

Patient safety incident response plan 2024-2026

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1.0 Purpose, Scope, Aims and Objectives

1.1 Purpose

1.1.1 This patient safety incident response plan sets out how **Ashford and St Peter's Hospitals NHS Foundation Trust** intends to respond to patient safety incidents over a period of 18 to 24 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

1.1.2 Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors that lead to patient safety incidents. These findings are then targeted with strong systemic improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

1.1.3 We have committed to improving patient safety through the adoption of the Patient Safety Incident Response Framework, supporting a systematic, compassionate, and proficient response to patient safety incidents; anchored in the principles of openness, fair accountability, learning, and continuous improvement.

1.1.4 The 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. In line with the NHS Patient Safety Strategy (2019) and PISRF principles, Ashford and St Peter's Hospitals NHS Trust prioritise compassionate engagement with patients, families, and staff affected by incidents. This provides vital insight into how to improve care, ultimately making services safer for patients. The focus is on understanding how incidents happen – including the factors that contribute to them.

1.1.5 This plan should be reviewed alongside the Trust Patient Safety Policy, which provides more detail including roles and responsibilities, and support for those involved in a patient safety incident.

1.2 Scope

1.2.1 There are many ways to respond to an incident. This document covers responses **conducted solely for the purpose of system learning and improvement.**

1.2.2. Patient safety incidents are any unintended or unexpected incidents which could have, or did, lead to harm for one or more patient's receiving healthcare.

1.2.3. There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

1.2.4. Responses covered in this plan include:

- Patient Safety Incident Investigations (PSIIs)
- After Action Reviews
- Multidisciplinary Reviews
- SWARM Huddles

Please see Appendix A for details

1.2.5 It is equally important to identify and learn from areas of good practice, as well as learning from incidents. The tools and methods outlined in Appendix A can also be used to understand areas of good practice using a systems-based approach, which can then be shared across the Trust to proactively reduce risk and prevent incidents in other areas.

1.2.5. Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners' inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan.

1.2.6. To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

- human resource (employee relations) teams for professional conduct/competence issues and if appropriate, for referral to professional regulators
- legal teams for clinical negligence claims
- medical examiners and if appropriate local coroners for issues related to the cause of a death.
- the police for concerns about criminal activity

1.3 Aims and Objectives

1.3.1 The Trust's strategic objectives are;

- **Quality of Care** – Educate, Learn and Improve
    - Grow and develop as a place of learning, underpinned by a culture and mind-set of continuous improvement that reduces harm and improves patient experience.
- **People** – Include, Listen, Empower and Value

    - Being a great and safe place to be, where we continually listen, include, empower and value everyone.
- **Modern Healthcare** - Standardise and Optimise
    - Delivering the most effective and efficient treatment and care by standardising the delivery and outcome of clinical services.
- **Digital** – Automate and Innovate
    - Using digital technology to improve clinical pathways, safety and efficiency and empower patients.
- **Collaborative** – Sustain and Thrive
    - Working with our partners in health and social care to ensure provision of a high quality, sustainable NHS to the communities we serve.

1.3.2 Table 1 outlines the four key aims of the Patient Safety Incident Response Framework (PSIRF) alongside the Trust's strategic objectives and patient safety specific objectives.

Table 1

PSIRF Aim	Trust Strategic Objective	Patient Safety and Quality Improvement Specific Objectives
Compassionate engagement and involvement of those affected by patient safety incidents	• Quality of Care • People • Collaborative • Modern Healthcare	• Develop a climate that supports a just culture and an effective learning response to patient safety incidents. • Act on feedback from patients, families, carers and staff about their concerns with patient safety incident responses in the NHS. • Support and involve patients, families and carers, and staff in incident response, for better understanding of the issues and contributory factors.
Application of a range of system-based approaches to learning from patient safety incidents	• Quality of Care • Modern Healthcare • Digital	• Respond to patient safety incidents purely from a patient safety perspective.
Considered and proportionate responses to patient safety incidents	• Quality of Care • Modern Healthcare • Digital • People	• Reduce the number of duplicate PSIIs into the same type of incident, enable more resource to be focused on effective learning and enable more rigorous investigations that identify required system improvements.
Supportive oversight focused on strengthening response system functioning and improvement	• Quality of Care • Modern Healthcare • People • Collaborative	• Develop system improvement plans across aggregated incident response data to produce systems-based improvements. • Better measurement of improvement initiatives based on learning from incident response.

