Patient safety incident response policy

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Purpose

This policy sets out how Chelsea and Westminster NHS Foundation Trust (CWFT) will meet the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out our approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning across the North West London (NWL) Acute Provider Collaborative (APC).

Our work to ensure the prevention of harm and our responses to patient safety events are guided by our Trust **PROUD** values:

- **P**utting patients first
- **R**esponsive to, and supportive of, patients and staff
- **O**pen, welcoming and honest
- **U**nfailingly kind, treating everyone with respect, compassion and dignity
- **D**etermined to develop our skills and continuously improve the quality of care

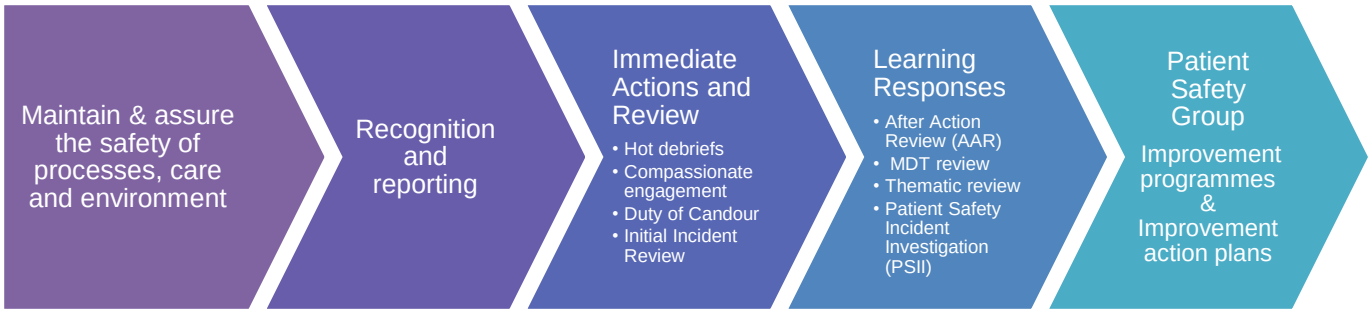
The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds the patient safety incident response within a wider system of improvement. This policy therefore underpins the development and maintenance of an effective patient safety incident response system that integrates 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 what we will be investigating and our plan for learning from patient safety events. Our incident management policy and risk management strategy also provide further detail on specific responsibilities and processes that support ongoing safety governance and improvement in the Trust.

Scope

Responses under this policy follow a ‘systems-based’ approach. This recognises that safety is provided by interactions between multiple components, not from a single one 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. Therefore, Patient Safety incident responses managed under this policy can be described with the following key stages:



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.

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

The Trust senior leadership have embraced nurturing a just and restorative climate and culture to mirror our **PROUD** values.

We will measure our 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.

In addition, our safety culture will help ensure:

Open and transparent reporting through prompt reporting of patient safety events and concerns which is a requirement of all our colleagues. 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.

Safety Climate / Safety Culture that reflects our **PROUD** values and behaviours. It is important to us that colleagues are fully supported to report all 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.

Compassionate Engagement and Restorative Practices whereby, as part of our incident responses, we will ask:

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

Effective oversight and safety governance is required to ensure we can meet our PSIRF ambitions. Specific information on roles and responsibilities and the responsibilities of groups involved in our safety governance is set out in our Patient Safety Incident Response Plan and our Incident Management Policy.

Patient safety partners

We have established Patient Safety Partner roles in line with the NHS England guidance, Framework for involving patients in patient safety guidance. Our Patient Safety Partners (PSP) have an important role in supporting the governance and oversight of Patient Safety Incident Responses. They provide community and patient perspectives to each Trust's safety improvement work and continuous improvement in patient safety.

Our PSP's are involved in the co-design of safer healthcare within our Trust. PSPs will 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 improve patient safety and help us to deliver high quality care.

PSPs will work alongside staff, volunteers, and patients, attend meetings (face-to-face and online), be involved in projects to co-design developments of patient safety initiatives, and join (and participate in) key conversations and meetings within the Trust focusing on patient safety. They will 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".

Full role descriptions are provided for PSPs along with any support requirements they may need to maximise their opportunities for involvement and ensure they are fully supported and enabled. Further information can be found in our Patient Safety Partner Involvement Policy.

