Patient Safety Incident Response Policy

Contents

1 Statement of Aims and Objectives

1.1. South East Coast Ambulance Service NHS Foundation Trust (the Trust) is committed to complying with legislation and standards that organisations are required to uphold for all patient safety incidents. The objectives are as follows.

- Identify the responsibilities of individual postholders and groups in response to Patient Safety Incidents.
- Ensure the Trust prioritises the management and governance of Patient Safety Incidents (PSIs).
- Maintain consistency in approach across the Trust.
- Ensure the Trust acts in a transparent manner.
- Engage and fully inform service users, stakeholders and staff and act in a manner consistent with Duty of Candour legislation.
- Ensure there is an emphasis on learning and action is taken to minimise reoccurrence of incidents.
- Share learning with our system partners, our people, and when appropriate, Ambulance Services across the UK.

1.2. This policy is applicable to all staff in the Trust and sets out the scope of practice to which all staff must adhere to when responding to a patient safety incident (PSI).

2 Purpose

2.1. This policy is specific to patient safety incident responses, conducted solely for the purpose of learning and improvement across all patient facing services, throughout the Trust.

2.2. This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the Trusts approach to developing and maintaining effective systems and processes for responding to patient safety incidents.

2.3. The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents to provide real insight. It embeds responses to patient safety incidents within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management, and away from apportioning blame or determining liability.

2.4. This policy supports the 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.

3 Principles

3.1. The Trust intends to balance effort between learning through responding to incidents or exploring issues and improvement work. PSIRF has identified thresholds to determine what method of response should be used to support learning and improvement for a small cohort of incidents, as documented in the Trust's Patient Safety Incident Response Plan (PSIRP).

3.2. Learning 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.

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

3.4. Information from a patient safety response can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response. This may include HR investigations and / or additional external investigations.

4 Our patient safety culture

4.1. Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

4.2. Our Trust is focused on transforming our culture, empowering managers and leaders to hold more autonomy and greater accountability, and it is this foundation that will complement our patient safety culture. We are creating more time and space for our people to connect within one another and talk, so that sharing stories, raising concerns and discussing issues is part of how we do things everyday.

4.3. A key priority within the Trust People strategy is to embed a 'Just and Learning culture' that facilitates continuous learning, creates psychological safety which supports staff to raise and address concerns, and focuses upon good practice that is shared and replicated within and beyond organisational boundaries. This priority is very much aligned to the patient safety culture sought to deliver the PSIRF.

- Evidence of our patient safety culture will be provided through a low threshold for reporting incidents and escalating concerns allowing the greatest range of learning opportunities. This culture requires a fundamental level of psychological safety that is driven through the just and learning culture priority.

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

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

- Justifiable accountability and a zero tolerance for inappropriate blame. The NHS Improvement just culture guide should be used to determine a fair and consistent course of action towards staff. Further focus on just and learning culture will eliminate the second victim scenarios where staff are unfairly treated following patient safety incidents and ensuring errors or omissions in care are seen primarily as an organisational responsibility.

4.4. Educating and empowering our leaders and building trust within teams will foster a culture that raises concerns and seeks to drive change. We

recognise culture transformation takes time, and we will monitor the impact of our interventions and progress through our Culture Dashboard.

5 Patient Safety Partners

5.1. The Trust will establish and recruit a patient safety partner (s) (PSP) in line with the NHSE guidance Framework for involving patients in patient safety as part of the Trust's commitment to patient involvement and engagement.

5.2. The PSP will have an important role in supporting our PSIRF journey, providing a patient perspective to developments and innovations to drive continuous improvement via our Patient Safety Oversight Group (PSOG).

5.3. PSP's will work alongside staff, volunteers, and patients, in projects to co-design patient safety initiatives, and participate in key conversations and meetings in the Trust focusing on patient safety. They will have a mind-set for improving outcomes, whilst representing patients, carers and families and ensuring the Trust is "walking in the patients' shoes".