1.3.2 It is recognised that when something goes wrong in healthcare it is usually the result of problems in processes or systems, rather than the fault of the individual members of staff.

The Trust supports and fosters a “no blame” patient safety culture; avoiding the use of sanctions without due consideration of all the factors involved.

1.3.3 The Trust is committed to embedding the use of the NHS Just Culture Guide (2018) to support the patient safety incident response process.

1.3.4 In order to support the development of a safety culture across the organisation, all staff will be required to complete the Patient Safety Syllabus Level 1 training and clinical staff must also complete Patient Safety Syllabus Level 2 training.

1.3.5 Enhanced training covering Just Culture and safety culture will also be provided to those in learning response lead, engagement lead and oversight lead roles

1.3.6 The Trust is committed to ensuring staff responding to incidents have the appropriate training and dedicated time to respond to safety incidents in line with the patient safety incident response standards. Further information regarding training and resource requirements are detailed in the Patient Safety Incident Response Policy.

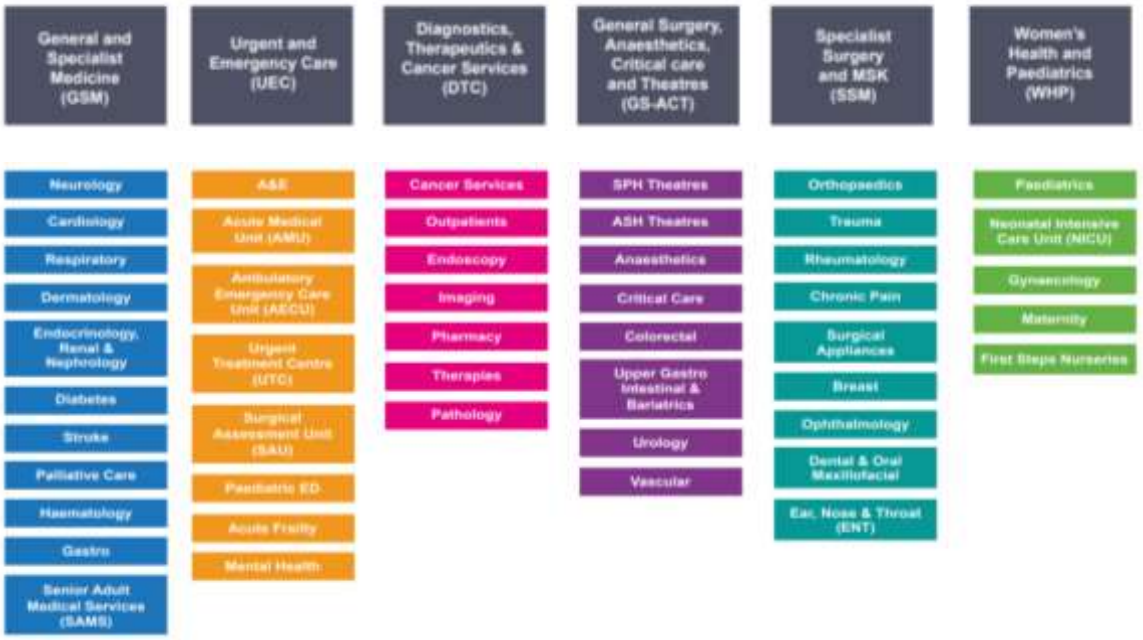
1.3.7 In addition to the Just Culture guide, the Trust has a Freedom to Speak Up Guardian and Freedom to Speak Up Ambassadors, who are able to support staff raising of concerns.

