GOV 50: Patient Safety Incident Review Policy (Website Version)

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Contents

Introduction 4

What this policy covers 4

Purpose 6

1.0 Our patient Safety Culture 7

1.1 What is a Just Culture? 8

1.2 What is psychological safety? 8

1.3 Developing a Just Culture 8

2.0 Patient Safety Partners (PSPs) 9

2.1 Engagement of PSPs 9

2.2 Engagement Activity 9

3.0 Addressing Health Inequalites 10

4.0 Engagement and Involvement of patients, families and staff following a PSI 11

5.0 Patient Safety Incident (PSI) Response Planning 12

6.0 Resources and Training to Support a PSI esponse 13

7.0 Patient Safety Incident Response Plan 14

8.0 Reviewing the PSIR Policy and Plan 14

9.0 Responding to PSIs 15

9.1 PSI reporting arrangements 15

9.2 PSI Response decision-making 15

9.3 Response to cross-healthcare system incidents/issues 17

9.4 Timeframes for learning responses 17

9.5 Safety Action Development and Managing Improvement 17

9.6 Safety Improvement Plans 18

10.0 Oversight (supporting and monitoring) Roles and Responsibilities 18

10.1 Internal Oversight 18

10.2 External Oversight 19

11.0 Complaints and Appeals 19

Policy author declaration 21

Equality and Diversity Statement 21

Monitoring and review 21

Nuffield Health Copyright Statement 21

Glossary of Terms 22

1.0 Introduction

This policy supports the requirements of the new Patient Safety Incident Response Framework (PSIRF) and sets out Nuffield Health's approach to responding to patient safety incidents (PSIs) or safety concerns for the purpose of learning and improving patient safety.

NHS England (2022) defined patient safety incidents as *'…. unintended or unexpected events (including omissions) in healthcare that could, or did, harm one or more patients'*

PSIRF encourages organisations to make sensible decisions in response to patient safety incidents using the historical information they hold about the incidents which occur most frequently, or where safety risks are raised as concerns by staff or patients – these fall into categories known as 'near misses', no harm or low harm.

PSIRF wants responses to safety incidents to lead to changes in the way things are done in order to reduce the risk of a safety incident occurring at all, by addressing concerns raised by staff or patients, or occurring again by reviewing everything that may have contributed to the safety incident occurring in the first place. Looking at something in great detail and talking to all those involved can lead to improvements in the way care is delivered or a department is organised.

This policy brings together and supports the four key aims of PSIRF which are:

- ✓ being kind to and involving those affected by a patient safety incident – this incudes patients, their families or carers and staff.
- ✓ not trying to find someone to blame* for an incident but looking at the whole environment in which an incident occurred to find out everything that may have contributed to it happening.
- ✓ using different methods/ways to learn from patient safety incidents or concerns.
- ✓ the centre of an organisation and the other external organisations they work with providing support to lead to the best improvement in safety and care.

* if it is found that someone did something unsafe, which led to patient harm, then this would be dealt with in a formal way outside the incident investigation process.

What this Policy Covers:

This policy is specific to responses to patient safety incidents undertaken only for the purpose of learning and improvement across Nuffield Health's:

- 37 hospitals within England (34), Scotland (2) and Wales (1) delivering all, or a selection of, the following:

    - planned surgery to adults;
    - planned surgery to children and young people;
    - cancer services; diagnostic services (anything which helps find out what is wrong with someone such as an x-ray or ultrasound scan or specialist blood test);
    - decontamination (sterilisation) services
    - critical care (for example, intensive care, following surgical or medical procedures.

- Primary Care Services including:

    - Health Assessment Clinics;
    - GP Services, Mental Health Services;
    - Physiotherapy Services;
    - Clinical Fitness.

Responses to patient safety incidents under this policy uses an approach which recognises that patient safety is achieved through everything within the healthcare system complimenting each other i.e. just focusing on who is responsible for an incident, rather than what may have contributed to the healthcare staff involved taking the actions they did at the time, will not result in changes that reduce the chances of an incident happening again in the future. 'Human error', should not simply be stated as the cause of an incident.

PSIRF does not look for who is to blame or at fault, it looks for things that can be prevented or may have caused harm (or even death) so that learning and improvement can occur.

