Imperial College Healthcare
NHS Trust

Patient Safety Incident Response Policy

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Purpose

This policy sets out how Imperial College Healthcare NHS Trust (ICHT) will meet the requirements of the national Patient Safety Incident Response Framework (PSIRF). This includes our approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning across the Acute Provider Collaborative (APC).

PSIRF advocates a co-ordinated and data-driven response to patient safety incidents, embedding patient safety incident response within a wider system of improvement. 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
- application of a range of system-based approaches to learning
- considered and proportionate responses to patient safety incidents
- supportive oversight focused on strengthening response system functioning and improvement

This policy should be read in conjunction with our current patient safety incident response plan, which is a separate document that sets out our plan for learning from patient safety events and safety improvement.

Scope

Patient safety incident responses under this policy follow a systems-based approach. This recognises that safety is provided by interactions between components, 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. We understand that safety outcomes and work processes are influenced by work-systems that include people, tasks, tools and technologies, organisation of work, environmental factors, and external factors.

Reviews undertaken under this policy have 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.

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

Our patient safety culture

Our organisational values, developed through extensive involvement with our staff and stakeholders, provide the foundations for all that we do. Our work to ensure safety (prevent harm) and our responses to patient safety events are guided by our Trust values:

- Kind: we are considerate and thoughtful, so you feel respected and included
- Expert: we draw on our diverse skills, knowledge and experience, so we provide the best possible care
- Collaborative: we actively seek others' views and ideas, so we achieve more together
- Aspirational: we are receptive and responsive to new thinking, so we never stop learning, discovering and improving

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk and improve safety. Specifically, they are not to apportion blame, liability, define avoidability or cause of death. We are committed to enabling a just and learning culture, where people feel able to speak up when things go wrong to enable us to share knowledge, learn and continuously improve. We demonstrate our commitment to a just and learning culture throughout our organisation, and this is reflected in our policies and procedures, including our human resources policies and procedures.

In addition, work on our safety culture will seek to ensure:

Open and transparent reporting through prompt reporting of patient safety events and concerns which is a requirement of all our colleagues. We know that open and transparent cultures, where colleagues feel able to report incidents and raise concerns without fear of recrimination, are essential to improving safety. It is important to us that all colleagues are fully supported to report patient safety incidents, near misses and to raise any safety related concerns to ensure timely safety improvement and learning so that system risks can be addressed, and future harms prevented.

Freedom to speak up. We want our staff to feel confident and able to speak up about any concerns they may have and feel safe when doing so. However, we recognise sometimes staff do not wish to raise concerns with their direct line manager. Therefore, we have freedom to speak up guardians in place who support staff to raise concerns and facilitate escalation in these circumstances. Further information can be found in our Freedom to Speak Up: Raising Concerns and Whistleblowing Policy.

To enable this in practice, as part of our incident responses and compassionate engagement we will ask:

- Who has been hurt?
- What are their needs? What matters to them?
- How do we best meet those needs?

We will measure of safety culture through local and national staff survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture.

Patient Safety Partners

We have established Patient Safety Partner (PSP) roles in line with the NHS England guidance, Framework for involving patients in patient safety guidance. Our PSP's have an important role to play in the co-design of safer healthcare within our Trust. Our PSPs use their lived experience as a patient, carer, family member or a member of the local community to support and advise on activities, policies and procedures that will help us to improve patient safety and deliver high quality care.

Our PSP's work alongside staff, volunteers, and patients, to co-design safety improvement initiatives, and participate in key conversations and meetings within the Trust focusing on patient safety. They have a mind-set for improving outcomes, whilst representing the patient, carer, family view and ensuring committee/meeting members are "walking in the patients' shoes".

Our PSPs have been involved in the development of our PSIRF plan, and in particular the design and development of our compassionate engagement and involvement processes. We will continue to seek their valuable insight as we continue to embed our PSIRF plan and policy.

Full role descriptions are provided for our PSPs along with any support requirements they may need to maximise their opportunities for involvement. Further information around the roles and responsibilities of our PSPs can be found in our Patient Safety Partner Involvement Policy.