5.4. Full role descriptions will be provided for PSPs along with any additional requirements to support them to maximise their involvement in Trust activities.

6 Addressing health inequalities

6.1. Addressing health inequalities is a priority for the ambulance service and will increasingly feature in a range of quality improvement (QI) and quality assurance (QA) processes across this Trust, including the implementation of the PSIRF. Learning identified through serious incident (SI) investigations has already identified improvements required regarding support for effective communication with our patients.

6.2. Patient safety responses will continue to consider health inequalities through a variety of routes. These routes will consider:

- Outcomes for patients across a range of specific characteristics to ensure any unwarranted variation is identified as an area for improvement for consideration.
- Specific support needs to encourage engagement in patient safety responses from all patients, focusing on what each person can add to the learning process and collectively removing any barriers to participation.
- During recruitment of PSPs consideration will be given to diversity and where gaps in partners with specific characteristics are

identified, active recruitment will be led to ensure diversity in this key stakeholder group.

6.3. The Trust will seek to utilise data and learning from investigations to identify actual and potential health inequalities. System-based themes will be highlighted to their respective System Governance Group (SGG).

6.4. The PSOG may also make recommendations to our Trust Board and partner agencies on how to tackle actual and potential health inequalities at a regional level.

6.5. The Framework's holistic and integrated approach to patient safety will require the Trust to be more collaborative with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda.

6.6. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the Duty of Candour / being open process.

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

7.1. The Framework recognises that learning and improvement following a PSI 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).

7.2. This involves working with those affected by PSIs to understand and answer any questions they have in relation to the incident and signpost them to support as required using standards set out in 'Engaging and involving patients, families and staff following a patient safety incident' guidance.

7.3. Involving Patients & Families

7.3.1. The Trust recognises the importance of, and is committed to, involving patients and families following PSIs, engaging them in the investigation process and fulfilling the Duty of Candour requirements.

7.3.2. 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, noting that not all patients and their families will wish to receive a copy.

7.3.3. The Trust recognises from experience and supported by available research, that patients and families often provide a unique insight into the circumstances around patient safety incidents. They are also more likely to have different priorities, questions or needs to that of the Trust.

7.3.4. This policy therefore reinforces existing guidance relating to the Duty of Candour and 'being open' and recognises the need to involve patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved.

7.3.5. The Trust is committed to delivering on the Patient Safety Syllabus including "Involving those affected by patient safety incidents in the learning process" module. Local staff, identified at a system-led Incident Review Group (IRG) will support patients and families following a PSI. This will extend to those where Duty of Candour is not legally required, nor a Patient Safety Incident Investigation (PSII) prescribed.

7.3.6. A named contact will be allocated to support engagement and involve those affected. This contact will prioritise:

- Keeping those involved fully informed about what happened
- Giving those affected the opportunity to provide their perspective
- Giving those affected an opportunity to raise questions about what happened and to have these answered openly and honestly
- Helping individuals to access counselling or therapy where needed.
- Offering the opportunity to receive information from the outset on whether there will be a specific learning response and what to expect from the process.
- Signposting to specialist advice, advocacy and/or support from independent organisations regarding learning response processes

7.3.7. Where a PSI is identified, via complaint or Patient Experience Questionnaire, complainants will be engaged with to ensure all learning is captured. These individual PSIs should be reported and be referred to the system-led Incident Review Group via DATIX.

7.3.8. The Trust will engage with service users via the Patient Experience Team and Community Forum to identify themes, risks and involve service users in the development of continuous quality improvement.

7.3.9. The Trust recognises the value of having those affected input to the terms of reference of the PSII and agree timeframes, but also commit to giving those involved the opportunity to feedback on their experience of the learning response.

7.3.10. Patient and their families will be invited to reflect and share their experience following a PSII with executives at PSOG or via the Patient Experience Group.

7.4. Involving Staff, Colleagues and Partners

7.4.1. The Trust recognise that PSIs 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.

7.4.2. Staff involved in patient safety incidents have the opportunity to access professional advice from their relevant professional body or union, staff counselling services, and occupational health services via the Wellbeing Hub on the Trust intranet.

