Sussex Community
NHS Foundation Trust

Patient Safety Incident Response Framework Policy

Policy Date: 2023/2025

Policy Version: V1

August 2023

This document remains valid whilst under review.

TARGET AUDIENCE (including temporary staff)	
People who need to know this document in detail	Chief Medical Officer, Chief Nurse, Associate Director Quality and Safety, Patient Safety Team and Area Heads of Nursing/AHPs and Governance.
People who need to have a broad understanding of this document	Quality and Safety Department, service managers / team leaders and Head of Safeguarding.
People who need to know that this document exists	All staff

Policy Author/ Reviewed by:	Patient Safety Lead. Patient Safety Manager. Associate Director of Quality and Safety.		
Approved by:	Trust Wide Governance Group	Date:	01/08/2023
Ratified by:	Executive Management Group	Date:	16/08/2023
Expiry date:	August 2025		

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VERSION CONTROL

Record of Document Changes		
Date	Version	Changes / Comments
May 2023	1.0	This is the first version of the policy, which has been written as part of the transition to the Patient Safety Incidence Response Framework (PSIRF).

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1. Introduction

1.1 Purpose

Sussex Community NHS Foundation Trust (SCFT) is committed to promoting a positive safety culture enabling open and honest reporting and learning from patient safety incidents safely and supportively, with the aim of reducing the risk of subsequent similar incidents occurring.

"Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients." – NHS England 2022.

This policy focuses solely on patient safety incidents and describes the systems and processes that SCFT has in place to learn and improve following a patient safety incident. Within the policy we have referenced the Patient Safety Incident Response Standards, available here, to demonstrate as evidence of implementation. These standards sit within the following headings:

- policy, planning and oversight
- competence and capacity
- engagement and involvement of those affected by patient safety incidents
- proportionate responses

Patient Safety Incident Response Framework (PSIRF), advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. This policy encompasses the four key aims of PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

This policy sits alongside the SCFT Patient Safety Incident Response Plan (PSIRP), which outlines our SCFT incident profile and how we will respond to key incidents and manage learning improvement plans. Both documents will be published on the Trusts external website in accordance with standard 1.6 of the patient safety incident response standards. In

addition the main processes outlined in this policy can be found in the flowchart in appendix A, and other simplified versions will be created for staff.

1.2 Scope

This policy is specific to learning responses conducted solely for the purpose of learning and improvement across all SCFT services when a patient safety incident occurs. In accordance with standard 15, responses under this policy follow a systems-based approach, and 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 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 learning response and are outside the scope of this policy. Information from a patient safety learning response process can be shared with those leading other types of investigations, but other processes should not influence the remit of a patient safety learning responses.

The policy will cover all patient safety incidents which have occurred whilst the patient was under the care of SCFT. Where SCFT delivers services in partnership with other organisations, the management of the incident and any investigation carried out will be completed as a cross-system response as per standard 16.

This policy applies to all employees of SCFT when the individual is working on official Trust business, either as a permanent employee, a temporary employee on short term/fixed contract, working on the bank, a placement student, working as an agency nurse, or a volunteer.

1.3 Definitions

After action reviews (AAR)	This is a focussed and facilitated local investigation method that takes place within 5 days of the incident occurring. The method uses a structured discussion to look at 'what was expected to happen?' 'what did happen?' 'what was the difference?' and 'what can be learned?'
Duty of Candour (DOC)	A legal duty to follow the process laid down in regulation 20 of The Health and Social Care Act 2008, when a patient safety incident results in significant harm. A professional duty imposed by health care professionals registering bodies. A contractual duty in the NHS Standard Contract.
Freedom to Speak up Guardian (FTSUG)	*"Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to in other ways."* - https://nationalguardian.org.uk/ (accessed 09/11/2023).
Integrated Care Board (ICB)	*"A statutory NHS organisation 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*

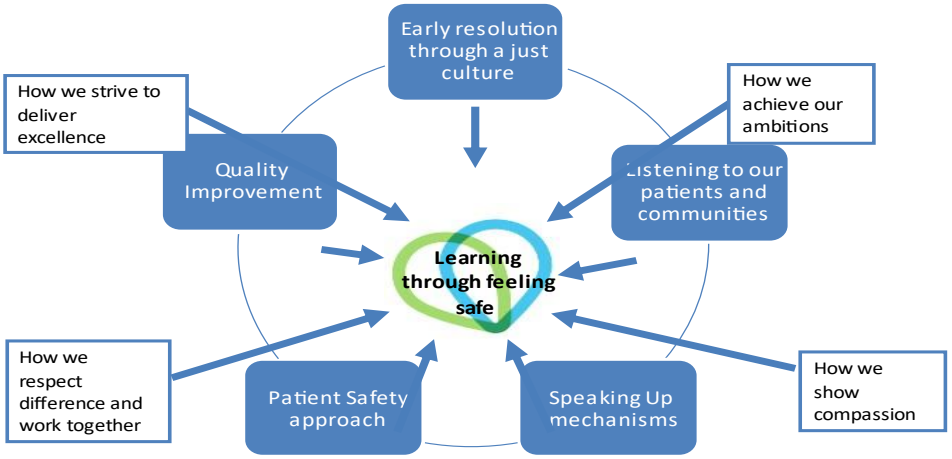
	the ICS area. The establishment of ICBs resulted in clinical commissioning groups (CCGs) being closed down." - https://www.england.nhs.uk/integratedcare/what-is-integrated-care/#:~:text=Integrated%20care%20board%20(ICB),services%20in%20the%20ICS%20area (accessed 09/11/2023)
Just Culture	"*The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated. In any organisations or teams where a blame culture is still prevalent, this guide will be a powerful tool in promoting cultural change."* - https://www.england.nhs.uk/patient-safety/a-just-culture-guide/ (accessed 09/11/2023)
Patient Safety Incident Investigation (PSII)	An in-depth investigation using systems based and human factors methodology which must be completed by a Patient Safety Lead or other person who has completed the required training.
Patient Safety Incident Response Framework (PSIRF)	A framework setting out the NHS approach for responding to patient safety incidents for the purpose of learning and improving patient safety. This replaces the NHS Serious Incident Framework 2015 and removes the classification and threshold of Serious Incidents, making no distinction between patient safety incidents. Further information available here. This has been accessed 09/11/2023.
Patient safety incidents	*"Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients."* – NHS England 2022.
Systems Engineering Initiative for Patient Safety (SEIPS)	A model that is centred around human factors, and is used to ensure that investigations take a system based approach. It explores the following factors for contributory elements : technology and tools, environment, task, person and organisation.
Patient Safety Incident Response Standards	*A set of specific standards that organisations are required to uphold to ensure that they meet the minimum expectations of the Patient Safety Incident Response Framework. The standards sit within four main subjects;* *Policy, planning and oversight* *Competency and capacity* *Engagement and involvement of those affected by PSIs* *Proportionate responses.* *More information is available here:* *https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf* (accessed 09/11/2023).