1.3.8 The Trust has also implemented the Learning from Patient Safety Events Service which enables patients and families to also raise safety concerns via the online portal.

1.3.9 The Trust is committed to facilitating and monitoring quality improvement through the Patient Safety Incident Response Framework. A clear governance process, including the introduction of Patient Safety Partners and Key Performance Indicators are outlined in the Patient Safety Incident Response Policy.

2.0 Our services

2.1 ASPH provides a range of acute services as outlined below.



2.2 In addition to the acute services outlined above the Trust has the following Corporate or Centralised teams.



2.3 The Trust also works closely with other providers of NHS Services and clinical networks to deliver care on both the Ashford and St Peter's Hospital sites. This includes;

- Berkshire and Surrey Pathology Services
- Surrey and Borders Partnership NHS Foundation Trust
- Northwest Surrey Integrated Care Services
- Royal Surrey NHS Foundation Trust
- Frimley Health NHS Foundation Trust
- CSH Surrey
- Epsom and St Helier University Hospitals NHS Trust
- Local Maternity and Neonatal System
- Vascular Services Network
- South Thames Paediatric Network
- Surrey County Council
- Primary Care services across Surrey
- South East Coast Ambulance Service

2.4 Where an incident occurs and more than one organisation is involved, a collaborative approach will be undertaken to identify and implement the most appropriate and proportionate learning response.

3.0 Defining our patient safety incident profile.

3.1 Overview

3.1.1 This section outlines how we have identified, defined and agreed the patient safety issues most pertinent to our organisation.

3.2 Data Sources

3.2.1 Over 18,000 reported patient safety incidents covering a two-year period were initially reviewed, cleansed, and themed, resulting in the following initial list of categories (listed with most reported first).

- Pressure Ulcers / Skin
- Clinical
- Women's Health and Paediatrics
- Delays / Cancellations
- Falls
- Medication
- Patient Behaviour
- Safeguarding
- Administration / Communication
- Nutrition and Hydration
- Admissions

- Discharge
- Health and Safety
- 7-day service
- End of Life Care
- VTE

3.2.2 Further deep dives and thematic analysis of each category was then carried out, taking into consideration.

- Place of the incident
- Patient demographics
- Patient vulnerabilities
- Implementation of Surrey Safe Care
- Day the incident occurred
- Hospital and community associated incidents
- Level of harm and Never Events

3.2.3 This was then triangulated with other data sources including.



3.2.4 Further triangulation was completed against national audit, surveys and research data.

3.3 Stakeholder Engagement

3.3.1 We know that the most frequently reported incidents are pressure ulcers, clinical related incidents, and delays/cancellations. However, that does not mean these will provide the most learning and opportunity for improvement.

3.3.2 The patient safety team met with representatives from different stakeholders both internally and externally to share the data and gain an understanding of how this matches the experiences of staff and patients. This included.

- Patients, Families and Carers including feedback via Viewpoint
- Executive Team and Trust Board
- Divisional representatives
    - General and Specialist Medicine
    - Urgent and Emergency Care
    - Diagnostics, Therapeutics and Cancer Services
    - General Surgery, Anaesthetics, Critical Care and Theatres
    - Specialist Surgery and MSK
    - Women's Health and Paediatrics
- Specialist Groups and Services
    - Surgical Site Infection Group
    - Harms Free Care Group
        - Tissue Viability
        - Falls
        - VTE
        - Nutrition
        - Intravenous access
    - Infection Control Team
    - Blood Transfusion Team
    - Safeguarding Team
    - Quality Improvement and Transformation Team
    - Practice Standards Group
    - Discharge Team
    - Medicines Governance Committee
    - EDI Team
    - HR
    - Estates
- Patient Panel
- Maternity Voices Partnership
- Trust Community Open Day Visitors
- Trust wide Team Talk presentation

3.4 Patient Safety Incident Response Gap Analysis

3.4.1 A review of the existing processes within the Trust was undertaken and compared against the Patient Safety Incident Response Standards to ensure PSII's are undertaken in compliance with these standards.