Other processes, such as those shown in the table below differ from those of a patient safety incident response and are not included in this policy:

Legal Claims	Financial Investigations
Complaints	Human Resources/personnel Investigations
Coroners Investigations into deaths	Data protection issues
Criminal Investigations	Professional Standards Investigations i.e. those involving doctors/nurses or other healthcare professionals
Building and equipment Issues	Safeguarding (abuse) concerns

Information from a patient safety response process can be shared with people leading other types of investigations, but other investigations, such as those listed above, should not be taken into account when investigating a patient safety incident.

Purpose:

The purpose of this Policy is to ensure that all Nuffield Health employees in patient-facing roles working across the Charity:

- ✓ understand the new NHS England (NHSE) Patient Safety Incident Response Framework (PSIRF), which the Charity has chosen to adopt for all its patients.

- ✓ receive training to ensure they understand PSIRF and apply it in their everyday work to improve patient safety.

- ✓ understand and adhere to the Nuffield Health Patient Safety Incident Response Plan available on www.nuffieldhealth.com

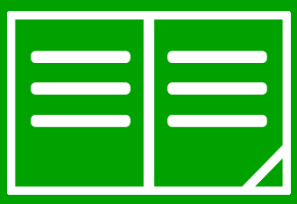
- ✓ report patient safety incidents, including low/no harm events or near misses in order that the Charity can clearly identify its most frequently occurring incidents and those which may cause harm if preventative safety actions are not identified.

- ✓ are confident to speak out about any patient safety incidents, or risks which they believe could develop into incidents, in order to learn from them to help prevent future harm to patients

- ✓ are confident to ask patients and their families what they think about the service and care they have received in order to improve patient safety

- ✓ follow the PSIRF guidance for being kind to (and involving) those affected by a patient safety incident – this incudes patients, their families or carers and staff Understand the language associated with both PSIRF and Duty of Candour (responsibility to be open and honest when things go wrong) – a Glossary of terms is provided on page 22 of this document to facilitate this.

Documents which may be of interest:



NHSE Patient Safety Incident Response Framework (2022). Available at: NHSE PSIRF 2022

NHSE and the Healthcare safety Investigation Branch (2022) Engaging and involving patients, families and staff following a patient safety incident. Available at: NHSE HSIB 2022 Engaging and involving patients, families and staff following a PSI

NHSE (2022) Guide to responding proportionately to patient safety incidents. Available at: NHSE Guide to responding proportionately to PSIs 2022

NHSE (2022) patient safety Incident Response Standards. Available at: NHSE PSIRF Standards 2022

Oversight roles and responsibilities specification (2022). Available at: NHSE Oversight roles and responsibilities 2022

1.0 Our Patient Safety Culture:

An environment where staff feel valued, well supported and enjoy and understand their work is most likely to lead to one where patient safety is of the highest importance.

There have been many well-known court cases in healthcare in the last few decades that have highlighted the failure of some organisations to be open and honest with patients and their families in response to patient safety incidents that have caused harm. Examples of these include:.:

- The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Enquiry, Feb 2013) available at: Easy read Francis report 2013
- The Report of the Morecombe Bay Investigation (March 2015) available at: Kirkup Report 2025
- The Ockenden Review (March 2022) available at: Easy Read Ockenden Report 2022

Nuffield Health recognises the importance of creating an environment for staff and patients which encourages them to feel safe to speak out if they are worried about or involved in anything which impacts the safety of the Charity's patients.

1.1. What is a Just Culture:

A 'just culture' is '*one that balances fairness, learning and accountability.*' (Nursing and Midwifery Council (NMC), 2021). Accountability means a person taking responsibility for their own decisions and actions.

The success of PSIRF will rely on a just culture where staff, patients and their families can expect to be:

- treated with kindness when a patient safety incident occurs
- told the truth about what is known at the time the incident is recognised
- asked what they would like to find out during the learning response (investigation) to the incident
- involved in the response process if they choose to be
- allowed to read, in full, the written response to the incident
- asked to contribute to any actions which could improve safety where the learning response shows that these are required.