Addressing health inequalities

We recognise that the Trust has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. Our aim is to improve health, wealth, wellbeing and equity for our patients and within our local communities and we are committed to our vision of 'better health for life' for our patients and communities. To achieve this, we must focus on improving disparities in health outcomes, especially between people from different ethnic and socioeconomic groups.

We recognise that some groups and communities experience variations in patient safety outcomes and can be disproportionately impacted by patient safety events. Through our implementation of PSIRF and in line with the Patient Safety Healthcare Inequalities Framework, we will seek to collate and utilise data, including our learning responses to identify actual and potential health inequalities and make recommendations to our Trust Board, as well as across the Acute Provider Collaborative on how to tackle these. Our approach is guided by NHS England's framework for involving patients in patient safety, ensuring that our strategies are both collaborative and focused on systemic improvement.

We recognise that our direct engagement with patients, families and carers following a patient safety incident must also recognise diverse needs and ensure equity and inclusivity for all. We are using the expertise of our patient safety partners to support the development of an inclusive compassionate engagement and involvement process. For example, we will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the

needs of those concerned and maximise their potential to be involved in our patient safety incident response.

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

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

This policy supports compassionate engagement at all levels to:

- Build trust with our patients/service users/carers and their families, as well as with our staff
- Ensure that the incident is clearly communicated with those involved, so they are aware of what occurred and that their experience of the situation is listened to and included in any review or learning response
- Reduce the risk of compounded harm
- Improve organisational learning by listening to and incorporating the perspectives of all involved in the incident
- Ensure that any support needs are communicated and met, where possible, and otherwise signposted to services to provide support.

Involving Patients and Families

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers. We are committed to involving and engaging with patients, families and carers following patient safety incidents or events. We want to be open and transparent as we want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence.

Getting involvement right with patients, families and carers in how we respond to patient safety incidents is crucial, particularly to support improving the safety of services we provide. We recognise that patients and family involvement can bring a different perspective to the circumstances and system factors linked to patient safety events and that people involved with and affected by patient safety events may have different questions and needs to that of the organisation.

We will follow national guidance and meet duty of candour requirements and ‘being open’. We recognise the need to involve patients and families as soon as possible in learning responses (where appropriate) via our initial incident review process and in all stages of patient safety incident investigation (PSII). This will be supported by an agreed key point of contact within the organisation and written materials which will be shared with patients and families, explaining the learning response process and signposting to support options where required.

Further information can be found in our Duty of Candour and Being Open Policy, and our compassionate involvement and engagement guidance. This includes the responsibilities of an engagement lead / named contact.

Involving Staff, Colleagues and Partners
Similarly, involvement of staff and colleagues (including partner agencies) is essential when responding to a patient safety incidents to ensure all perspectives are considered from the outset, key learning points are identified, and safety improvements are effective and timely. We will continue to promote, support, and encourage our colleagues and partners to report any incidents or near-misses. We will strive to be inclusive and support a wide range of contributions to patient safety learning and improvement.

The new approaches set out within PSIRF represent a culture shift to ensure staff have a voice and feel 'part of' the change. We have a responsibility to provide colleagues with support and guidance utilising the principles of good change management, so staff feel 'part of' rather than 'done to'. We will therefore ensure regular communication and involvement through our communication framework and our wider organisational governance structures.

It is essential that all staff are supported during and after patient safety incidents to allow them to recover and contribute to the learning and improvement processes. We will continue to develop our processes to support staff who have been involved in an incident, building on the comprehensive staff support services that we already have in place. CONTACT is a comprehensive staff support service inclusive of all. They provide a range of professional, confidential services, including counselling and trauma support. Further information on the support available to our staff can be found on the Trust intranet.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their local context and the populations they serve rather than only those that meet a certain defined threshold.

We will take a proportionate response to patient safety incidents and endeavour to focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improvement in safety. This is outlined within our patient safety incident response plan.

We have developed our understanding and insights over the past year, including regular discussions and engagement through our PSIRF task and finish group, as well as discussion at the executive management board for quality (EMBQ) and quality committee.

