responses

The Trust will aim to complete all PSII that are not aligned to an Inquest or are non-reliant on input from external organisations within 60 working days of the PSII being confirmed. PSII that are also subject to an Inquest and/or require input from an external organisation will be monitored for completion at the Patient Safety Panel. 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 and within the 60 working days; it may be revisited later should new information indicate the need for further investigative activity. Where a PSII requires input from an external organisation but completion is not achievable with 60 working days of the PSII being confirmed an external escalation from the Director of Nursing, Midwifery and AHPs will be implemented.

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 Trust's PSII will not commence until permission from the external agency has been granted.

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.

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 Trust's incident management system and monitored through the Trust wide governance framework for implementation, sustainability and effectiveness. For cross-system incidents that the Trust leads the learning response the safety improvements will be shared with all relevant stakeholders.

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

Safety improvement plans will be available to the ICB on request and shared through the BHNFT and ICB Quality Improvement Group.

4.6 Complaints and appeals
Any patient/carer/family member complaints related to the Trust's patient safety incident response process should be made through the Trust's formal complaints process available here.

Please refer to the following policies for any staff complaints related to the Trust's patient safety incident response process:

- Freedom to speak up policy
- Supporting staff involved in an incident, inquest, complaint or claim
- Supporting staff to raise concerns policy

5.0 Roles and responsibilities
Board of Directors

- Monitor the quality of the Trust's learning responses
- To be compliant with the national PSIRF training requirements

Medical Director and Director of Nursing, Midwifery and AHPs

- Executive lead for PSIRF
- To ensure that the Trust meets the national Patient Safety Incident Response Standards (PSIRS)
- To ensure that PSIRF is central to the Trust's overarching clinical governance arrangements
- To provide quality assurance and oversight of learning response outputs
- To be compliant with the national PSIRF training requirements
- To ensure executive oversight and escalation where required of any PSII requiring input from an external organisation

CBU and Corporate Senior Leaders

- To ensure that this policy and associated Trust approved documents are implemented within their areas of responsibility
- To report/escalate patient safety incidents in accordance with this policy
- To take responsibility for analysis and sharing the learning from learning response output
- To ensure that appropriate action is taken to implement any recommendations arising from learning outputs
- To ensure that staff are compliant with the relevant national PSIRF training requirements

Head of Quality and Clinical Governance

- To provide oversight of patient safety incident learning responses
- To be compliant with the national PSIRF training requirements

Clinical Governance Facilitators/Governance Midwife

- To dedicate time to conduct learning responses
- To be compliant with the relevant national PSIRF training requirements
- To contribute to a minimum of two learning responses per year
- To engage with the patient/family/other relevant stakeholder as appropriate in relation to their involvement in the learning response

- To support the delivery of appropriate systems based training using the SEIPS model to Investigation Officers

Clinical Governance and Compliance Manager/Women's Services Quality Safety and Governance Lead

- To provide oversight of patient safety incident learning responses
- To be compliant with the national PSIRF training requirements
- To ensure the delivery of appropriate systems based training using the SEIPS model to Investigation Officers

Investigation Officers

- Are not involved in the incident or directly manage staff involved in the incident
- Are identified and nominated by CBU and Corporate Senior Leaders
- To dedicate time to conduct learning responses
- To complete the Trust's patient safety incident investigation training
- To undertake systems based investigations using the SEIPS model

6.0 Associated documents and references *(Documents highlighted in yellow are under development)*

BHNFT

Duty of candour policy (May 2023)
Incident management policy (March 2023 – under review)
Policy for handling concerns and complaints (August 2021)
Legal services policy (October 2022)
Learning from deaths policy (November 2022)
Risk management policy and procedure (February 2021)
Supporting staff to raise concerns policy (October 2022)
Women's Services Quality Safety and Governance policy (February 2023)
Procedure for monitoring and completion of safety actions from patient safety incident learning responses (October 2023)
Patient safety incident response plan (November 2023)
Procedure for a patient safety incident investigation (PSII) (October 2023)
Procedure for an after action review (AAR) (October 2023)
Procedure for a multidisciplinary (MDT) review (October 2023)
Procedure for a SWARM huddle (October 2023)
Procedure for patient safety incident investigation assurance reviews (October 2023)

National

Never Event Policy and Framework. NHS Improvement

Maternity investigations | MNSI

Patient Safety Strategy NHS England

https://secondvictim.co.uk/

A Just Culture Guide NHS England

PSIRF

SEIPS (england.nhs.uk)

NHS Standard Contract Service Condition 33

7.0 Training and resource

Corporate induction
All staff will be made aware of how access to policies and how to report patient safety incidents as part of the Trust's corporate induction programme.

Local induction
On induction into their department all staff will receive a local induction to include patient safety incident reporting processes. It is the responsibility of managers to ensure that staff are made aware of and comply with this policy.

The Corporate Governance and Clinical Governance teams provide training sessions on the Passport to Management programme which covers the patient safety incident reporting and investigation, from a management perspective. Ad-hoc training can also be provided by the Corporate Governance and Clinical Governance teams upon request on a one to one basis or group session. This can be tailored to people and teams requirements i.e. incident reporting, incident investigation or generating incident reports.