7.4.3. Trauma Risk Management (TRiM), a post exposure assistance service is available to all staff and is provided by appropriately trained and equipped TRiM practitioners.

7.4.4. All staff who feel unfairly treated following a PSI will be encouraged to liaise directly with the local Leadership Teams and/or the Head of Patient Safety. The Trust Freedom to Speak Up guardian will also support if issues are unresolved.

7.4.5. The Trust will recognise the voice of staff when developing sustainable, effective improvements following a patient safety incident and this will be captured when responding to PSIs.

7.4.6. Staff will be invited to reflect and share their experience following a PSI with executives at PSOG or via Schwartz rounds.

8 Patient safety incident response planning

8.1. Beyond nationally set requirements, organisations can explore PSIs relevant to their context and the populations they serve, rather than only those that meet a certain defined threshold.

8.2. The Trust recognises that our planning needs to account for other sources of feedback and intelligence such as complaints, risks, legal claims,

mortality reviews and other forms of direct feedback from staff and patients. The Framework guidance specifies the following standards that our plans should reflect:

- A thorough analysis of relevant organisational data
- Collaborative stakeholder engagement
- A clear rationale for the response to each identified patient safety incident type

8.2.1. The PSIRP will reflect these standards, be updated as required and in accordance with emerging intelligence and improvement efforts. It will also be published on our external facing website.

8.2.2. The Trust will expect the three-system based IRGs (Kent & Medway, Sussex, and Surrey & Frimley) to oversee day to day management of all patient safety incidents, their responses, learning and patient and staff engagement, on a weekly basis.

8.3. **Resources and training to support patient safety incident response**

8.3.1. Nominated staff must receive training in line with the Patient Safety Syllabus to provide three core functions:

- Learning response leads
- Patient and staff engagement following an incident
- Those in PSIRF oversight roles

8.3.2. Learning responses will not be led by staff who were involved in the patient safety incident itself or by those who directly manage those staff, nor will learning response leads work in isolation.

8.3.3. Staff leading PSIIs must be competent, meeting standards set out in the Patient Safety Syllabus and be allocated time and support to complete PSII's.

8.3.4. Resources should be allocated at the system led IRG to support engagement and involvement of those effected.

8.2.5 PSIRF recognises that resources and capacity to investigate and learn effectively from PSIs is finite. It is therefore essential that as an organisation we evaluate our capacity to deliver our plan. Capacity should be reviewed annually in line with the PSIRP and reported to the Quality and Clinical Governance Group (QCGG) via the respective SGG.

8.4. Our patient safety incident response plan

8.4.1. 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 and the needs of those affected, as well as the plan.

8.4.2. This plan will help us measurably improve the efficacy of our local PSIIs by:

- Refocusing PSII towards a systems approach, i.e. the identification of interconnected causal factors and systems issues.
- Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents.
- Demonstrating the added value from the above approach.

8.4.3. The patient safety incident risks for the Trust has been profiled using organisational data from patient safety incident reports (approximately 36,000 PSI reports over a three year period), complaints, freedom to speak up reports, mortality reviews, Regulation 28 reports (Prevention of Future Death reports), clinical audit, staff survey results, claims and risk assessments.

8.5. Reviewing our patient safety incident response policy and plan

8.5.1. Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 months to ensure our focus remains up to date; 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.

8.5.2. Updated plans will be published on our website, superseding the previous version, and reviewed at least annually.

8.5.3. A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and

improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient PSII reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

8.5.4. This policy is written with the aim of supporting the Trust's transition to PSIRF and working towards meeting the patient safety incident response standards. The policy should be reviewed in no more than three years with an aim for patient safety incident response standards to become business as usual.

8.5.5. The PSOG should be consulted on any amended or new versions of both the PSIRP and this policy. NHS Surrey Heartlands ICB remain a core member of this group.