3.4.2 In addition, a review of the existing response to incidents such as falls and pressure ulcers has been undertaken to support the planning of appropriate and proportional responses using different techniques, where PSII is not indicated.

3.4.3 In order to meet the requirements of the Patient Safety Incident Response Standards we will:

- Assign an appropriately trained member of the Executive Team to oversee delivery of the PSII standards and support the sign off of all PSIIs.
- Provide PSIRF Oversight training for all board members.
- Provide access to training for staff who will undertake the Learning Response Lead and Engagement Lead roles.
- Ensure Learning Response Leads have not been involved in the incident and/or do not directly line manage those involved in the incident
- Produce new documentation for patients, families and staff members involved in patient safety incidents and ensure they are available on a public-facing area of our website.

Further information related to this can be found in the Patient Safety Incident Response Policy.

3.5 Proactive resource planning

3.5.1 Resource, restructuring and training is needed to meet the requirements of the patient safety incident investigation standards and the PSIRF.

3.5.2 An estimate of the resource allocation required for patient safety incidents per year is shown in Table 2. This was considered when identifying the number of PSII's to be undertake defined in the local priorities.

Table 2

Response Type	Category	Hours
PSII	Nationally and locally defined PSII	**Minimum 60 hours per investigation for:** • Learning Response Lead **Up to 30 hours per investigation for:** • Subject matter expertise • Engagement Lead **Plus, up to 30 hours per investigation for**: • investigation oversight and support • administration support • interview and statement time of staff involved in the incident. • Executive Patient Safety Incident Panel (EPSIP) approval and sign off

3.5.3 As the Trust transitions to the PSIRF additional resources will be required to enable us to meet the PSIRF standards. This is be considered under the 2024/2025 business planning process and includes;

- Increased patient safety team staffing
- Dedicated paid time for staff involved in an incident to be part of the learning response
- Dedicated paid time for learning response leads and engagement leads
- Commissioning of a new incident reporting system to support triangulation and proactive risk management
- Development of a patient safety academy with associated bursaries
- Ongoing training and education for all staff
- Training and support for patient safety partners

3.6 Criteria for defining patient safety priorities

3.6.1 Some patient safety incidents were less frequently reported, however were clearly identified as an area of concern through stakeholder engagement and other data sets (e.g. mortality reviews, patient feedback and complaints, local and national audits). Therefore, we also considered the criteria in Table 3 when defining our patient safety priorities.

Table 3

Criteria	Considerations
Potential for harm	• People: physical, psychological, loss of trust (patients, family, caregivers) • Service delivery: impact on quality and delivery of healthcare services; impact on capacity • Public confidence: including political attention and media coverage
Likelihood of occurrence	• Persistence of the risk • Frequency • Potential to escalate

4.0 Defining our patient safety improvement profile.

4.1 Existing quality and patient safety priorities and improvement workstreams

4.1.1 Ashford and St Peter's Hospitals NHS Trust has committed through its overarching strategy to 'grow and develop as a place of learning, underpinned by a culture and mind set of continuous improvement that reduces harm and improves patient experience'.

4.1.2 The Trust's identified **quality and patient safety priorities** include;

- Learning from errors and reducing avoidable harm and in-hospital infection;
  - Medication errors
  - Surgical site infections
  - Hand hygiene
  - Recognition and management of sepsis
  - Treatment delays
  - Blood stream infections
- Learning from deaths and addressing episodes of poor care
- Learning culture reducing harm to improve patient experience.

4.1.3 Current Trust quality improvement initiatives include;

- GIRFT
- Epilepsy 12 national clinical audit
- SSNAP Stroke Audit
- LeDeR
- TARN – trauma audit
- NACEL – end of life care
- Age Related Macular Degeneration Outpatient Clinic
- Pregnancy Skin Care Clinic
- Emergency pre-operative hair removal
- Ultrasound reporting of varicocele
- Management of suspected testicular torsion in children
- Redundant group and saves in incisions and drainage abscess surgery.