1.2 What is psychological safety?

Psychological safety is created in an environment where there is *openness and trust that allows team members to feel comfortable taking risks and making mistakes. To be able to work in a psychologically safe environment, it is vital for healthcare professionals and patients to feel comfortable in sharing their concerns, fears or any other issues that might hinder (reduce) the quality of patient care.'* (Psychological Safety Academy, 2022)

1.3 Developing a Just Culture:

Nuffield Health's has appointed a Head of Safety Culture who has developed a detailed plan which includes how concerns about patient safety can be reported and escalated to senior managers at the centre of the Charity, if necessary, to make sure they are investigated and acted upon

The plan has been formulated with, and supported by, the Nuffield Health Executive Committee and Board of Governors.

The Charity is ensuring that staff throughout the organisation receive training in speaking out, listening and following up on patient safety concerns

There is additional face-to-face training for Senior Leaders within the Charity to ensure they understand the importance for patient safety of both a just culture and psychological safety for the staff they are responsible for.

2.0 Patient Safety Partners (PSPs):

2.1 Engagement of PSPs:

Involving and talking to patients and their families about patient safety is one of the most important parts of PSIRF for 3 main reasons:

- it is the best way to learn from a patient safety incident in which they are involved
- it recognises the vital role they play in improving the safety of care delivered across the charity by asking them to be the voice of the patient
- it involves them as partners in their own safety

PSPs fulfil the role that patients and their carers can play in supporting and contributing to Nuffield Health's processes for monitoring and responding to patient safety incidents or concerns.

2.2 PSP Engagement Activity

Initially PSPs will be members of a new Committee called the Patient Safety Improvement Forum (PSIF), which monitors how incidents are being investigated, lessons are being learned and safety improvements are being shared. Further details of which can be found on Page 20, 9.6

Over time this will enable them to provide the patient's perspective in the following areas:

- patient safety improvement projects
- patient information design and review
- national/charity policy implementation
- committees which monitor the safety of what the charity does for patients
- staff training programmes

The intention is to start with PSP involvement in central committees and project work and as PSIRF becomes more widely and confidently used, to increase the number and involve them in visits to the healthcare facilities throughout England, Wales and Scotland to support patient safety activity at a more local level.

Nuffield Health plan to have the PSPs in place by the end of 2023.

3.0 Addressing Health Inequalities:

Figure 2 demonstrates how Nuffield Health addresses Health Inequalities overall through its connected health and wellbeing services:

NHS England explains health inequalities as meaning 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. Specific Actions the Charity is taking to address health inequalities include:

- Making access to the Charity easier for patients and clients and having closer relationships with local NHS Trusts.
- Providing opportunities for people who do not have private health insurance, or their own money, to access the Charity's services and benefit from its broad health and wellbeing expertise.
- Providing Equity, Diversity and Inclusion Training (EDI) across all levels of the Charity
- Working with health professionals and policy makers to better understand and support faith-based communities in order to improve their experience of healthcare.

When a patient safety incident occurs, staff at the site will ensure they understand anything which may affect the patient of family's ability to be fully involved in any learning response (investigation):

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex, and sexual orientation

These are known as 'protected characteristics' and there will be a requirement to address them prior to the learning response beginning.

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

PSIRF has openness and honesty at its heart when a patient safety incident occurs and requires an approach which is kind and also involves staff, patients and/or their families in any learning response.

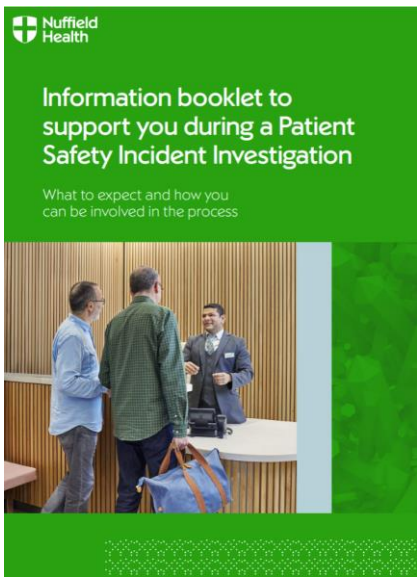
PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if the right support is provided and done so in a way that meets the needs of the staff, patient and/or their family.

This can only be achieved by working with those affected by patient safety incidents to understand and answer any questions they have about the incident and provide them with information about how they can access emotional or mental health support as required.