9 Responding to patient safety incidents

9.1.1. The following described the patient safety incident reporting arrangements.

9.1.2. Patient safety incident reporting will remain in line with the Trust's Incident Reporting Policy. It is recognised that staff must continue to feel supported and able to report any incidents, or concerns in relation to patient safety, to promote a system of continuous improvement and a just and open culture.

9.1.3. PSIs will be recorded via the Trust's incident reporting tool and may be recognised in real-time or in retrospect through audit, complaints, Learning from Death reviews and notification from coroner or external partners.

9.1.4. Complaints will be escalated via the Trust's incident reporting tool to the IRGs where a PSI is recognised. Learning responses may be utilised and patients and/or their families should be included in setting a reasonable timeframe, if managed via the IRG and not the complaint process.

9.1.5. Cross-system PSIs will be shared directly with partners for a joint response where appropriate using existing partnerships and forums. Commissioners will be informed of cross-system learning.

9.1.6. PSIs incidents will be reviewed by the IRGs, where senior leaders will follow the incident decision making tool (section 9.2) and prescribe the most appropriate learning response as per the Trusts PSIRP, including those incidents outside of the Trust's PSIRP.

9.1.7. Incidents recognised to propose significant risk to staff, patients and the Trust should be escalated to the executive members of the PSOG immediately. This should be completed by the chair of the IRG.

9.1.8. PSIs with an Infection Prevention and Control theme will be reviewed at the IRG and subject matter experts will be utilised throughout the learning responses. Safeguarding incidents should follow local policy when highlighted.

9.1.9. The Trust will support any ongoing Police investigations and will identify the most appropriate learning response once appropriate to do so. The Trust should be guided by Police and Legal representatives.

9.1.10. Certain incidents require external reporting to national bodies such as HSSIB, HSE, RIDDOR and MHRA. Please refer to the Trust's SOP for Managing and Investigating Incidents to and from External Organisations for full details and guidance.

9.2 Patient safety incident response decision-making

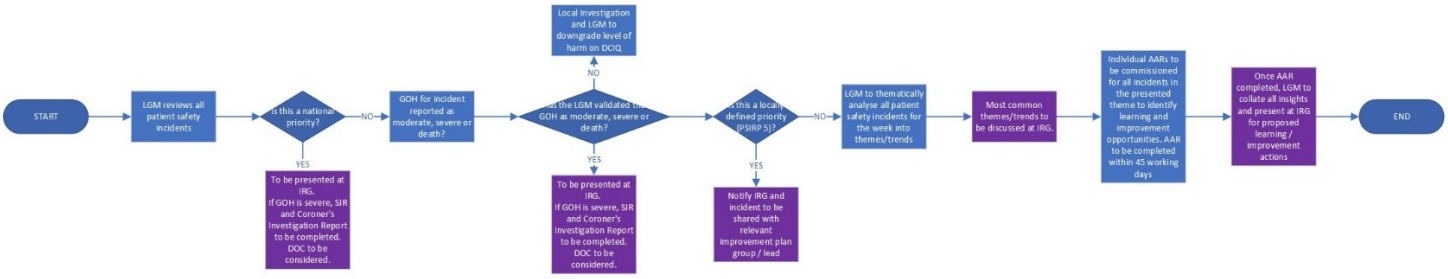

Image 1

9.2.1. PSIs where a 'Never Event' has occurred or where a patient's death has been assessed by a clinician using a structure judgement review to have been avoidable (SJR outcome 1) due to lapse in care, should be considered for a PSII.

9.2.2. Where a PSI is recognised and mandatory onward referral is required to an appropriate investigating body, the Trust should consider a PSII or other proportionate response to ensure learning is captured in timely manner.

9.2.3. The IRG will be responsible for ensuring patient safety incidents falling outside of the PSIRPs priorities are allocated the most appropriate learning response lead. Competency and capacity should be considered whilst prioritising the considered and proportionate responses set out in the PSIRP.

9.2.4. The IRG may recommend patient, family, and staff engagement. The Patient Safety Team should monitor 'open conversation' and 'Duty of Candour' compliance and report to the respective SGG.