Further information regarding the above quality improvement initiatives can be found in the Trust Annual Quality Account (2023).

4.1.4 In addition our CQUIN workstreams include;

- Flu vaccinations for frontline healthcare workers
- Supporting patients to eat, drink and mobilise (DrEaM) after surgery
- Prompt switching of intravenous to oral antibiotics
- Compliance with timed diagnostic pathways for cancer services
- Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway
- Identify and respond to frailty in emergency departments
- Recording of response to NEWS2score for unplanned critical care admissions
- Achieving high quality shared decision-making conversations in specific specialised pathways to support recovery
- Assessment and documentation of pressure ulcer risk

5.0 Our patient safety incident response plan

5.1 National Patient Safety Incident Response Requirements

5.1.1 Outlined below in Table 4 are patient safety incident types that have a nationally mandated response, as set out in national guidance, regulations or legislation. Further information about the Trust patient safety governance processes can be found in the ASPH Patient Safety Incident Response Policy

Table 4

Patient safety incident type	Required response	Anticipated improvement monitoring route
Incidents meeting the Never Events criteria	PSII	Executive PSI Panel (EPSIP) Safety and Quality Committee
		Executive PSI Panel End of Life and Mortality Group Safety and Quality Committee
Deaths of patients detained under the Mental Health Act (1983) or where the Mental	PSII	Executive PSI Panel

Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)		Safety and Quality Committee
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII or Locally led PSII	Executive PSI Panel Safety and Quality Committee
Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations (formerly HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to Maternity and Newborn Safety Investigations (MNSI) or SpHA for independent PSII.	Safety and Quality Committee Mat Neo Board Quality of Care Committee
Child Deaths	Refer for Child Death Overview Panel (CDOP) review. Locally-led PSII (or other response) may be required alongside the CDOP review –liaise with the CDOP.	Executive PSI Panel End of Life and Mortality Group Safety and Quality Committee
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	Executive PSI Panel Safeguarding, Learning Disability and Dementia (SLD) Sub Committee End of Life and Mortality Group Safety and Quality Committee
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful	Refer to local authority safeguarding lead. The Trust must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide	Safeguarding, Learning Disability and Dementia (SLD) Sub Committee Quality of Care Committee

neglect or domestic abuse/violence. • adults (over 18 years old) are in receipt of care and support needs from their local authority. • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.	reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response See: Guidance for managing incidents in NHS screening programmes	Safety and Quality Committee Quality of Care Committee
Deaths in custody (e.g. police custody, in prison, etc) where health provision is delivered by the NHS.	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. The Trust must fully support these investigations where required to do so.	Safety and Quality Committee Quality of Care Committee
Domestic Homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a domestic homicide review	Safeguarding, Learning Disability and Dementia (SLD) Sub Committee Quality of Care Committee

	(DHR) are met, it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs.	

5.2 Local Patient Safety Incident Investigation Criteria

5.2.1 Based on the analysis and review of the local incidents and risk profile, local priorities for PSII have been agreed by the Trust for the next 18 to 24 months. These are outlined in Table 5.

5.2.2 These local priorities will be reviewed on an ongoing basis via the Executive PSI Panel with a full review and update of this plan no later than 24 months from the date of issue.

5.2.3 Additional PSII's where learning may be extracted will be considered by the Executive PSI Panel.

5.2.4 The Executive PSI Panel will be responsible for the sign off, of completed PSII's. Further information regarding the governance of patient safety incident responses can be found in the Patient Safety Incident Response Policy.