Nuffield Health is developing a detailed Policy explaining how it will ensure openness and honesty with patients and their families following a patient safety incident and ensure they are included throughout learning response process.

The Charity has also developed the following guides to assist employees and those leading learning responses to provide the highest standards of support when they have been involved in a patient safety incident:

For Patients:



5.0 Patient Safety Incident Response Planning:

PSIRF provides guidance for organisations to respond to patient safety incidents and safety issues in a way that allows the most learning and improvement.

There are national requirements, set by Government bodies, for certain types of patient safety incident which Nuffield Health MUST investigate, but also the Charity can choose very specific patient safety incidents that have occurred the most frequently to investigate in greater depth, even if they have caused no or very little harm.

The idea behind this is to allow the greatest improvement to patient safety by concentrating on understanding those things which happen most often, not those which almost never occur, although these will not be ignored.

There are different methods of learning from a patient safety incident and those undertaking learning responses can choose which method is the best one depending on the type of patient safety incident that has occurred. Examples of these include:

- Gathering together all the people who were involved in the incident immediately or within 24 hours to discuss what each person thinks may have contributed to the incident occurring – this is called a Swarm
- Gathering together all the people who were involved in the incident, 3 – 5 days after the incident occurred, but also inviting other experts or people in leadership roles who can help work the team out what safety actions may be needed and who needs to be involved – this is called an After-Action Review
- Making a list of questions about what needs answered about a patient safety incident. These come from the leaders at the site, the staff, patient and/or family involved in the incident.

  Once this is done, gathering together all the people who were involved in the incident, but also speaking to them individually to understand in much more detail each person's understanding of what happened and what they think may have contributed to the patient safety incident occurring. This also includes asking the patient and/or their family.

  Finally, writing a detailed investigation report which is shared with all those involved including the patient and/or their family – this is called a Patient Safety Incident Investigation.

- Reviewing a series of patient records for patient safety incidents which are similar in nature to understand the similarities between the incidents – this is called a case notes review.

6.0 Resources and Training to support patient safety incident response:

Nuffield Health's created a PSIRF training plan, which met the requirements of the NHS England PSIRF Standards (2022) included:

- online learning for all staff,
- online learning for those in leadership roles
- face-to-face training provided by external trainers for:
  - those who carry out learning responses,
  - those who work closely with staff, patients and or their families to support them when a patient safety incident occurs,
  - those leaders in the charity who provide extra support for all the staff in patient-facing roles.

7.0 Patient Safety Incident Response Plan (PSIRP)

The Nuffield Health PSIRP sets out how the Charity intends to respond to patient safety incidents over a period of 12 to 18 months from October 1st, 2023. The plan is not a permanent set of rules that cannot be changed. The specific circumstances in which each patient safety incident occurred will be taken into account, including the needs of those affected.

It can be found on www.nuffieldhealth.com and describes the steps the charity took to develop its plan, including:

- talking to people inside the Charity and outside it,
- examining patient safety incident records,
- describing safety issues found in the patient safety incident records,
- identifying safety improvement work the charity was already doing,
- agreeing the type of responses methods which could be used to respond to a patient safety incident.

8.0 Reviewing our Patient Safety Incident Response Policy and Plan

Nuffield Health's PSIRP will be reviewed every 12 to 18 months to ensure it works and that it concentrates on putting patient safety improvement at its heart. And that this improvement is based on the most frequently occurring incidents at the time of the review.

This will also provide an opportunity to re-engage with people inside and outside the charity to discuss and understand any improvements that have been made in the previous 12 to 18 months.

Updated plans will be published on the www.nuffieldhealth.com website, replacing the previous version.

A rigorous planning exercise will be undertaken at least every four years, to ensure there continues to be a strong balance between learning and improvement.

This Policy will also be reviewed in 12 months, or sooner if needed, as the organisation learns and adapts to PSIRF ensuring that it considers how effective the different learning response tools have been and the feedback from those using them when learning from a PSI.

9.0 Responding to Patient Safety Incidents

Nuffield Health has a document called a Quality Manual that describes how the Charity manages everything associated with delivering and reviewing safe care and services. To support with PSIRF there are guides available to the staff for all of the following:

- Swarm Huddles
- After Action Reviews
- Patient Safety Incident Investigations (PSII) Reports and guidance
- How to conduct staff interviews as part of an incident investigation

9.1 Patient Safety Incident Reporting Arrangements

Nuffield Health has an electronic incident reporting system, Radar, which can be used by any employee across the whole organisation as well as any of the medical consultants working with the Charity to report a patient safety incident.