We will also use the NHS England guidance above to inform our practice in seeking to involve patients and families following a patient safety incident.

Addressing health inequalities

CWFT serves a catchment area in excess of one million people in the following areas:

- Brent
- Central London
- Ealing
- Hammersmith and Fulham
- Harrow
- Hillingdon
- Hounslow
- Richmond
- Wandsworth
- West London

We seek to ensure that services are equitable, accessible and useful to everyone, regardless of any protected characteristic or socio-economic factors. We recognise that the Trust has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. During 2022/23, we formalised our position as part of the APC, one of whose key aims is to reduce health inequalities. We have co-developed a range of collaborative pathways across NWL, whilst also offering mutual aid as a means to start reducing health inequalities.

CWFT wholeheartedly supports the principles of equality and diversity and human rights in employment and service provision for patients, their family and carers. We aim to design and implement services, policies and practices that meet the diverse needs of our patients and staff (6,986 across all sites from 109 nationalities), ensuring that no-one is at a disadvantage and everyone is supported.

Our Equality and Diversity Policy broadly sets out how we can achieve this. In development of the Trust's PSIRF implementation plan, we recognise that some groups and communities experience variations in patient safety outcomes and can be disproportionately impacted by patient safety events and have considered this in our priority setting.

In line with the Patient Safety Healthcare Inequalities Reduction Framework, CWFT will ensure that our incident reviews and responses actively consider the impact of ethnicity, deprivation, and other protected characteristics. This includes using available data to identify disparities in the occurrence, reporting, and outcomes of incidents, and embedding equity-focused questions into our learning response processes. Our direct engagement with patients, families and carers following a patient safety investigation will ensure that our approach to learning and improvement is inclusive, culturally competent, and responsive to the needs of all population groups.

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 are committed to involving and engaging with patients, families and carers following patient safety incidents or events, and to fulfilling duty of candour requirements. 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.

Therefore, we will follow national guidance and meet duty of candour requirements and ‘being open’ and recognise the need to involve patients and families as soon as possible in learning responses (where appropriate) and in all stages of patient safety incident investigations (PSII). Further information is available in our Duty of Candour Policy.

Involving Staff, Colleagues and Partners

Similarly, involvement of staff and colleagues (including partner agencies) is essential when responding to a patient safety incident 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 incident 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 wider organisational governance structures.

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. Further information on the support available to our staff can be found in the Stress Management Policy.

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 context and the populations they serve rather than only those that meet a certain defined threshold.

We will endeavour to focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improvement in safety. It is also recognised 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. PSIRF guidance specifies the following standards that our plans will reflect:

1. A thorough analysis of relevant organisational data
2. Collaborative stakeholder engagement
3. A clear rationale for the response to each identified patent safety type

They will also be:

1. Updated as required and in accordance with emerging intelligence
2. Published on the Trust's external facing website

We have developed our understanding and insights over the past year, including regular discussions and engagement through our PSIRF steering group, as well as discussion at the Trust executive management board (EMB) and quality committee. Our patient safety profile has been identified from the following data sources:

- Review and analysis of four years of incident reporting data, across all levels of harm including serious incidents
- Key themes from complaints / mortality reviews / claims and inquests
- Key themes and issues from sub-groups of committees with a remit relating to quality and patient safety (medication safety group, falls steering group etc.)
- Review of our risk register
- Stakeholder discussions – divisional and non-executive directors

CWFT's patient safety incident response plan (PSIRP) will reflect the standards above and will be published alongside this overarching policy framework.

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.

It is therefore essential that the Trust evaluates their capacity and resources to deliver their plan on an on-going basis.

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, patient safety incident investigations and lead on compassionate engagement and involvement of people affected by safety incidents.

All 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, either more widely or targeted at specific staff groups or individuals.

Patient safety incident response plan (PSIRP)

Our PSIRP 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. The Trust 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:

- moving us towards a systems approach and rigorous identification of inter-connected causal factors and systems issues
- focusing on addressing these causal factors and the use of improvement science to prevent or continuously reduce repeat patient safety risks
- transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (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

The PSIRP is a ‘living document’ that will be monitored as the Trust to respond to patient safety incidents. The Trust will review the plan every 12 to 18 months to ensure our focus remains aligned with our APC partners and up to date. 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 the Trust website, replacing the previous version.