2. Safety culture at SCFT

2.1 Just Culture

SCFT promotes a just restorative culture, a learning approach to dealing with adverse events, which focuses on who has been harmed and not who is to blame. This approach recognises that people make mistakes, whilst enabling people to understand their accountability. It aims to repair trust and relationships damaged after an incident. At SCFT a

Safety Culture part of a bigger picture for learning and improvement



Kindness, compassion and dignity
We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

just restorative culture enables and supports a safety culture and creates the foundations that underpin the ambitions of the NHS Patient Safety Strategy and PSIRF. These principles have been aligned with the Trust's values, beliefs and the CQC Quality Statements, which is presented in an infographic below.

2.2 Good reporting culture

SCFT has a good incident reporting culture, which is evidenced by a year on year increase in incident reporting without a correlating increase in the harm caused to patients. This is

recognised as a positive indicator of a thriving safety culture, and staff are encouraged to report all patient safety incidents.

2.3 Freedom to Speak Up

At SCFT the Freedom to Speak Up (FTSU) Guardian sits within the Quality and Safety Department, enabling close working with other teams across the department, including the Patient Safety Team. At SCFT the FTSU Guardian works within the Trust to improve speaking up and to ensure that lessons are learnt, and improvements implemented when workers do speak up. SCFT also has Freedom to Speak Up Ambassadors who support the guardian by offering a confidential listening and signposting service.

3. Patient Safety Partners

Patient Safety Partners (PSPs) are part of the Patient Safety Team. They are not employees, and sit external to the Trust to provide the voice of patients, and they will support the Trust in improving patient safety through the following ways

- attending the Quality Improvement Committee (QIC) (this will be the primary PSPs only, and payment will be given for attendance – see the SCFT Patient and Public Voice Policy).
- advise on policies, procedures and trust activities that are pertinent to patient safety and quality patient care.
- provide a voice for patients.
- support key patient safety projects.
- support with PSIRF.

The Patient Safety Team is working with the PSPs to support their development and it is expected that they will provide valuable insight and contributions to learning responses and safety action developments.

4. Ensuring a fair learning response

4.1 Taking a system-based approach

SCFT takes a systems-based approach to all learning responses, and acknowledges incidents do not tend to happen due to one person, and that they often occur due to problems across the wider systems. We do not apportion blame to those involved in patient safety incidents.

4.2 Methods and tools used

SCFT will use a range of learning responses including patient safety incident investigations (PSIIs), thematic reviews, hot debriefs and after action reviews (AARs). The consideration of health inequalities will be explicitly incorporated into these learning responses and the development of safety actions, as per the details given in the above section. Further detail on each of the learning responses is provided in the SCFT Patient Safety Incident Response Plan (PSIRP).

4.3 Addressing health inequalities

The fundamental factors driving inequalities in health are beyond the sole responsibility of the health care system and include, for example, the education system; economic and community development in deprived neighbourhoods; employment levels; pay and conditions and the availability and quality of housing. As a large provider of community services, however, the Trust has a role to play in tackling health inequalities in partnership with our local partner agencies, services and communities.

4.3.1 Using data to monitor health inequalities

Through our implementation of PSIRF, we will seek to use data collection and learning from incidents to identify actual and potential health inequalities and make recommendations to our Trust board and partner agencies on how to tackle these. Our holistic and integrated approach to patient safety will ensure that we collaborate with the patient experience and inclusivity agenda and we will ensure that investigations and learning do not overlook these important aspects of the wider health and societal agenda.

4.3.2 Responding to health inequalities

Our engagement with patients, families and carers and staff following a patient safety investigation must recognize diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues will be identified through the investigation process during duty of candour / being open and just culture processes.

5. Engagement and involvement following a patient safety incident

SCFT will take a trauma-informed approach when supporting both staff and patients/service users/clients involved in a patient safety incident, i.e. offering safety, choice, collaboration, trust and empowerment in our approach. SCFT will take into consideration the impact of past and current traumatic and adverse experiences on their ability to engage with the process, on understanding their reactions and possible barriers to engaging or speaking up, their

levels of stress during interactions and the relevance of paying attention to this. A brief overview of how SCFT will engage with patients and their representatives and staff is outlined below, but full details are provided as part of our PSIRP. This section supports the requirements of standards 12 and 13 for the engagement and involvement of those affected by patient safety incidents.