New employees receive training about how to use this system within the first two weeks of starting to work for the charity and this makes it clear that incidents must be reported at the time they occur, as soon after the incident as possible or as soon as a member of the Charity is made aware that an incident has occurred. For example, if a patient has been discharged from hospital but found to have been treated for an infection by their GP or at a local NHS Hospital.

Recording all patient safety incidents on Radar allows the Charity to see if there are any patterns developing in the types of incidents which occur and where these are seen, a group of experts can work together to look at all the incidents at one time and develop safety actions to reduce the risk of the incidents happening again. These are called themed reviews, and the results can be shared across the whole Charity for the benefit of all patients/clients.

9.2 Patient Safety Incident Response Decision-making

Having looked at the last five years' worth of patient safety incidents within Nuffield Health, the Charity has been able to identify six areas which it wants to understand more about so it can look at how improvements can be made to reduce the chances of similar patient safety incidents of the same type happening again. These areas are:

- Venous Thrombo-embolism – a condition that occurs when a blood clot forms in a vein. There are two types – a Deep Vein Thrombosis (DVT) which usually forms in the lower leg, thigh or pelvis or a Pulmonary embolism, where the clot is in the blood vessels of the lungs.

- Medicines administration or omission errors in non-cancer patients (giving or failing to give medicine to a patient when it has been prescribed by a doctor).
- Medicines administration or omission errors in cancer patients.
- Unplanned transfers of patients from a Nuffield Health Hospital to an NHS Trust for either cardiac (heart) problems or other unexpected medical problems.
- Wound infections following surgery after the patient has left a Nuffield Health Hospital.
- Patients going back to the operating theatre following their operation because they have not recovered in the way expected. For example, they may be bleeding from their wound.

The PSIRF Plan provides the staff caring for patients/clients with any of the problems listed above on the response options (the choices they have to investigate why these incidents may have happened and what they can learn from them). Examples of these response options were described on Page 14.

As well as this, the Charity has a weekly meeting to discuss all significant incidents, or those which have the potential for significant harm, at the Adverse Event Forum and monthly at the Patient Safety Improvement Forum. These meetings are also designed to provide extra support with these decisions to sites as they start working with PSIRF.

Other incidents which have resulted in significant harm, or a near miss where there is a potential to learn and prevent harm, will also need to have a response. The options for these will be based on the level of harm and include those already mentioned on page 14.

The way in which improvements can be made and shared across the organisation will depend upon the type of incident that has occurred.

Two new Forums have been created in order to recognise where there are repeated incidents of the same type, agree how they will be investigated and understood and what will need to be done to support the safety actions that need to be done in order to reduce the chance of similar incidents happening again in the future.

They are the weekly Adverse Event Forum and the monthly Patient Safety Improvement Forum. Other means of sharing learning are:

- Quality Flashes – these are urgent email messages containing a document which has the details of either a serious incident that has already occurred, or a risk to patient safety that has been identified. The idea being that every hospital or clinic in the Charity can check whether they think the incident could happen, of the risk become an incident, at their site.
- Monthly discussions with senior clinical leaders to explain either one or a series of patient safety incidents which have been investigated and the action needed to prevent them happening in the future.
- Weekly 'lunch and learn' virtual meetings which any employee across the Charity can attend. Each week a different presents information about something related to patient

safety and everyone attending the meeting has the opportunity to ask questions or give their own experience of the subject.

- Quarterly meetings with local NHS organisations to share learning from patient safety incidents between everyone providing care in a specific area of the country.

9.3 Responding to patient safety incidents /issues involving an NHS patient

Nuffield Health Hospitals which provide care to NHS patients must agree with their local NHS organisations how they will report and investigate patient safety incidents which affect a patient that has received care in both places. For example, where a patient has their surgery in a Nuffield Health Hospital but is then moved into the NHS for another part of their care.

N.B. How this is done must be agreed in writing.