A rigorous planning exercise will be undertaken every 3 years and more frequently if appropriate (as agreed with our 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, looking at key organisational data (such as PSII reports, improvement plans, complaints, claims, staff survey results, and inequalities data) and liaising with our APC stakeholders.

As part of our regular 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.

Responding to patient safety incidents

Patient safety incident reporting arrangements

"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)

Patient safety incident reporting will remain in line with the Trust's Incident Management 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.

Certain incidents require external reporting to national bodies such as MNSI, HSSIB, HSE, and MHRA as per the Trust's Incident Management Policy. This will include escalation of appropriate incidents to the ICB, such as never events, incidents where there is likely media interest, a regulatory breach or a high-risk unexpected patient safety incident investigation (PSII).

The CWFT clinical governance team will continue to 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

As explained above, reporting of incidents should continue in line with existing Trust policy and guidance. The Trust also has governance and assurance systems to ensure oversight of incidents at both a divisional and organisational level. Governance teams work with clinical 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
- 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

The process for completion of an initial incident review to determine if any further investigation or escalation is required will remain. This will now include a wider range of options for further learning and improvement responses as outlined in the 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 the PSIRP. This may often mean no further review / response is required, especially where the incident falls within one of the improvement themes identified in the PSIRP.

Appendix 1 outlines the Trust's incident response decision making process that will be followed. It is recognised that some incidents may still require a case based comprehensive investigation, using a Patient Safety Incident Investigation (PSII) and applying the Patient Safety Incident Response Standards. Where this is the case, reference must be made to available investigatory capacity and resources as detailed in the PSIRP.

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 governance teams 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. We will be mindful to address cross-system themes via our shared APC quality priorities.

Likewise, the Trust 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.

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.

The Trust's PSIRP 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 – as soon as possible, within 5 working days of reporting
- After Action Review – within 20 working days of the initial report
- Multi-Disciplinary Team (MDT) Review – 1 to 3 months depending on complexity
- Thematic Review – 1 to 4 months depending on complexity
- Patient Safety Incident Investigation – comprehensive, 60 to 120 working days (2 – 4 months) depending on complexity, 6 month maximum in exceptional circumstances*

*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

PSIRF moves away from the identification of 'recommendations' which may lead to seeking solutions at too early a stage of the safety action development process. "Learning response" methods enable the collection of information to acquire knowledge. This is important, but it is only the beginning. A thorough human factors analysis of a patient safety incident does not always translate into better safety actions to reduce risk. You must move from identifying the learning to implementation of the lessons. Without an integrated process for designing, implementing, and monitoring safety actions, attempts to reduce risk and potential for harm will be limited.

Safety actions arising from a learning response should follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and thought must be given to monitoring and measures of success. Further guidance on this can be found in NHSE Guidance at https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