5.1 Involvement of patients/service users/clients and their relatives/carers/parents/representatives

SCFT will ensure that patients/service users/clients or their relatives/carers/parents/representatives will be fully involved and engaged with throughout an investigation process. SCFT will liaise with these people to ensure that they are supported and are able to share their experience and insight about what happened. SCFT will ensure that their concerns and preferences are considered and documented in the investigation records, including noting where they have chosen not to contribute or be involved in the investigation process. If involved they will be kept up to date throughout the process, and a draft investigation report will be offered and they will be supported to help to verify details, agree any amendments and share their ideas for safety improvements. SCFT will also ensure that they comply with the Duty of Candour legal requirement. Please see the SCFT Being Open and Duty of Candour Policy 2023 for full details on this.

5.2 Engagement and involvement with staff

The involvement of staff is critical to understand what has happened, and to ensure that we reflect a just culture. SCFT will support staff who report a patient safety incident, as per their wishes. There are a number of resources available to support staff involved in a patient safety incident. The Patient Safety Team will take a supportive approach, and ensure that staff are as involved in an investigation as they wish to be, and that safe spaces are created for staff to discuss what happened in a way that is comfortable for them.

6. The process for responding to patient safety incidents

6.1 SCFT local process for reviewing and investigating incidents

SCFT has a well-established safety system in place that has been reviewed and adapted for continuation under PSIRF. The process for incident response and decision making is detailed below, and a flow chart outlining the process is attached as an appendix (see appendix A). This section describes how SCFT will respond to patient safety incidents. This section explains how we will meet the standards for policy, planning and oversight by

confirming the clear processes in place at SCFT and how different data is brought together throughout this process to ensure insight is shared.

6.1.1 Patient safety incident reporting arrangements

Trust staff report patient safety incidents via the Trust's online reporting system. These incident reports are triaged by Patient Safety Leads. Additional information required is requested and incidents of concern are escalated for senior review. Triage considers the level of perceived risk to patients and not just the degree of harm reported. Emerging themes or trends can be identified as part of the triage process and escalated to senior staff.

6.1.2 Triangulation, Evaluation and Analysis (TEA) group

The TEA group meets every Monday and discusses all escalated incidents, complaints, safeguarding concerns, and inquest referrals brought to the meeting for discussion. The group agrees which of the items discussed need to be escalated, and the proposed learning response. The group also monitors the progress of Safety Alert actions and NICE guidance. The terms of reference (TOR) outlines the meeting in further detail.

6.1.3 Patient Experience and Safety Escalation (PEASE) call

Safety critical incidents and key patient safety issues escalated by the TEA group, are discussed with the Chief Medical Officer (CMO) and Chief Nurse (CN) at the PEASE call. PEASE occurs every Wednesday. The CMO and CN review and agree the learning response method for the patient safety issue or incident in line with the Trust's Patient Safety Incident Response Plan. The TOR outlines the meeting in further detail.

6.1.4 Safety critical incidents

Where a safety critical incident of immediate concern occurs between the scheduled TEA and PEASE meetings, this is escalated immediately to the CN and the CMO for review, and to discuss immediate actions to be taken. The Area Heads of Nursing/Allied Health Professionals (AHPs) and Governance, responsible for the area where the incident occurred, are included in this communication to ensure that they are fully aware and able to support any immediate actions with the operational team.

6.1.5 Emergent issues identified

Emergent issues identified and included in the PSIRP will follow the same processes as above. Members of TEA will first analyse available information and consider the most proportionate response required. The proposals will then be escalated to the CMO and CN at PEASE for the final decision on how the issue will be managed. Emergent issues will be reviewed for inclusion in the Patient Safety Incident Response Plan.

6.1.6 Informing specialist leads and core committees

Throughout the process detailed above, the relevant subject matter experts, service leads or chairs of a key committee or group will be cited on the outcome of the review of the incident, the decision taken for how it will be managed, and what actions that are due to be taken.

6.2 Responding to cross-system incidents and issues

Patient safety incidents involving both SCFT and other local NHS Trusts or organisations across the health care system, SCFT will support taking a collaborative approach to the learning response. SCFT supports and promotes system wide investigations identifying the value of system-wide learning and actions to minimise the risks of recurring harm to patients and in improving overall patient experience of NHS organisations and services.

SCFT will work with other Trusts and organisations to undertake learning responses. This includes the sharing of information, joint investigation meetings and, where possible, aiming to complete one investigation report for all the involved organisations.

The Integrated Care Board (ICB) Patient Safety Team may support or co-ordinate the more complex multi-agency investigations. The ICB can then confirm how this will be carried out and who will lead it, as well as how the identified actions will be implemented and then monitored to ensure improvement across the system.

SCFT will ensure that they work with the ICB and other organisations and Trusts to carry out cross-system learning responses. NHS England regional teams can also be approached, if needed, to provide support to enable cross-system learning responses to be undertaken.

6.3 Timeframes for learning responses

The time frame for each of the learning responses will initially be agreed at the PEASE Call with the CMO and CN along with confirming the learning response method. The timeframe will be made on a case-by-case basis with an aim of being proportionate to the incident and recommended learning response. In addition, timeframes for Patient Safety Incident Investigations will be agreed with the patient and staff groups involved. Time frames for hot debriefs and after-action reviews are time specific and this is detailed in the SCFT PSIRP.

6.4 Safety action development and monitoring improvement

SCFT has developed a clear and robust process to ensure that Patient Safety Incident Investigations and Patient Safety Learning Responses are reviewed, signed off and any improvement actions are implemented and monitored for effectiveness through a Quality Improvement approach. SCFT supports system wide learning and collaboration, and will work with the ICB, coroners, Medical Examiners and other local partner organisations. Our ICB partners will be routinely consulted with to provide support and facilitation in particular

with incidents where multiple agencies or providers may be involved. The following sections provide further details on how this will be accomplished. This process at SCFT supports a number of the PSIRF standards.