9.2.5. The system IRG will use local intelligence and reporting to identify emerging themes and trends, highlighting to the SGG.

9.2.6. The system IRG will inform the Trust's executive led PSOG where commissioners are also members, once a PSII has been prescribed.

10 Responding to cross-system incidents/issues

10.2 If more than one organisation is involved in the care and service delivery in which a patient safety incident has occurred, the organisation that identifies the incident is responsible for recognising the need to alert relevant stakeholders to initiate discussions about subsequent investigation and action.

10.3 All relevant stakeholders involved should work together to undertake one single investigation wherever this is possible and appropriate. The integrated care system should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process.

11 Timeframes for learning responses

11.1 The Trust recognise the impact of prolonged investigations on patients, their families, and our staff. The Trust are committed to limiting timeframes to ensure the opportunity to implement change has not passed, and that patient, their families, and staff, get a satisfactory timely response.

- Incident review groups will take place weekly, reviewing patient safety incidents reported over the previous calendar week.
- Learning responses should be completed as soon as reasonably possible but closed within 45-days of the incident.
- PSII's should be completed within a timeframe agreed with staff, patients and their families but within three-months (in line with national guidance) of the incident.

11.2 Any learning response which will not meet these timeframes should include patient, their families, and staff in agreeing a reasonable timeframe.

11.3 Any proposed extension to the completion of a PSII should be agreed by the PSOG.

12 Safety improvement plans

12.1 The development of continuous quality improvement should include input from staff, patients, and their families.

12.2 Immediate actions identified at the IRG should be monitored for completion including effectiveness, and sustainably through the SGG.

12.3 Continues improvement plans for the Trust's current priorities (as per the PSIRP) will fit into larger improvement workstreams, which will report to PSOG.

12.4 It is proposed improvement actions identified from further learning responses, not included in the PSIRP should be developed using the Trust's Quality Improvement (QI) methodology, reporting to SGG.

13 Complaints and appeals

13.1 Any complaints relating to this guidance, or its implementation can be raised informally with the Trust Head of Patient Safety, initially, who will aim to resolve any concerns as appropriate.

13.2 Formal complaints from patients or families can be lodged through the Trust's Patient Experience Team; pet@secamb.nhs.uk.

14 Definitions

14.1 A glossary can be found as Appendix A.

15 Responsibilities

15.1 The **Trust Board** is responsible for oversight of the framework and should agree transition.

15.2 The **Executive Director of Quality and Nursing**, as Executive Lead holds responsibility for effective monitoring and delivery of PSIRF.

15.3 The **Patient Safety Oversight Group** is responsible for the ongoing effectiveness of this policy.

15.4 **All employees** are responsible for adhering to this policy.

15.5 The reporting structure is attached as appendix B.

15.6 Oversight

15.6.1 The Trust's oversight roles and responsibilities were identified using NHSE guidance on 'Oversight roles and responsibilities specification and Patient safety incident response standards'.

15.6.2 The Trust recognises and is committed to close working, in partnership, with the local ICB and other national commissioning bodies as required. Representatives from the Lead ICB will sit on the Trust's PSOG. Oversight and assurance arrangements will be developed through joint planning and arrangements must incorporate the key principles detailed in the guidance above, namely:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Policy, planning and governance
- Competence and capacity
- Proportionate responses
- Safety actions and improvement

15.6.3 Incident Review Groups

- The purpose of the IRG is to oversee day to day management of all patient safety incidents, their responses, learning and patient and staff engagement.

15.6.4 Patient Safety Oversight Group

- The purpose of the PSOG is to provide executive oversight of all patient safety incidents, their responses, and their learning.

15.6.5 There is a paradigm shift from monitoring of process, timescales and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients. It should be noted that similarly the ICB's role will focus on oversight of PSIRF plans / priorities and monitoring progress with improvements. There will no longer be a requirement to 'declare' an SI and have individual patient safety responses 'signed off' by commissioners. However, they will wish to seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety. The metrics, measures (objective and subjective) and

evidence required to do this will need to be defined within the PSIRP for each priority which will be agreed in discussion with the ICB.