9.4 Timeframes for learning responses

It is important to ensure any response to a patient safety incident is completed within an agreed amount of time after the incident occurs.

NHS England makes recommendations for certain types of learning response, as detailed below and Nuffield Health will adhere to these:

Swarm Huddles – as near to the time the incident occurs as possible but, as a maximum, within 24hrs it occurring.

After Action Reviews – within 3 – 5 days of the incident occurring.

Patient Safety Incident Investigations – these should take a maximum of 6 months but in general should be completed within 3 months of the incident occurring.

9.5 Safety Action Development and Monitoring Improvement

A Safety Action is an action taken to reduce the risk of harm happening again and improve the level of safety for patients and staff within healthcare.

Nuffield Health Hospitals/Clinics will use the NHS England '*Safety Action Development Guide*' to support their safety action plans. This can be found at NHSE Safety Action Development Guide 2022

It is known that the outcome of patient safety incident learning responses i.e. safety actions, can be upsetting for those involved in a patient safety incident and Nuffield Health recognises that it is important to do this in a sensitive and supportive way so that the staff support the improvements which are recommended.

Nuffield Health Hospitals/Clinics will use the NHS England '*SHARE debrief tool*' which has been developed to support leaders achieve this. This can be found at NHSE Share Debrief Tool

Ensuring safety actions are used within the Charity is important and will be done as follows:

- In hospitals, by the Director of Clinical Services (matron) who will include this in the local relevant quality and safety meetings.
- At non-hospital sites by Clinic Managers who will include this in their local team meetings.
- Regionally and centrally by the Directors of Quality with any safety actions, which could benefit the organisation, or actions which are not progressing being discussed at the weekly Adverse Event Forum and monthly Patient Safety Improvement Forum.

The Patient Safety Improvement Forum reports key information to the Nuffield Health Quality Board which monitors all aspects of safety and quality across the Charity.

9.6 Safety Improvement Plans

The Patient Safety Improvement Forum has been developed to ensure that what is learned from patient safety incidents and issues throughout Nuffield Health can be shared across the organisation as a whole where necessary.

It is the intention that safety improvement plans will be developed to include the safety actions from learning responses which are useful for the whole Charity to make positive changes for patient safety.

10.0 Oversight (support and monitoring) Roles and Responsibilities

10.1 Internal Oversight:

The training which has been delivered to staff who work with patients has ensured, and will continue to ensure, that each Hospital Site and Clinic, have leaders who are trained to investigate and learn from incidents and to involve staff, patients and/or families throughout the investigation process, if they wish to be involved.

'An Introduction to PSIRF and Proportionate Response Tools' training has been delivered to over 350 staff across both Hospitals and clinics and is available as a recording on the Charity's internal extranet PSIRF site for new employees, or those who have been unable to attend any of the live training.

Monitoring of improvements made in response to patient safety incidents will occur a number of ways:

1. Expert Advisory Groups (these represent the different specialist areas of the business. For example, Medicines Management; pre-operative assessment; theatres and infection control0.
2. Patient Safety Improvement Forum
3. Director of Quality Site visits/virtual reviews.
4. Annual Hospital Quality Reviews (internal process similar to a CQC inspection)

10.2 External Oversight:

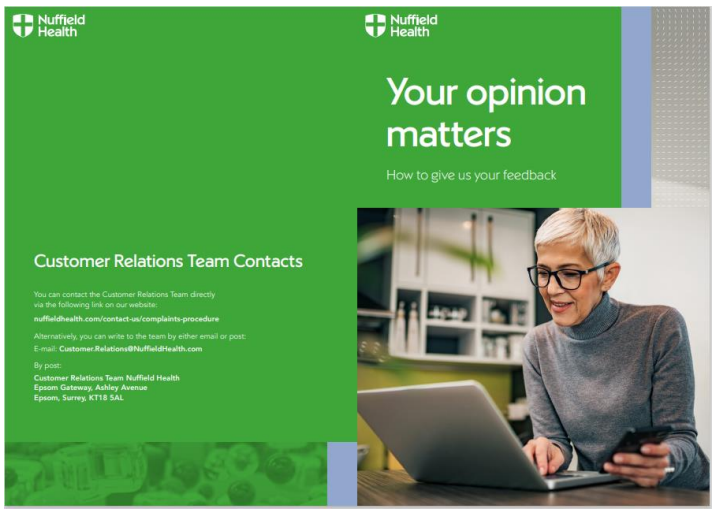
The NHS Leicester, Leicestershire and Rutland Integrated Care Board (ICB) an NHS organisation involved in the purchasing of healthcare from the Independent Sector and NHS Trusts for a local population, in agreement with NHS England, has provided support (and will continue to do so) with the PSIR Plan.
This includes an invitation to be part of their PSIRF Implementation and Safety Improvement Network Meetings for the Nuffield Health Leads for Patient Safety and Clinical Effectiveness.