6.4.1 Safety Critical Oversight Review Group (SCORG)

SCORG occurs on the third Monday of each month and is chaired by the CMO. This will include invited attendees from the ICB to contribute and support our ongoing processes and improvements. The purpose is to review the reports presented following a PSII or learning Response, and establish whether the investigation or learning response has been effective and proportionate and has identified clear plans or actions to improve patient safety. It will ensure that there is provisional agreement on how the improvements identified will be implemented using a Quality Improvement (QI) methodology. If all of this is in place, then the group will agree whether the investigation or learning response can be closed and the improvement actions taken forward. The Terms of Reference (TOR) provides further detail.

6.4.2 Safety and Quality Improvement Review of Evidence (SQUIRE)

The SQUIRE group sits alongside SCORG, and is chaired by the Associate Director of Quality and Safety and Associate Director of Quality Improvement, with the Patient Safety Manager supporting. This group will also include invited attendees from the ICB to contribute and support our ongoing processes and improvements. The aim of the group is to support, monitor and review improvement actions arising from patient safety incident investigations or learning responses, to ensure these follow QI methodology. This might, for example, include a clinical audit, or a QI Project. Each meeting will first focus on any new actions and deciding on the right next steps, and following this will review existing actions and monitor the progress and effectiveness of any improvements. The Terms of Reference (TOR) provides further detail. This group supports the standard "Proportionate responses" by ensuring a clear process is in place to monitor the implementation of all safety actions.

6.4.3 Sharing the learning

Following a patient safety incident, SCFT will ensure that the learning is shared as widely as required, for example Trust Wide or within a particular service. Learning may be shared via several routes, including the patient safety newsletter, workstream meetings (for example the Falls Steering Group), or monthly area Quality Assurance and Development meetings. There is also a shared learning template which has been developed to enable learning response leads to share learning from any patient safety incident to enable across their teams. The Medicines Management team also issue a specific Learning from Incidents newsletter on a monthly basis. SCFT continues to explore additional methods for sharing key patient safety learning.

The Quality and Safety Department will also hold a quarterly Blending our data (BOD) meeting, which will enable a review of a range of patient safety data (including incidents, patient experience data and inquests), alongside feedback from the Area Heads of Nursing

and Allied Health Professionals and feedback from staff in patient safety drop sessions. This will enable a thorough review and identification of key themes.

6.5 Safety improvement plans

The SCFT PSIRP has a section on current improvement and service transformation work, which outlines individual safety improvement plans that focus on a specific service, pathway or location, or are Trust Wide. These will be under continuous review. In addition, the SQUIRE group will continuously review and monitor actions coming out of learning responses. As a result, new themes and trends may be identified through this monitoring process, which can be added to the SCFT PSIRP.

7. How SCFT will respond to patient safety incidents

PSIRF enables SCFT to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, under PSIRF, SCFT is able to explore patient safety incidents relevant to their context and the populations we serve rather than only those that meet a certain defined threshold.

7.1 SCFT patient safety incident response plan

As mentioned in section 1, the SCFT PSIRP sits alongside this policy and outlines how we intend to respond to patient safety incidents from September 2023 to March 2025. It was created following an in-depth review of patient safety data from a wide range of sources, and there has been thorough stakeholder involvement throughout including subject matter experts and specialist leads. This enabled us to identify the Trust's Incident Profile (the top four types of patient safety incidents occurring across SCFT), which are falls, pressure ulcer, medication incidents and deterioating patient incidents, and the plan outlines which learning response will be taken for these incidents. SCFT's PSIRP is a 'living document', and to ensure our focus remains current it will be reviewed at least every 12-18 months. The creation of the SCFT PSIRP, and the process taken to do so, supports the PSIRF standard "Policy, planning and oversight". Please see SCFT PSIRP for full details of the plan itself.

7.2 Responding to additional incidents

In addition to the incidents outlined in the SCFT PSIRP, this policy outlines how SCFT will respond to other types of incidents which may result in harm to patients and/or staff.

7.2.1 Infection prevention and control (IPC)

Infection prevention and control related incidents will be reviewed at the TEA group and escalated to the PEASE call as required to confirm the learning response required. These will include incidents relating to:

- Outbreaks of Healthcare Associated Infections (this includes presumed transmission within a hospital and causes significant morbidity/mortality and/or impact significantly on activity, untoward significant impact i.e. high media interest or multiple hospital outbreaks).
- Infected healthcare workers
- Breakdown of infection control procedures/serious decontamination failures with actual or potential for cross infection
- Cases of Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridioides difficile (C.diff), where it is part of a sequence of events leading to death (Part 1 on death certificate) or in the event of an outbreak.
- Incidents requiring look back reviews. Investigation reviews will typically be led by a member of the Infection Prevention & Control Team.

The specific IPC learning response tool will be used to complete these learning responses. A thematic review may also be used if there are several incidents or outbreaks involving the same infection.

7.2.2 Information Governance breaches (IG)

Information Governance breaches will be assessed using the Department of Health Guidance 'Checklist for reporting, managing and investigating Information Governance and (IG) Serious Incidents' (May 2015). In line with this Guidance, any level 2 incident (scoring 2 or more) will be reported as a SI and reported to the Information Commissioners Office by the Information Governance Lead. A copy of the checklist can be accessed via the Pulse or a member of the information governance team. The check list content is based upon the Health and Social Care Information Centre (HSCIC) Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation (May 2015).

7.2.3 Information Technology incidents (IT)

In line with Health and Social Care Information Centre (HSCIC) Information Standards Board (ISB) guidelines and standards, IT systems implemented in healthcare settings must be delivered, deployed and operated in an acceptably safe manner for patients. Information technology incidents/failures, which have or have the potential to put patients at risk, will be reviewed and a proportionate learning response agreed.