Table 5.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Failure to recognise or escalate a deteriorating patient resulting in critical care admission (HDU/ITU/NICU/PICU) - this includes in-utero deterioration requiring NICU admission after birth	PSII – up to 4 per year MDT Review or After Action Review	• Executive PSI Panel • Safety and Quality Committee • Practice Standards Group
Patients receiving minimal nutrition and/ or hydration for over 48 hours due to a delay in referral to a dietician or failure to follow the nutritional care plan	PSII – up to 4 per year SWARM Huddle or After Action Review	• Executive PSI Panel • Safety and Quality Committee • Harms Free Care Group
Patients whose; • appointments have been cancelled or delayed, and • who experience harm due to a deterioration in their condition whilst waiting, and • require additional treatment/ higher level of care than would have been originally required as a result	PSII – up to 4 per year MDT review or After Action Review	• Executive PSI Panel • Safety and Quality Committee • Waiting Well Pathway Oversight Group
Emerging risks and trends or incidents of significant concern	MDT Review PSII (if agreed at Weekly Executive PSI Panel)	• Executive PSI Panel • Safety and Quality Committee • Other committees as identified by the Executive PSI Panel

5.3 Additional incidents for alternative defined response and monitoring

5.3.1 In addition to the above local focus, the following patient safety incident types will have a specific response and monitoring. The responses have been agreed following review of the local data, ongoing monitoring, and existing quality improvement work.

5.3.2 Where more than one potential planned response is recorded, the clinical team in collaboration with the patient safety team, and specialists (e.g. Harms Free Care Team) will agree the appropriate response type for each incident.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Medication errors for in-hospital patients	SWARM huddle	• Medicines Governance Committee
Hospital acquired pressure ulcers	SWARM huddle After Action Review MDT Review	• Harms Free Care Group
Inpatient falls	SWARM Huddle After Action Review MDT Review	• Harms Free Care Group
Unsafe Discharge	Thematic review of discharge issues from 3 care homes the Trust has a contract with.	• Safety and Quality Committee
Post Partum Haemorrhage	Obstetric Bleeding Study UK	• Mat Neo Board/MNAG • Safety and Quality Committee
Surgical Site Infections	After Action Review	• Surgical Site Infection Surveillance Group

5.4 Timescales for PSIIs

5.4.1 PSIIs will ordinarily be completed within 60 working days of their start date. The specific timeframe for completion will be agreed at Executive PSI Panel.

5.4.2 Only in exceptional circumstances, will a longer timeframe be required for completion of a PSII. In this case, any extended timeframe will be agreed by the Executive PSI Panel following collaboration with the patient and /or family. A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on the patient and family, others involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

5.5 Infection Prevention and Control Reviews

5.5.1 In line with NHS England guidance the Trust has aligned Infection Prevention and Control (IPC) Reviews with PSIRF.

5.5.2 This does not change the current methods of mandatory reporting through HCAI Data Capture System of key alert infections such as MRSA, E. coli, MSSA bacteraemia's and C. difficile.

5.5.3 Appendix B outlines the Trust response under PSIRF to specific IPC incidents.

Appendix A – Learning response methods and tools

Adapted from Guide to responding proportionately to patient safety incidents

There are four patient safety learning response methods;

Method	Description
Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.
Multidisciplinary team (MDT) review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
Swarm Huddle	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
After Action Review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning?

Thematic Review	A thematic review may be useful for understanding common links, themes or issues within a cluster of investigations, incidents or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety.

Additionally, there are learning response tools which can be used to supplement the above methods and support the identification of learning from incidents. These include;

Tool	Description
Observation Guide	Observations help us move closer to an understanding of how work is actually performed, rather than what is documented in training, procedures or equipment operating manuals (work as prescribed), how we imagine work is conducted (work as imagined) or how people tell us work is performed (work as disclosed).
Walkthrough Guide	Walkthrough analysis is a structured approach to collecting and analysing information about a task or process or a future development (e.g. designing a new protocol). The tool is used to help understand how work is performed and aims to close the gap between work as imagined and work as done to better support human performance.
Link Analysis Guide	Link analysis creates a visualisation of the frequency of interactions observed in a specific location or environment. It can be used to highlight frequently used paths within an environment that are critical for safety. This can inform the design of the environment to locate items or areas based on what tasks are carried out most frequently.
Interview Guide	This interview planning guide contains questions that help plan an interview with staff involved in a patient safety incident or with patients, families or carers.
Timeline Mapping	A working document to help create a narrative understanding of a patient safety incident. This can be added to as further information is collected. It is useful for understanding any gaps in information and defining early thoughts on lines of enquiry.
Work System Scan	A checklist and documentation tool to ensure the full breadth of the work system is considered. The tool is used to indicate any aspects of the system design that hinder or support people in the work system to do their job (i.e. barriers and facilitators)
Horizon Scanning	The Horizon Scanning Tool supports health and social care teams to take a forward look at potential or current safety themes and issues. It can be used to proactively identify safety risks.