For Hospital sites, the Directors of Clinical Services and Health Service Directors, will organise similar relationships with their local ICB equivalents in order to ensure they enable and participate in sharing of learning across the wider healthcare network as specified within PSIRF. This document will be updated as how this works will become clearer during transition.

NHSE have indicated that they are working with the Care Quality Commission (the government body who regulates, monitors and inspects healthcare in England) to provide guidance to healthcare providers on how their inspections will change with the implementation of PSIRF. Again, this document will be updated once that guidance has been received.

11.0 Complaints and Appeals

Nuffield Health's Complaints Management Policy is separate from PSIRF. It is hoped that patients and their families will not feel the need to complain about how a patient safety incident, in which they were involved, is managed because staff at the site will have offered them the opportunity to be involved in the learning response. However, staff must still provide patients with a copy of the *'Your Opinion Matters'* Leaflet which details the way patients can provide feedback to Nuffield Health and how they can expect any concerns or complains to be managed. The hyperlink for this can be found below:



The leaflet details the four-stage process for all England, Scotland and Wales, which includes how patients/their families can appeal which include locally (at the site the incident occurred), organisationally (Nuffield Health Central Customer relations Manager) or externally (by an Independent Adjudicator).

Policy author declaration

The document style and format are consistent with Nuffield Health Policy GOV 04 – Quality Governance Framework (including footer and explanation of terms used) and are relevant to this Policy.

The title/outcome/objective/target audience and monitoring arrangements are clear and unambiguous.

The relevant expertise has been used, and the evidence-base is relevant and current. There are supporting references, and a cross-reference to associated documents (where applicable).

Stakeholder, user and ratification forum consultation confirms accuracy and clarity of document/statements.

Superseded documents have been referenced on page 1, and master location, for this document has been documented.

Equality and Diversity Statement

I confirm that this document does not discriminate on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation.

Monitoring and review

This Policy/Protocol/SOP shall be reviewed no later 1 year from the date of issue and sooner if required as PSIRF evolves or to meet new or revised legislation, regulation, national guidance or Nuffield Health strategy or policy.

Monitoring of local facility compliance to the policy will be undertaken annually and reported to the relevant Committee or Board.

Copyright Statement:

Glossary of terms:

After Action Review (AAR)	A structured approach for reflecting on the work of a group and identifying strengths, weaknesses and areas for improvement.
Candour	The quality of being open and honest.
Duty of Candour	Responsibility to be open and transparent in relation to a safety incident
Integrated Care Boards (ICBs)	A statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area. Formerly known as a CCG.
Just Culture	A culture that balances fairness, learning and accountability.
Learning Response	Any response to a patient Safety incident that incorporates a system-based approach to capturing learning to inform safety actions for improvement. The system here is the 'Work System' (see below).
Patient Safety Incident (PSI)	Something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm.
Patient Safety Incident Investigation (PSII)	A PSII is undertaken when an adverse event or near-miss indicates significant patient safety risks and the potential for new learning.
Psychological Safety	An environment characterised by openness and trust that allows team members to feel comfortable taking risks and making mistakes.
Safety Actions	Actions to reduce risk following the identification and agreement of the aspects of a work system (see below) where change could reduce risk and the potential for harm.
SHARE Debrief	Scene, Hear, Articulate, Response, Embed is a tool that can be used to support healthcare leaders to engage staff and teams who may be affected by the outcome (safety actions) of a learning response (investigation).
Swarm Huddle	A quick analysis occurring immediately (or within 24 hrs) of an incident to understand what happened, how it happened and what needs to be done to reduce the risk of it happening again. Includes all those involved in the incident 'swarming' together.