PSIRF training requirement	BHNFT roles
Complete level 1 and level 2 of patient safety syllabus	Medical Director Director of Nursing, Midwifery and AHPs Head of Quality and Clinical Governance Clinical Governance and Compliance Manager Clinical Governance Facilitator
At least two days' formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents	Head of Quality and Clinical Governance Clinical Governance and Compliance Manager Clinical Governance Facilitator
Undertake CPD and network with other leads at least annually	Medical Director Director of Nursing, Midwifery and AHPs Head of Quality and Clinical Governance Clinical Governance and Compliance Manager Clinical Governance Facilitator
Six hours of training involving those affected by patient safety incidents in the learning process	Head of Quality and Clinical Governance Clinical Governance and Compliance Manager Clinical Governance Facilitator
Training is conducted by those who have attended courses in learning from safety incidents amounting to more than 30 days, are up to date in learning response best practice and have both conducted and reviewed learning responses	Clinical Governance and Compliance Manager Clinical Governance Facilitator

8.0 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/ committee for development of action plan	Responsible individual/group/ committee for monitoring of action plan and Implementation
PSII are completed within 60 days	Report to Patient Safety and Harm Group	Clinical Governance and Compliance Manager	Monthly	Patient Safety and Harm Group	Clinical Governance and Compliance Manager	Patient Safety and Harm Group

PSIRP is reviewed and approved in line with this policy	Report to Patient Safety and Harm Group	Clinical Governance and Compliance Manager	12-18 months	Patient Safety and Harm Group	Clinical Governance and Compliance Manager	Patient Safety and Harm Group
A comprehensive review of the PSIRP is undertaken in line with this policy	Report to Patient Safety and Harm Group	Head of Quality and Clinical Governance	4 yearly	Patient Safety and Harm Group	Head of Quality and Clinical Governance	Patient Safety and Harm Group

9.0 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This policy can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this policy. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all policies will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1

EQUALITY IMPACT ASSESSMENT TEMPLATE
INITIAL ASSESSMENT STAGE 1 (part 1)

<table>
<tr><td>Department:</td><td colspan="3">Quality and Clinical Governance</td><td>Division:</td><td>Nursing Directorate</td></tr>
<tr><td>Title of Person(s) completing this form:</td><td colspan="3">Tracy Church</td><td>New or Existing Policy/Service</td><td>New</td></tr>
<tr><td>Title of Policy/Service/Strategy being assessed:</td><td colspan="3">Patient Safety Incident Response Policy</td><td>Implementation Date:</td><td></td></tr>
<tr><td>What is the main purpose (aims/objectives) of this policy/service?</td><td colspan="5">This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the Trust’s approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.</td></tr>
<tr><td rowspan="5">Will patients, carers, the public or staff be affected by this service?</td><td></td><td>Yes</td><td>No</td><td colspan="2" rowspan="5">If staff, how many individuals/which groups of staff are likely to be affected?
All staff may be directly or indirectly involved in a patient safety incident.</td></tr>
<tr><td>Patients</td><td>✓</td><td></td></tr>
<tr><td>Carers</td><td>✓</td><td></td></tr>
<tr><td>Public</td><td>✓</td><td></td></tr>
<tr><td>Staff</td><td>✓</td><td></td></tr>
<tr><td rowspan="5">Have patients, carers, the public or staff been involved in the development of this service?</td><td>Patients</td><td>✓</td><td></td><td colspan="2" rowspan="5">If yes, who did you engage with? Please state below:</td></tr>
<tr><td>Carers</td><td>✓</td><td></td></tr>
<tr><td>Public</td><td>✓</td><td></td></tr>
<tr><td>Staff</td><td>✓</td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>What consultation method(s) did you use?</td><td colspan="5">News article on the intranet, all specialty and CBU governance meetings, slide at Team Brief, emails to leads and staff in corporate teams, external stakeholders and partners, Trust social media channels, patient panel, Trust’s external website</td></tr>
</table>

Equality Impact Assessment Stage 1 PART 2

Based on the data you have obtained during the consultation what does this data tell you about each of the above protected characteristics? Are there any trends/inequalities?

No. This policy and supporting procedures aims to promote and enable the reporting of all categories of incidents and near misses. It supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
This policy is in line with the national Patient Safety Incident Response Framework (PSIRF).

What other evidence have you considered? Such as a 'Process Map' of your service (assessment of patient's journey through service) / analysis of complaints/ analysis of patient satisfaction surveys and feedback from focus groups/consultations/national & local statistics and audits etc.

National policies and templates. Examples and information shared through national and local discussion forums and webinars.

Equality Impact Assessment Stage 1 PART 3

ACCESS TO SERVICES

What are your standard methods of communication with service users?

Please tick as appropriate.

Communication Methods	Yes	No
Face to Face Verbal Communication	✓	
Telephone	✓	
Printed Information (E.g. leaflets/posters)	✓	
Written Correspondence	✓	
E-mail	✓	
Other (Please specify) Trust social media platforms	✓	

If you provide written correspondence is a statement included at the bottom of the letter acknowledging that other formats can be made available on request?