16 Education and training

16.1 Nominated staff must receive training in line with the Patient Safety Syllabus to provide three core functions:

- Learning response leads (investigators)
- Patient and staff engagement following an incident
- Those in PSIRF oversight roles

16.1 The Trust will have an NHSE approved supplier deliver this training in year one. Subject matter experts have received training in oversight, learning responses and patient engagement and have been integral in developing the PSIRP, policy and implementation of the Incident Review Groups.

16.2 The Trust is developing a sustainable solution to meet the training standards through the Executive-led Education, Training and Development Group and training should be delivered at system level.

16.3 The Trust should nominate at least one Patient Safety Specialist, who should complete level 3-5 of the Patient Safety Syllabus.

17 Monitoring compliance

17.1 The Incident Review Group has devolved responsibility for ensuring the appropriate and timely response to patient safety incidents, that includes escalation of emerging themes and concerning trends.

17.2 The Quality Lead is responsible for monitoring duty of candour compliance as set out in the policy.

17.3 The Patient Safety Oversight Group is responsible for timely submissions, and the quality assurance of all Patient Safety Incident Investigations.

18 Audit and Review (evaluating effectiveness)

18.1 All policies have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

18.2 Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

18.3 This document will be reviewed in its entirety every three years or sooner if new legislation, codes of practice or national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

18.4 All changes made to this policy will go through the governance route for development and approval as set out in the Policy on Policies.

21 Financial Checkpoint

21.1 This document has been confirmed by Finance to have no unbudgeted financial implications.

22 Equality Analysis

22.1 The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

22.2 Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

Appendix A – Glossary of terms

Term/Acronym	Definition
AAR	After Action Review is a method of evaluation that is used when the outcomes of an activity or event have been particularly successful or unsuccessful.
Arbitrary or Subjective	Chosen randomly or influenced by/based on personal beliefs or feelings, rather than on facts
Being open	Being open and transparent with patients and families when treatment or care goes wrong.
Care Group	A grouping of multi-disciplinary staff working together to provide care within a certain area.
CQC	Care Quality Commission - independent regulator of health and social care in England
Definitions of Harm	Unanticipated, unforeseen accidents (e.g., patient injuries, care complications, or death) which are a direct result of the care dispensed rather than the patient's underlying disease
Duty of Candour	Statutory duty of candour legislation requiring the Trust to be open and honest when moderate or greater harm occurs.
Governance Structures	System that provides a framework for managing organisations
HSE	Health and Safety Executive, an independent regulator for workplace health and safety.
HSSIB	Health Service Safety Investigation Body (formally HSIB)
Human Error	A human error is an action or decision which was not intended that has negative consequences or fails to achieve the desired outcome
Inequalities data	Facts and statistics collected relating to health inequalities which are unfair and avoidable differences in health across the population, and between different groups within society.
Integrated Care Board (ICB)	Statutory organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS.
Just Culture Approach	The treating of staff involved in a patient safety incident in a consistent, constructive, and fair way.
MDT	Multi-Disciplinary team
Neonatal Death	A baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born
Never Events	Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that

Term/Acronym	Definition
	provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
NHSE	National Health Service England
Principles of Proportionality	The least intrusive response appropriate to the risk presented
PSI	Patient Safety Incident (unintended or unexpected incidents which could have or did lead to harm for one or more patients receiving healthcare)
PSII	Patient Safety Incident Investigation (PSII) is a formal investigation tool which aims to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident.
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
SEIPS	System Engineering Initiative for Patient Safety - a framework for understanding outcomes within complex socio-technical systems.
SOP	Standard Operating Procedures
Stakeholder	People or groups who have an interest in what an organisation does, and who are affected by its decisions and actions.
Swarm Huddle	Swarm-based huddles are used to identify learning from patient safety incidents. 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.

Appendix B – Reporting structures