Our patient safety issues, and risks have been identified from the following data sources:

- Review and analysis of patient safety incident reporting data, across all levels of harm

- Key themes from complaints, PALS contacts, claims and inquests
- Key harm-free care metrics
- Key themes and issues from committees and groups with a remit relating to aspects of quality and patient safety (for example our medicines safety group, falls steering group etc).
- Risk registers
- Clinical audit
- Key themes from learning from deaths reviews
- Stakeholder discussions

Resources and training to support patient safety incident response

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite and that the quality of investigation, learning and improvement should be valued more than the quantity of investigations conducted. The Trust recognises and will work to the patient safety incident response standards.

We have implemented a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the PSIRF standards and the national patient safety syllabus.

We have trained learning response and engagement leads who can lead learning responses and compassionate engagement and involvement of people affected by safety incidents. Time will be allocated within job plans for these activities.

We have supported training and competency development in line with PSIRF requirements for our oversight leads, board members and senior leaders with specific responsibilities for quality and safety. We will review and seek to improve our practice and outcomes over time.

All our colleagues are required to complete mandatory training on the essentials of patient safety, including systems-thinking and human factors, basic requirements of reporting, investigating, and learning from incidents (reflecting the patient safety syllabus, 1a Essentials of Patient Safety for all staff).

We will seek regular feedback from colleagues about shared learning and systems improvement from patient safety events and consider whether any additional or bespoke training is required.

Patient safety incident response plan (PSIRP)

Our plan sets out how we intend 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, alongside the plan.

Our plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

- refocusing PSII towards a systems approach and the rigorous 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

Reviewing patient safety incident response policy and plan

Our plan is a 'living document' that will be monitored as we continue to respond to and learn from patient safety incidents. We will review the plan annually to ensure our focus remains aligned with our collaborative partners and reflects any emerging themes or concerns. This will include a review of our incident data and wider insights to inform our learning response and safety improvement priorities. 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.

As part of our review of the PSIRP, we will assess whether our learning responses have effectively identified and addressed healthcare inequalities, including those related to ethnicity, socio-economic status, and other protected characteristics, in line with the Patient Safety Healthcare Inequalities Reduction Framework.

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

Responding to patient safety incidents

Patient safety incident reporting arrangements

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

Certain incidents will require external reporting to national bodies in line with national guidance, as outlined in our Incident Reporting Policy. This will include escalation of appropriate incidents to the ICB, including never events, incidents where there is likely media interest, a regulatory breach or a high-risk unexpected patient safety incident investigation (PSII).

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

Patient safety incident response decision-making

"Where an incident type is well understood – for example, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness – resources may be better directed at improvement rather than repeat investigation (or other type of learning response)."

Taken from PSIRF supporting guidance, Guide to responding proportionately to patient safety incidents (NHSE 2022)

The Trust has governance and assurance systems to ensure oversight of incidents at both a divisional and organisational level. The patient safety team works with clinical leads and operational managers to ensure the following arrangements are in place:

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends or clusters of incidents within a specific service or site
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risks and issues (e.g. CQC concerns)
- Identification of any incidents requiring external reporting or scrutiny (e.g. never events, neonatal deaths, RIDDOR)
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures

Appendix 1 outlines our incident response decision making process that will be followed.

Initial incident reviews will be used to determine if any further investigation or escalation of an event is required. This will now include a wider range of options for further learning and improvement responses as outlined in our PSIRP. The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under our plan. This may often mean no further learning response is required, especially where the incident falls within one of the safety improvement plans.

A toolkit of learning response types is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

Responding to cross-system incidents

Relevant divisional leads and the patient safety team will continue to ensure any incidents that require cross system or partnership engagement are identified and shared through existing channels and networks, and that partnership colleagues are fully engaged in investigations and learning. Likewise, we will ensure we are responsive to incidents reported by partner colleagues that require input from another Trust, primarily by directing enquires to the relevant clinical teams or colleagues and seeking assurance that engagement, information sharing, and learning has been achieved, or taken forward. We will be mindful to address cross-system themes via our shared APC quality priorities.