- Loss of clinical data with no access to back up
- Data corruption, such as incorrect merging of clinical records

- Inappropriate access to clinical records
- Misuse of access rights, such as using smartcard to inappropriately view clinical records

7.2.4 Medical devices

If an incident involves the use of a medical device, an incident report must be completed using the Trust reporting system for review and advice from by the Medical Devices Team.

- Remove the device from use and quarantine
- Include the asset number and/or serial number of the device
- Include manufacturer, product code, lot number and expiry date for any consumable products and quarantine similar stock
- Report to the Medicines and Healthcare products Regulatory Agency (MHRA) via the Yellow Card system when advised

7.2.5 Never events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures are implemented. NHS England defines a core set of Never Events, all of which must be declared and reported to the Trust Board. A list of this can be found here (this link has been accessed 09/11/2023). Any reported Never Events will also be published in the Trust's Annual Quality Accounts. Incidents meeting the Never Events criteria will be investigated using a patient safety incident investigation as outlined in the plan.

7.3 Resources and training to support learning responses

The Patient Safety Team has undertaken accredited investigation training with the Healthcare Safety Investigation Branch (HSIB) to be effectively trained in taking a systems-based approach and utilising the Systems Engineering Initiative for Patient Safety (SEIPS) model for examining all the interactions involved in an incident.

A training needs analysis is being undertaken that is in line with the requirements of the Patient Safety Incident Response Standards to identify the level of training required by staff across the Trust, to enable the implementation of PSIRF. This document will form an appendix to this policy, once completed. It is essential staff undertake training before completing an incident learning response so that they are effective in applying a systems approach and using the related learning response tools. In-house training is being developed, and focuses on the use of SEIPS as an investigation tool, understanding human factors, and how to meet the requirements for involving and engaging with patients, relatives and staff. The Patient Safety team will provide support for staff members carrying out learning responses.

8. Oversight

8.1 Internal oversight to seek assurance on this policy

- All patient safety incidents are triaged by the Patient Safety Team (see appendix 1 A).
- All investigation decisions are approved by the CNO and CMO
- All investigation reports are approved by the Area management team and internal scrutiny at SCORG, chaired by the CMO
- A quarterly report on Patient Safety which includes a summary of incidents reported, investigations completed and learning is presented to the Trust Wide Governance Group.
- The quarterly Patient Safety Report is scrutinised at the Quality Improvement Committee, chaired by a Non-Executive Director prior to submission to the Trust Board.

8.2 Collaboration across the system

SCFT also supports a joined up, supportive and collaborative approach with their local partners across Sussex as part of PSIRF. SCFT champions the importance of working together across the Sussex Integrated Care System (ICS) to ensure that learning, resources and ideas are shared, and investigations are carried out together when different organisations are involved. SCFT therefore aims to work closely with their many partner organisations across Sussex to promote a cross-system approach, by doing the following:

- Working closely with the ICB.
- Inviting the ICB to attend the SCORG meeting 3 times a year and when there is a complex system report going through the meeting.
- Working closely with the Care Quality Commission (CQC).
- Sharing good practice, key learning from learning responses, resources and ideas with partners across Sussex.
- Carrying out joint learning responses, such as patient safety incident investigations with other local NHS Trusts and organisations across the Sussex ICS.
- Joining meetings with other local NHS Trusts and organisations across the Sussex Integrated Care System.
- Meetings to share learning between NHS Trusts, and feedback about incidents reported about another provider with the emphasis on shared learning and improvement.
- Attending the ICB network meetings.

9. Linking in with other processes

The SCFT PSIRP will link closely with other processes across the Trust and system. This includes complaints, claims, inquests, safeguarding, medical examiners, child death reviews and Learning from Lives and Deaths People with a Learning Disability and autistic people (LeDeR).

9.1 Complaints

SCFT ensures that patients and their relatives involved in a patient safety incident investigation are provided with information to seek further support as and when this is required. Patients and their relatives can make enquiries or raise concerns via the Patient Advice and Liaison Service (PALS) or access the formal complaints process. If a patient safety incident is reported which relates to an open complaint, and it is decided that a learning response is required, then this will be completed first and the outcome used to inform the complaints investigation. Listening to the voice of the patient and their families/carers is a key element of providing quality, safe care and the Patient Safety and Patient Experience teams work closely to ensure opportunities to provide and act on feedback are available and accessible. Further details on our services and methods of feedback can be found on our website Comments, Compliments, Concerns or Complaints (sussexcommunity.nhs.uk). (This link has been accessed 09/11/2023).

9.2 Claims

Patients and their relatives are able to make a claim for damages when harm has been caused by the care received at SCFT. All claims are handled by the Claims and Inquests Senior Advisor in partnership with NHS Resolutions. Staff are advised to contact the Claims and Inquests Senior Advisor for advice and support if they are contacted by a solicitor representing a person who is contemplating litigation against the Trust.

9.3 Inquests and coroners

When a Coroners referral requesting information or witness statements is received, the Claims and Inquests Senior Advisor will liaise with the Patient Safety Team, and log the inquest on the Trust's risk management system. They will liaise directly with the Clinical Services Manager or Area Head of Nursing/AHPs and Governance. Inquests of concern are brought to the TEA meeting on a Monday, and escalated to the PEASE call as required to ensure Executive oversight. The Patient Safety Team will work closely with the Claims and Inquests Senior Advisor to ensure that all learning responses support the inquest process. The Claims and Inquests Senior Advisor will support staff involved throughout coronial processes. This includes preparing written statements, witness preparation, securing legal representation where this is deemed necessary and attending inquests.