Perinatal Mortality Review Tool	A tool to support objective, robust and standardised multidisciplinary review of deaths of babies (up to 28 days post birth). Specific case criteria apply.
Structured Judgement Review	A tool to support a clinical case note review of adult in hospital deaths using a standardised approach. Specific case criteria apply.

Appendix B – Infection Prevention and Control Incident Responses

Incident	Apportioned to	Mandatory Reporting	Datix	Infection Control Review	Formal Duty of Candour	Patient Safety Investigation	Internal Governance	External Governance
Outbreak, with no healthcare associated infection resulting in death	NA	Covid is reported to National E-portal	No	SWARM Huddle with clinical team	Clinical team to confirm to patients if positive test result or exposure	Not routinely	Lessons learned: -Clinical Teams -COIC -Added to Annual IPC Trust wide Action plan	IPC Team Email notification of outbreak to syheartlandsicb.shipc@nhs.net and syheartlandsicb.shoc@nhs.net
Outbreak with healthcare associated infection resulting in death(s)	NA	Covid is reported to National E-portal	Yes	Yes	Yes – by Clinical Team	To be presented at Weekly Executive PSI Panel to determine type of investigation	Lessons learned: -Clinical Teams -COIC -Added to Annual IPC Trust wide Action plan	IPC Team Email notification of outbreak to syheartlandsicb.shipc@nhs.net and syheartlandsicb.shoc@nhs.net
C. difficile toxin positive stool	HOHA and COHA	UKHSA Data Capture system (DCS)	Yes HOHA No COHA	SWARM Huddle with clinical team Complete DCS Risk Factors info	Clinical team to confirm positive test result to patient	Not routinely. If any concern raised at huddle to be presented at Weekly Executive PSI Panel	If Lessons learned: -Clinical Teams -COIC -Added to Annual IPC Trust wide Action plan	
	All other	UKHSA Data Capture system (DCS)	No	No	No	No	NA	IPC Team email ICB to confirm that case has been entered on DCS

Group A Strep. (GAS)	Acquired or detected in hospital	NA	No	Yes	Clinical team to confirm positive test result to patient	No	If Lessons learned: -Clinical Teams -COIC -Added to Annual IPC Trust wide Action plan	Notifiable. Local HPU
Incident	**Apportioned to**	**Mandatory Reporting**	**Datix**	**Infection Control Review**	**Formal Duty of Candour**	**Patient Safety Investigation**	**Internal Governance**	**External Governance**
Gram negative blood stream infection (GNBSI)	HOHA and COHA	UKHSA Data Capture system (DCS)	No	SWARM Huddle with clinical team Complete DCS Risk Factors info	Clinical team to confirm positive test result to patient	No	If Lessons learned: -Clinical Teams -COIC -Added to Annual IPC Trust wide Action plan	
	All other	UKHSA Data Capture system (DCS)	No	Complete DCS Risk Factors info	No	No	NA	
MRSA blood stream infection	HOHA	UKHSA Data Capture system (DCS)	Yes	SWARM Huddle with clinical team Complete DCS Risk Factors info	Clinical team to confirm positive test result to patient	Not routinely. If any concern raised at huddle to be presented at Weekly Executive PSI Panel	If Lessons learned: -Clinical Teams -COIC -Added to Annual IPC Trust wide Action plan	IPC Team email ICB to confirm that case has been entered on DCS
	Other	UKHSA Data Capture	No	No	Clinical team to confirm positive test result to	No	No	IPC Team email ICB to confirm that case has been entered on DCS