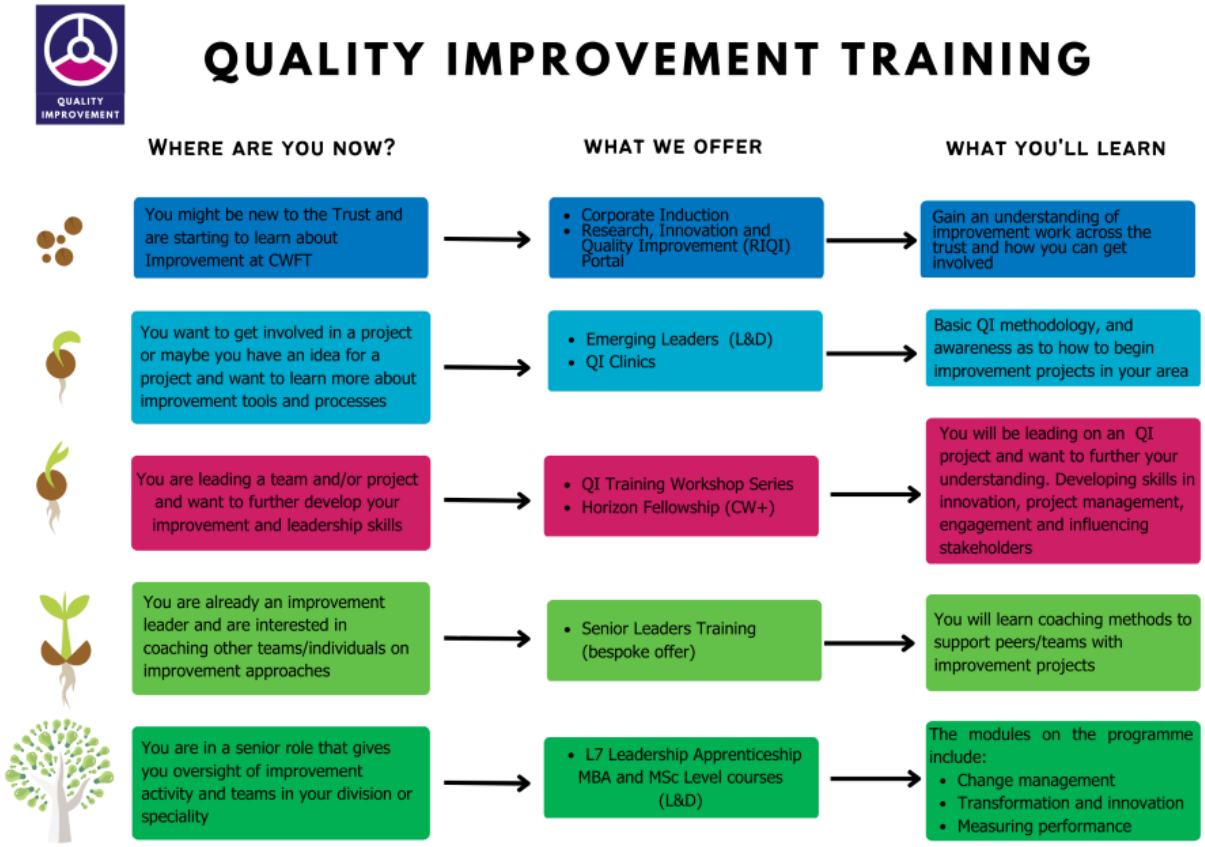
Safety Action Monitoring
Monitoring of completion and efficacy of safety actions will be through existing Trust governance processes with oversight at the patient safety group level and reporting assurance corporately to the quality committee. The CWFT clinical governance team will maintain an overview across the organisation to identify themes, trends, and triangulation with other sources of information (including complaints, inquests, patient surveys) that may reflect improvements and reduction of risk.

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 will therefore develop governance systems focused more on measuring and monitoring these outcomes, utilising subjective as well as objective measures.

When developing safety actions at CWFT, services will be advised to check for ongoing and past improvement projects to ensure they align the safety actions appropriately, or seek improvement advice from the clinical governance or improvement teams 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.

Quality Improvement
As referred to throughout this policy, CWFT has developed a Patient Safety Incident Response Plan (PSIRP) that clarifies what our Trust improvement priorities are. The Quality Improvement (QI) programme in our Trust supports with delivery of the wider quality priorities for the Trust, picked annually as part of our strategic priorities.

Comprehensive training on QI methodology is provided to all staff to support them with development of safety improvement plans as defined in our PSIRP.



The quality improvement team work closely with the clinical governance team to ensure that leadership and expertise are provided to work streams associated with our safety improvement priorities as outlined within our plan.

These are monitored through the Patient Safety and Clinical Effectiveness Groups respectively on a monthly basis.

Safety improvement plans

The PSIRP details how the Trust will ensure patient safety incidents are investigated in a more holistic and inclusive way, to identify learning and safety actions which will reduce risk and improve safety and quality using both PSIRF and QI methodology.

We will also look to engage with wider networks where there is an opportunity to join up our improvement plans on cross-cutting themes to share learning and encourage adoption and spread of innovation.

This will be via networks such as the APC, national patient safety collaborative and the local maternity and neonatal system.