9.4 Safeguarding adults

If an adult with care and support needs is experiencing harm, abuse, or neglect (including self-neglect, and capacitated self-neglect) all members of staff must consider a referral to the Local Authority. All incidents of abuse and neglect, including self-neglect, to an adult are notified through Safeguarding Adults procedures. This includes completion of both an incident report on the Trust's online reporting system and raising an adult safeguarding concern via the Local Authority. The safeguarding team are automatically notified of any safeguarding related incident reports raised internally.

The adult safeguarding team complete Safeguarding Adults section 42 Enquiries (s42) when a safeguarding concern is raised regarding SCFT delivery. The adult safeguarding team will bring any of these enquiries to the TEA group for discussion when findings indicate that SCFT contributed to cause of risk.

If it is decided that a PSII is required for patient safety incident that is also a safeguarding s42, then this will take priority and the outcome of the investigation will be used to inform the Safeguarding Adults s42 Enquiry response.

9.5 Safeguarding children

All SCFT staff, regardless of their role, have a duty to keep children safe. As such, they have a responsibility to record and report safeguarding children concerns. In line with the SCFT Safeguarding Children Policy and the Pan Sussex Safeguarding Children Procedures, a decision must be taken as to whether the level of concern necessitates a referral to Children's Social Care. If staff are not certain as to whether to make a referral to Children's Social Care, concerns should be raised with a line manager or the Safeguarding Children Advice Line, to determine the appropriate response. A Safeguarding Children referral to Children's Social Care will be made via the relevant County/ City website, with a copy of the referral held in the child's health records.

9.6 Child death reviews

All child deaths (between the time of live birth and the child's 18th birthday) are notified to the NHS England Sussex Area Team Child Death Overview Panel by the Safeguarding Lead Nurse.

When the child death is expected, a PSII will not be required where the death of a child was anticipated within a 24-hour period and there are no suspicious concerns or health management and quality of care issues.

When the child death was unexpected, this will be reviewed via the Trust's processes and a PSII will be completed. This is where the death of a child was not anticipated within a 24-hour period and where there are healthcare management issues identified. Where there are

suspicious concerns or child protection issues the Local Safeguarding Children Board (LSCB) Serious Case Review Subgroup will decide if a Serious Case Review is required.

9.7 LeDeR

SCFT will complete a PSII for safety critical incidents involving people with learning disabilities or autism or both that are under SCFT care. Where the patient is deceased the PSII will contribute to the Learning from Lives and Deaths for people with a learning disability and/or autism Review (LeDeR. SCFT will incorporate the learning from the National LeDeR Audit.

9.8 Screening incidents

National screening programmes are public health interventions, which aim to identify disease or conditions in defined populations in order to reduce morbidity or mortality. Screening programmes are sometimes complicated because activity often takes place within pathways across several organisations.

If there are actual or possible failures at any stage of screening, which exposes the programme to unknown levels of risk, that screening and assessment or treatment of patients is inadequate, with the potential for serious clinical management consequences, then this will be reviewed through the patient safety processes to decide on the learning response. Whilst the individual risk to individual patients may be low, because of the large number of patients involved the over-arching risk may be high. The learning response will be undertaken in accordance with national screening programme guidance on incident reporting and will be overseen by the local screening Board.

10. Patient Focus

This policy is aligned with SCFT's commitment to ensuring patients receive safe and quality care. The policy focuses on responding and investigating patient safety incidents, which have, or could have, led to harm to a patient/patients, in line with PSIRF and the SCFT PSIRP. This policy will ensure that the most proportionate method of learning response is used, balancing resources and ensuring that learning is used to reduce the risks to other patients and continuously improve care. The patient voice is key to patient safety, and patients should be fully involved and engaged with throughout an investigation to ensure that their voice is heard, they can relay their experience, and have an opportunity for any questions to be answered, and this policy promotes that.

11. Responsibilities

The **Chief Executive** has ultimate responsibility for the organisation and is supported by the Executive Directors.

The **policy author** is responsible for ensuring the policy follows the appropriate SCFT format and complies with the recognised development, consultation, approval and ratification process.

The **Chief Medical Officer** is accountable for the implementation and assurance of this policy and SCFT Patient Safety Incident Response Plan. They will have responsibility for chairing SCORG and signing off patient safety investigations presented (the Deputy Chief Medical Officer may deputise in their absence).

The **Chief Nurse** is accountable for the implementation and assurance of this policy and SCFT Patient Safety Incident Response Plan.

The **Quality Improvement Committee** is responsible for scrutinising and supportively challenging to ensure a transparent and robust implementation of this policy.

The **Associate Director of Quality and Safety** is responsible for supporting with the implementation of this policy and SCFT Patient Safety Incident Response Plan.

The **Patient Safety Manager** is responsible for taking a lead on the implementation of this policy and the SCFT Patient Safety Incident Response Plan.

The **Patient Safety Team** are responsible for promoting the policy, supporting staff with following the policy on a day to day basis with the contents of this policy and PSIRF.

The **Area Heads of Nursing/Allied Health Professionals and Governance** are responsible for promoting the policy, and supporting staff with following the policy on a day-to-day basis with regards to incident reporting, completion of leaning responses, monitoring actions and promoting and sharing of learning.

Subject matter experts/specialist leads are responsible for ensuring that they use the policy when reviewing incidents and supporting the learning responses.

Service managers / team leaders are responsible for promoting and implementing the policy.

All staff are required to complete in full and as directed any templates or proformas as instructed, for use as part of this policy.

12. Associated Documents and References

Care Quality Commission (2022) *Key questions and quality statements.* Available here: https://www.cqc.org.uk/about-us/how-we-will-regulate/five-key-questions-and-quality-statements (accessed 09/11/2023).

NHS England and NHS Improvement. 2021. *Framework for involving patients in patient safety.* Available here: *https://www.england.nhs.uk/wp-content/uploads/2021/06/B0435-framework-for-involving-patients-in-patient-safety.pdf* (accessed 09/11/2023).