NWL Integrated Care Board (ICB), as our host ICB, has confirmed they will support us and other NHS providers in the ICB with cross system incidents, to ensure positive responses and effective learning is disseminated. We will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

Timeframes for learning responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

One of the most important factors in ensuring timeliness of a learning response is thorough, complete and accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team. These principles are set out in the current incident reporting guidance but must be reinforced through the PSIRF.

Our plan provides more detail on the types of learning response considered most appropriate to the circumstances of the incident. Highly prescriptive timeframes for learning responses may not be helpful so the following are included as a guideline only:

- Debrief / Huddle – as soon as is safe to complete once an incident has happened
- Initial Incident Review (IIR) – as soon as possible, within 5 working days from date the IIR is requested
- After Action Review (AAR) – within 20 working days of decision to complete an AAR
- Thematic Review – 1 to 4 months depending on complexity
- MDT Review – 1 to 4 months depending on complexity
- Patient Safety Incident Investigation – comprehensive, up to 4 months depending on complexity, with a 6 month maximum in exceptional circumstances and only when extension has been agreed with the patient and family as outlined in the standards.

In exceptional circumstances (e.g. when a partner organisation requests an investigation is paused), a longer timeframe may be needed to respond to an incident. In this case, any extension to timescales should be agreed with those affected (including the patient, carers and staff).

Safety action development and monitoring improvement

We will use our learning responses to inform our areas for improvement and safety action development. We will develop our safety actions in line with best practice outlined within the NHS England safety action development guide. Our governance teams will maintain an overview across the organisation to identify themes, trends,

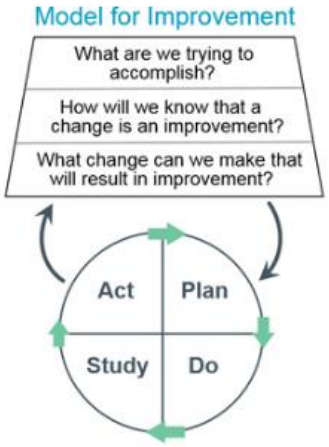
and triangulation with other sources of information that may reflect improvements and reduction of risk. Monitoring of safety actions and safety improvement plans will be overseen by the Safety Improvement Group, who will also support the triangulation of learning and adoption and spread of improvement.

It is important that monitoring of completion of safety actions does not become an end in and of itself, but rather a means to improve safety and quality outcomes and reduce risk. The Trust must therefore develop governance systems focused more on measuring and monitoring these outcomes, utilising subjective as well as objective measures.

Safety improvement plans

At Imperial College Healthcare NHS Trust we aim for all staff to feel confident and capable at making improvements in their workplace. In order to do this, we advocate to the use of the model for improvement to drive continuous improvement and provide a structure for improvement projects. This model consists of two parts. The first three questions help us define what we want to achieve, what ideas we think might make a difference, and what we'll measure to help us understand if change is an improvement.

The second part is the PDSA (Plan Do Study Act) cycle – outlining the steps for the actual testing of the change ideas. The cyclical nature allows the change to be refined and improved through repeated cycles of testing and learning.



We provide a comprehensive quality improvement training programme based on a competency framework that is accessible to all staff. Further information on our training programme can be found on our intranet.

We have had a safety improvement programme in place since 2018. The safety improvement team provide leadership and expertise to our safety improvement priorities outlined within our plan, with steering groups in place for individual work streams and overall reporting to our executive management board quality group. The safety improvement team work closely with the patient safety team and the quality improvement team to share learning and improvement expertise.

Outlined in our plan, our safety improvement priorities have been developed following review of quality insight data, including incidents, complaints, patient feedback, claims and inquests, audit, mortality data including structured judgement reviews, outcomes from our ward accreditation programme, risks and emerging issues, as well as

national, acute collaborative and local priorities and planned improvement work. These are reviewed and updated on an annual basis, using the learning from our patient safety incidents and wider sights to inform our priorities. Alongside the overarching programme, each priority has an individual improvement and measurement plan in place to address the specific learning and themes within the priority.