Oversight roles and responsibilities

"When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures". To achieve this, organisations must look carefully not only at what they need to improve but also what they need to stop doing (e.g. panels to declare or review Serious Incident investigations).
Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control."
NHSE, PSIRF Guidance 'Oversight roles and responsibilities specification and Patient safety incident response standards' (p2)

Responsibility for oversight of the PSIRF for provider organisations sits with Trust Boards. The 'responding to patient safety incidents' section above also describes some of the more operational principles that underpin this approach. In Appendix 1, the following governance and oversight groups will be responsible for steering our responses to patient safety incidents:

Initial Incident Review (IIR) 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 severe harm or death
- 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

Learning Response Approval Group
The purpose of this group is to:

- Review PSIIs and learning responses which have been through IIR Group to assess report content including; compassionate engagement, robustness of the systems based learning response and recommendations
- Make recommendations to the Patient Safety Group or Clinical Effectiveness Group for the progression of safety actions and improvements

Patient Safety Group and Clinical Effectiveness Group
These monthly safety improvement groups will bring our learning together and provide challenge / assurance to our safety improvement plans. The groups will:

- Review learning response and improvement response outputs, including potential safety actions, contributory factors and triangulate with other data (e.g. audit)

- Review of progression and barriers to completion of safety actions and improvement plans
- Review learning outputs from across the Trust linked to relevant sub-groups to ensure emerging trends, issues and hotspots are being robustly identified
- Identify opportunities for adoption and 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 organisation's patient safety learning and improvement will be reported to our Executive Management Board and Quality Committee through quarterly and annual assurance reports.

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 ICB will sit on PSIRF implementation groups. Oversight and assurance arrangements will be developed through joint planning and arrangements must incorporate the key principles detailed in the guidance above, namely:

1. Compassionate engagement and involvement of those affected by incidents
2. Policy, planning and governance
3. Competence and capacity
4. Proportionate responses
5. Safety actions and improvement

It is important that under PSIRF 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' 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 to do this will need to be defined within our PSIRP for each priority which 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. Details of our complaints process, information on our Patient Advice and Liaison Service (PALS) and the support available to staff and patients can be found in the Complaints Policy. This includes details of how to contact the team.

References

NHS England (2019) The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients
Available from: https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

NHS England (2021) NHS Patient Safety Strategy: Progress so far
Available from: NHS England » NHS patient safety strategy priorities for leaders and patient safety specialists

NHS England (2022) Improving patient safety culture – a practical guide
Available from: NHS England » Improving patient safety culture – a practical guide

NHS England (2022) Patient Safety Incident Response Framework and supporting guidance
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NHS England (2022) Patient safety learning response toolkit
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NHS England (2022) Safety action development guide
Available from: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

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.

AAR – After action review
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.

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.

Health and Safety Executive (HSE)
The Health and Safety Executive (HSE) is Britain's national regulator for workplace health and safety. It prevents work-related death, injury and ill health. It is an executive non-departmental public body, sponsored by the Department for Work and Pensions.

Health Services Safety Investigations Body (HSSIB)
HSSIB (formerly HSIB) is funded by the Department for Health and Social Care and is responsible for carrying out independent investigations into NHS-funded care across England. HSSIB are also a key provider of Investigation Education.

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.

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.

Maternity and Newborn Safety Investigations (MNSI)
From 1 October 2023, the MNSI programme is being hosted by the Care Quality Commission (CQC). The programme of investigations into maternity and newborn safety incidents was previously overseen by the Healthcare Safety Investigation Branch (HSIB).

Medicines and Healthcare products Regulatory Agency (MHRA)
The Medicines and Healthcare products Regulatory Agency regulates medicines, medical devices and blood components for transfusion in the UK. They operate in a statutory framework set by HM Government, working within government and the wider health system to direct overall policy in their regulatory field.

MDT – Multi-disciplinary team review
An in-depth discussion of one or multiple patient safety incidents. They provide a structured, professional discussion involving senior staff representation from different disciplines.

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.

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.

PSII (Patient Safety Incident Investigation)
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.

PSIRP (Patient Safety Incident Response Plan)
Our local plan 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.

PSIRF (Patient Safety Incident Response Framework)
Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

Restorative Practice
A term used to describe behaviours, interactions and approaches which help to build and maintain positive, healthy relationships, resolve difficulties and repair harm.

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.

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.

https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

Appendix 1 – CWFT Decision-making flowchart