NHS England and NHS Improvement. 2021. Framework for involving patients in patient safety, Summary. Available here: https://www.england.nhs.uk/wp-content/uploads/2021/06/B0435-summary-framework-for-involving-patients-in-patient-safety.pdf (accessed 09/11/2023).

NHS England and NHS Improvement. 2019. *The NHS Patient Safety Strategy.* Available here: https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf (accessed 09/11/2023).

NHS England and Improvement, 2022. *Patient Safety Incident Response Framework*. Available here: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-1.-PSIRF-v1-FINAL.pdf (accessed 09/11/2023).

NHS England and Improvement, 2022. *Patient safety incident response standards.* Available here: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (accessed 09/11/2023).

NHS Just Culture Guide. Available here: https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf (accessed 09/11/2023).

SCFT Being Open and Duty of Candour Policy 2023. Available here: https://nhs.sharepoint.com/sites/RDR_intranetdocuments/Documents/Forms/AllItems.aspx?id=%2Fsites%2FRDR%5Fintranetdocuments%2FDocuments%2FThe%20Pulse%20Documents%2FOur%20Trust%2FPolicies%20and%20Procedures%2FQuality%20and%20Safety%2Fbeing%2Dopen%2Dand%2Dduty%2Dof%2Dcandour%2Dpolicy%2Epdf&parent=%2Fsites%2FRDR%5Fintranetdocuments%2FDocuments%2FThe%20Pulse%20Documents%2FOur%20Trust%2FPolicies%20and%20Procedures%2FQuality%20and%20Safety (accessed 09/11/2023).

SCFT Patient and Public Voice Policy 2023. Available here: https://nhs.sharepoint.com/sites/RDR_intranetdocuments/Documents/Forms/AllItems.aspx?id=%2Fsites%2FRDR%5Fintranetdocuments%2FDocuments%2FThe%20Pulse%20Documents%2FOur%20Trust%2FPolicies%20and%20Procedures%2FQuality%20and%20Safety%2Fpatient%2Dand%2Dpublic%2Dvoice%2Dpolicy%2Epdf&parent=%2Fsites%2FRDR%5Fintranetdocuments%2FDocuments%2FThe%20Pulse%20Documents%2FOur%20Trust%2FPolicies%20and%20Procedures%2FQuality%20and%20Safety (accessed 09/11/2023).

13. Monitoring Compliance

This policy will be monitored by the Trust Wide Governance Group for compliance with the contents of this Policy. SCORG is also responsible for monitoring the investigations completed, and ensuring that they are in line with the SCFT Patient Safety Incident Response Plan.

14. Dissemination and Implementation

This policy will be published on the Trust's intranet site "The Pulse" with links to the policy on the service specific intranet page of Patient Safety. It will also be published in the regular communications for policy review forums. A link to the policy will also be shared via the external Trust website, alongside the SCFT Patient Safety Incident Response Plan.

SCFT offers translations of all essential leaflets for patients in all major languages, plus Braille, easy read, large print, and audio formats.

15. Consultation, Approval, Ratification & Review

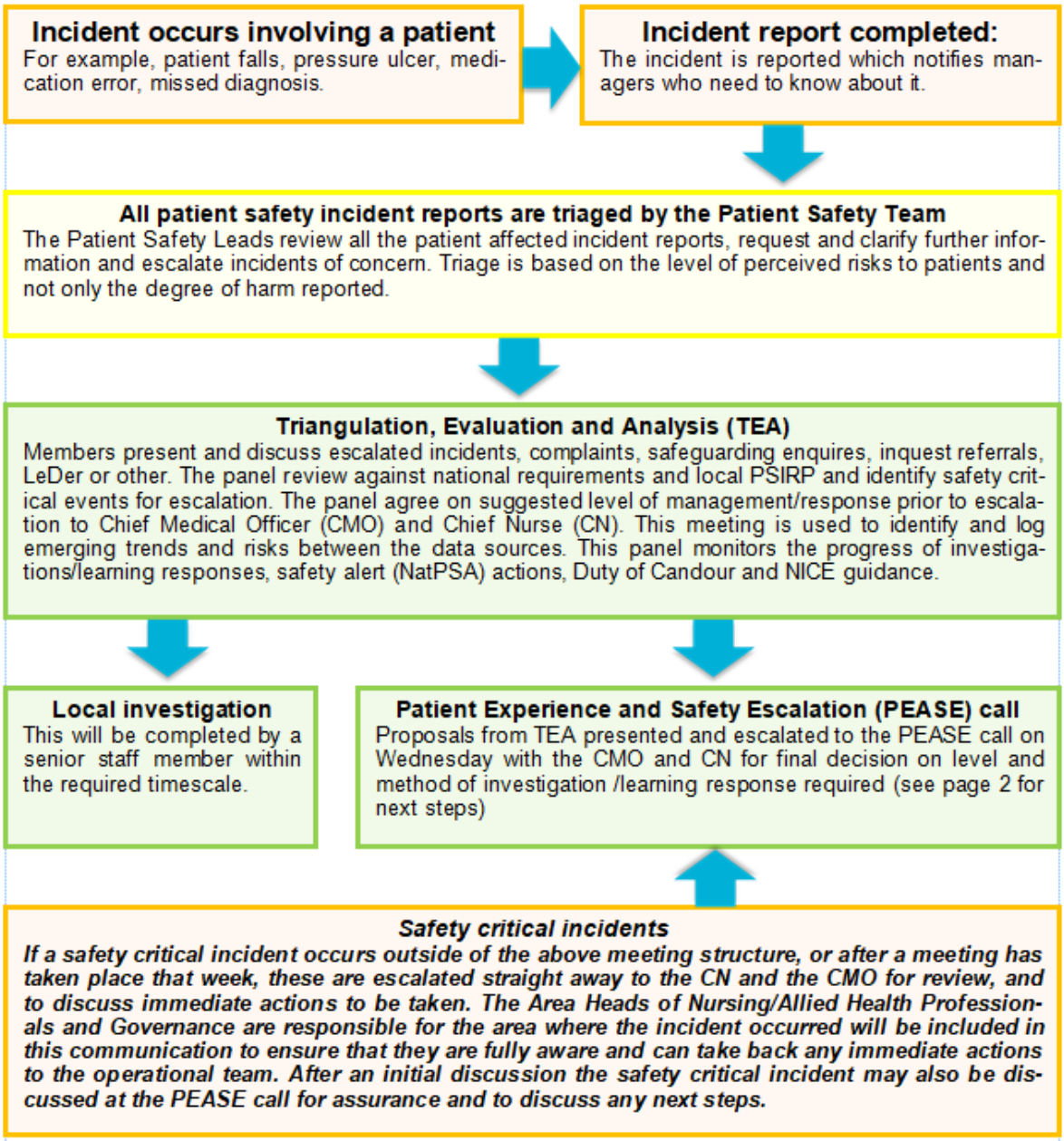
This policy has been written in consultation with the Patient Safety Manger, Associate Director of Quality and Safety and the Safety and Risk Manager. The policy was sent out for consultation with all core stakeholders involved with the implementation of PSIRF, as well as additional stakeholders for this policy. This includes the Area Heads of Nursing and Governance, the Area Head of Allied Health Professionals and Governance, the Patient Experience Team, the Quality Development Team, the Freedom to Speak up Guardian, the Claims and Inquests Senior Advisor, Head of Safeguarding, Named Nurse: Adult Safeguarding, Named Nurse: Children's Safeguarding and the Associate Director of Quality Improvement, the Deputy Director Infection Prevention Control, the Head of IT, and the Deputy Head of Information Governance. The policy has also been shared with our Patient Safety Partners for their input and review.