When developing safety actions, services are advised to check for ongoing and past improvement projects to ensure they align the safety actions appropriately or seek improvement advice from the safety improvement or quality improvement team on the best way to approach certain actions. This will ensure that the same safety actions are addressed consistently across the Trust, reducing duplication of effort and resource.

We will also look to engage with wider networks where there is opportunity to join up our improvement plans on shared themes to share learning and encourage adoption and spread of innovation. This will be via networks such as the acute provider collaborative, patient safety collaboratives and the local maternity and neonatal system.

Oversight roles and responsibilities

Effective oversight is required to ensure we can meet our PSIRF ambitions. Responsibility for oversight of PSIRF and implementation of our plan sits with our Trust Board. The 'responding to patient safety incidents' section above also describes some of the more operational principles that underpin this approach.

Our oversight will be:

- Focused on enabling learning and improvement
- Collaborative and compassionate
- Supportive of creating psychologically safe opportunities for learning and improvement
- Open and transparent
- Systems and data focused
- Through a lens of curiosity

The following governance and oversight groups will steer our response to patient safety incidents and ensure we deliver our PSIRF aims and objectives aligned to the oversight principles above.

The Initial Incident Review Group: The purpose of the group is to review and direct responses for newly reported safety events with a focus on:

- Incidents requiring comprehensive PSII response (as defined by the national priorities or local PSIRP)
- Incidents that have been reported as leading to moderate, severe or fatal harm
- Incidents where additional concerns have been raised by those involved
- Incidents that are linked to recurring themes
- Incidents that are being escalated through divisional teams

The Patient Safety Panel Review: The purpose of the group will be to:

- Review PSIIs and learning responses which have been through the EIRG to assess report content including; compassionate engagement, robustness of the systems-based learning response and recommendations
- Make recommendations to the Safety Improvement Group (SIG) for the progression of safety actions and improvements

The Safety Improvement Group: This monthly improvement group will bring our learning together and provide challenge / assurance to our safety improvement plans. The group will:

- Review learning response & improvement response outputs, including potential safety actions, contributory factors & triangulate with other data (e.g. complaints)
- Review of progression & barriers to completion of safety actions and improvement plans
- Review learning outputs from across the Trust to ensure emerging trends, issues and hotspots are being robustly identified
- Identify opportunities for adoption & spread of improvement
- Consider horizon scanning & thematic reviews
- Where applicable, generate safety actions based on insight and prioritise
- Inform the review and updates of this document

Outcomes and oversight of the organisations patient safety learning and improvement will be reported to our Executive Management Board for Quality, Quality Committee and Trust Board.

The Trust recognises and is committed to close working, in partnership, with the local ICB and other national commissioning bodies as required. 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 incidents
- Policy, planning and governance
- Competence and capacity
- Proportionate responses
- A focus on safety actions and improvement

It is important that under PSIRF there is a 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' a serious incident and have individual patient safety responses 'signed off' by commissioners.

The ICB 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 will be agreed in discussion with the ICB.

Complaints and appeals

Formal complaints from patients or families can be lodged through the Trust's complaints process, as described in our Concerns and Complaints Policy. Information on our Patient Advice and Liaison Service (PALS) and complaints service, including how to contact the team can be accessed here.

References

Imperial College Healthcare NHS Trust Duty of Candour and Being Open Policy – available on the Trust Intranet

Imperial College Healthcare NHS Trust Equality Diversity and Inclusion Policy – available on the Trust Intranet

Imperial College Healthcare NHS Trust Incident reporting Policy – available on the Trust intranet

Imperial College Healthcare NHS Trust Data Protection, Confidentiality and Information Sharing Policy – available on the Trust intranet

Imperial College Healthcare NHS Trust Patient Safety Partner Involvement Policy – available on the Trust intranet

NHSE (2021) Never Events list 2018. Available from: https://www.england.nhs.uk/publication/never-events/

NHSE (2021) Framework for involving patients in patient safety. Available from: https://www.england.nhs.uk/publication/framework-for-involving-patients-in-patient-safety/