Please tick as appropriate.

Yes	No
	✓

Are your staff aware how to access Interpreter and translation services?

Interpreter & Translation Services	Yes	No
Telephone Interpreters (Other Languages)	✓	
Face to Face Interpreters (Other Languages)	✓	
British Sign Language Interpreters	✓	

Information/Letters translated into audio/braille/larger print/other languages?	✓	

EQUALITY IMPACT ASSESSMENT – STAGE 1 (PART 4)

Protected Characteristic	Positive Impact	Negative Impact	Neutral Impact	Reason/comments for positive or negative Impact Why it could benefit or disadvantage any of the protected characteristics
Men	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Women	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Younger People (17 – 25) and Children	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Older people (60+)	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Race or Ethnicity	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Learning Disabilities	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Hearing impairment	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Visual impairment	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Physical Disability	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Mental Health Need	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Gay/Lesbian/Bi sexual	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Trans	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Faith Groups (please specify)	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Marriage & Civil Partnership	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Pregnancy & Maternity	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

Carer Status	✓			The policy supports all staff and patients by ensuring the Trust maintains effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.
Other Group (please specify)	N/A	N/A	N/A	N/A

INITIAL ASSESSMENT (PART 5)

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following protected groups?

YES	NO
	X

IF 'NO IMPACT' IS IDENTIFIED Action: No further documentation is required.

IF 'HIGH YES IMPACT' IS IDENTIFIED Action: Full Equality Impact Assessment Stage 2 Form must be completed.

(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary?

YES	NO
	X

Assessment Completed By: Tracy Church **Date Completed:** 12 June 2023

Line Manager Gill Feerick Date 12 June 2023

Head of Department Gill Feerick Date 12 June 2023

When is the next review? Please note review should be immediately on any amendments to your policy/procedure/strategy/service.

1 Year

Appendix 2

Incident review and escalation

Datix:

Description of incident

Timeline		
Date	**Action**	**Outcome**
		.

Overview

Relevant completed (within last 6/12) and ongoing learning responses
to be completed by clinical governance team

Date to be discussed at Patient Safety Panel:

Agreed learning response	PSIRP criteria
Refer to the MNSI for an independent PSII	Maternity and neonatal incidents meeting the Maternity and Newborn Safety Investigations (MNSI) criteria
BHNFT led PSII in line with guidance for managing safety incidents in NHS screening programmes	Incidents in NHS screening programmes
BHNFT led PSII	Incidents meeting the never events criteria
	Deaths clinically assessed as more likely than not due to problems in care
	Patient harm (excluding death) Incidents resulting in patient harm (excluding death) as a consequence of missed/delayed recognition or escalation of diagnosis or treatment where new system based learning is identified
	Digital systems Incidents as a result of the use of BHNFT's digital systems that have the potential for harm, loss of trust or an impact on quality and delivery of services where new system based learning is identified
	Repeated incident identified A source* (e.g. corporate lead, group, committee, complaints, incidents litigation, inquests, maternity dashboard etc.) identify the same issues in three investigation/responses

	when improvement work is known to have been implemented
	Patient involvement Where patients or their loved ones questions would not be fully answered by the proposed learning method or other Trust process* (e.g. complaint, litigation, subject access request etc.)
Multidisciplinary team review	Supports teams to learn from multiple incidents or a safety theme that occurred in the past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. Uses an open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting), to agree the key contributory factors and system gaps that impact on safe patient care.
Swarm huddle	A meeting initiated as soon as possible after an incident. Staff 'swarm' to the site to gather information about what happened, why it happened and decide what needs to be done to reduce the risk of the same thing happening in future.
After action review (AAR)	A structured facilitated discussion of an incident that gives individuals involved in the incident understanding of why the outcome differed from that expected and the learning to assist improvement. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning?

*not an exhaustive list

Appendix 3

Version	Date	Comments	Author
1	January 2023	First draft	Gill Feerick Head of Quality and Clinical Governance Tracy Church Clinical Governance and Compliance Manager
1.1	January 2023	Updated following review by PSIRF Implementation Group	Gill Feerick and Tracy Church
1.2	April 2023	Updated following feedback from internal stakeholders	Gill Feerick and Tracy Church
1.3	June 2023	Updated following feedback from external stakeholders	Gill Feerick and Tracy Church
1.4	August 2023	Update to training requirements	Gill Feerick and Tracy Church
1.5	January 2024	Updated following feedback from Healthwatch	Gill Feerick and Tracy Church
1.6	December 2024	Updated following 360 Assurance audit	Gill Feerick and Tracy Church

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
PSIRF Implementation Group	26/01/2023
Patient Safety and Harm Group	16/02/2023
Patient Safety and Harm Group	20/04/2023
Patient Safety and Harm Group	20/07/2023
Quality and Governance Committee	30/08/2023
Board of Directors	05/10/2023
Patient Safety and Harm Group	22/02/2024
Patient Safety and Harm Group	19/12/2024