		system (DCS)			patient if they are an in patient			
MSSA blood stream infection	HOHA	UKHSA Data Capture system (DCS)	Yes	SWARM Huddle with clinical team Complete DCS Risk Factors info	Clinical team to confirm positive test result to patient	Not routinely. If any concern raised at huddle to be presented at Weekly Executive PSI Panel	If Lessons learned: -Clinical Teams -COIC -Added to Annual IPC Trust wide Action plan	
	Other	UKHSA Data Capture system (DCS)	No	Complete DCS Risk Factors info	Clinical team to confirm positive test result to patient if they are an in patient	No	No	
IPC policy breach **	NA	NA	Yes	SWARM Huddle with clinical team	Based on harm and or contributing factors.	Not routinely. If any concern raised at huddle to be presented at Weekly Executive PSI Panel	-COIC	
Patient death where MRSA or Cdiff is recorded as Part I or II	HOHA and COHA	N/A	Yes	SWARM Huddle with clinical team	Yes – Clinical Team	Not routinely. If any concern raised at huddle to be presented at Weekly Executive PSI Panel	If Lessons learned: -Clinical Teams -COIC -Added to Annual IPC Trust wide Action plan	

Appendix C – Glossary

Term	Abbreviation	Definition
Community Onset Healthcare Associated	COHA	Cases that occur in the community when the patient has recently been an inpatient
Control of Infection Committee	COIC	ASPH NHS Foundation Trust Infection Control and Prevention Committee
Group A Streptococcus	GAS	A type of bacteria that can cause skin, soft tissue and respiratory tract infections.
Engagement Lead	-	A senior member of ASPH staff who is appropriately trained to liaise with and support those affected by a patient safety incident.
Epilepsy 12	-	A national clinical audit monitoring the care of and enabling improvement in the quality of care for children and young people with epilepsy.
Equality, Diversity and Inclusion Team	EDI team	ASPH Foundation Trust team which oversees all diversity and equality activities and standards within the Trust.
Getting It Right First Time	GIRFT	A national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.
Harms Free Care Group	-	ASPH NHS Foundation Trust group focussing on prevention of harm related to tissue viability, inpatient falls, venous thromboembolism, nutrition and intravenous devices/access.
Healthcare Associated Infection	HCAI	HCAIs are infections that develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting.
Healthcare Onset Healthcare Associated	HOHA	Cases that occur in the hospital after admission
Health protection unit	HPU	Local units from the UK Health Security Agency that provide specialist public health advice and operational support to NHS Trusts.
Infection prevention and control	IPC	A practical evidence-based approach preventing patients and health workers from being harmed by avoidable infections.
Learning from Lives and Death – People with a learning disability and autistic people	LeDeR	A nationally standardised review process of the care of patients with a known learning disability or autism following their death.
Learning Response Lead	-	A senior member of ASPH staff who is appropriately trained to lead the learning response following a patient safety incident.

Maternity and Newborn Safety Investigations	MNSI	The MNSI programme is part of a national strategy to improve maternity care across the NHS in England, undertaking independent investigations and making safety recommendations to improve services.
National Audit of End-of-Life Care	NACEL	A national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during their last admission leading to death in acute hospitals.
Never Event	-	Serious incidents that are entirely preventable because guidance and safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
Sentinel Stroke National Audit Programme	SSNAP	A national healthcare quality improvement programme monitoring the delivery of stroke care across the NHS.
Surgical Site Infection	SSI	An infection that occurs after surgery in the part of the body where the surgery took place.
System Learning		Is a concept that involves understanding all elements of a system and how they interact with each other.
Trauma Audit and Research Network	TARN	A national organisation that collects and processes data on moderately and severely injured patients in England and Wales, to enable benchmarking of trauma services and quality improvement within trauma care.