NHSE (2022) Patient Safety Incident Response Framework. Available from: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/

- Patient Safety Incident Response Standards
- Engaging and involving patients, families and staff following a patient safety incident
- Guide to responding proportionately to patient safety incidents
- Oversight roles and responsibilities specificationhttp://www.legislation.gov.uk/ukpga/2010/15/contents

NHSE (2022) Patient Safety Learning Response Toolkit. Available from: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

NHSE (2025) Being Fair Tool. Available from: NHS England » Being fair toolhttps://www.england.nhs.uk/patient-safety/patient-safety-culture/being-fair-tool/

NHS England (2025) Patient safety healthcare inequalities reduction framework Available from: https://www.england.nhs.uk/long-read/patient-safety-healthcare-inequalities-reduction-framework/

Definitions & Abbreviations

Acute Provider Collaborative (APC): A formal partnership of the four acute NHS Trusts in North West London, namely Chelsea and Westminster Hospital NHS Foundation Trust, Imperial College Healthcare NHS Trust, London North West University Healthcare NHS Trust and The Hillingdon Hospitals NHS Foundation Trust. The four Trusts remain independent organisations but work closely together to make the most effective use of their collective resources to improve patient care.

After action review (AAR): 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 to identify the opportunities to improve and increase to occasions where success occurs.

Compassionate engagement. Describes an approach that prioritises and respects the needs of people who have been affected by a patient safety incident.

Deaths thought more likely than not due to problems in care. Incidents that meet the 'Learning from Deaths' criteria. Deaths clinically assessed as more likely than not due to problems in care -using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery. nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

Duty of Candour: Being open and honest with patients and families when treatment or care goes wrong.

Governance: Systems and processes that provides a framework for managing quality and safety within organisations.

Healthcare inequalities: Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

Incident: An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or psychological distress to a patient, staff, visitors or members of the public

Inquest: An inquest is a formal investigation conducted by a coroner to determine how someone died.

Initial Incident Review: A process and template used to gather additional information about an event, which includes consideration of:

- compassionate engagement with people involved with / affected by an incident
- to support proportionate decision making and consideration of events alongside the PSIRP.
- to commence systems-based review and learning from an incident

- to identify and provide assurance of immediate improvement actions being taken

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: Treating people involved in a patient safety incident in a consistent and fair way.

Learning Responses: Tools and guides (methods) used to support the identification of learning from patient safety incidents. A number of key learning response tools used incorporate the SEIPS (Systems Engineering Initiative for Patient Safety) framework.

Learning Response Lead (or Investigator): A member of staff, normally employed by the NHS Trust, who has been trained to conduct patient safety incident investigations.

Morbidity and mortality (M&M) review: have a central function in supporting services to achieve and maintain high standards of care. All deaths must be reviewed at specialty based multi-disciplinary M&M reviews. In addition, clinical teams should undertake in-depth specialty M&M reviews and discussions of any case that demonstrates an opportunity for reflection or learning or any case where a Medical Examiner has identified potential concerns that require investigation.

Never Event: Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Patient Safety Incident: Any unintended or unexpected incident that could have led or did lead to harm or one or more patients receiving NHS-funded care.

Patient Safety Incident Investigation (PSII): PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

Proportionate response - PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm.

Patient Safety Incident Response plan (PSIRP) sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

Patient Safety Incident Response Framework (PSIRF) - Sets out the NHS's approach to developing and maintaining effective systems and processes for

responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient Safety Partner - A Patient Safety Partner is someone who works with the NHS to make care safer for patients. The play a role in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.

Safety Culture - Safety culture is one of the two key foundations of the NHS patient safety strategy. We define a positive safety culture as one where the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all.

Stakeholder: People or groups who have an interest in what an organisation does, and who are affected by its decisions and actions

Structured Judgement Review (SJR): is a clinical judgement-based review method with a standard format. SJR reviewers provide a score on the quality of care provided through all applicable phases of care and will also identify any learning. Further information can be found in our Learning from Deaths Policy

Appendix 1: learning response decision making process