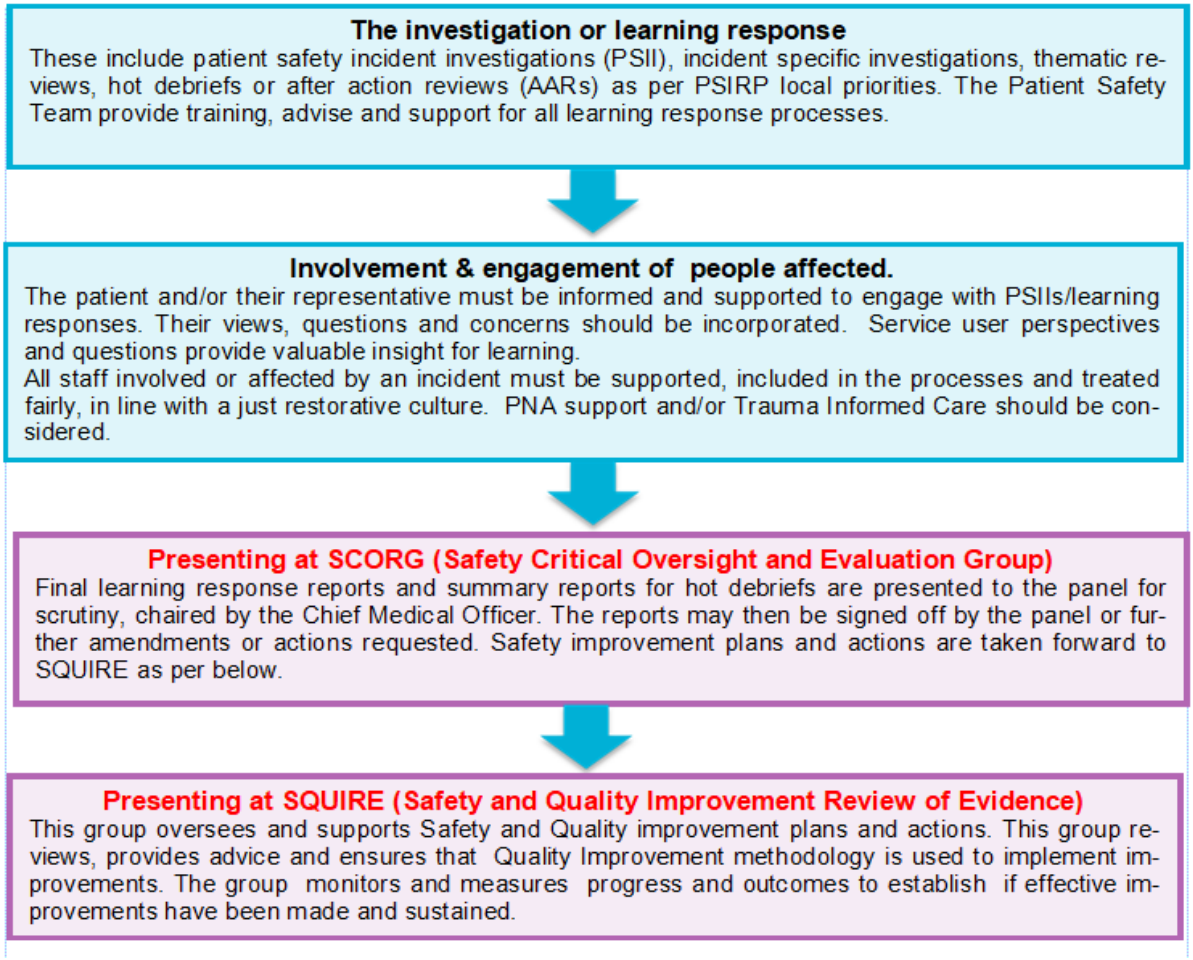
The Policy has been approved by Trust Wide Governance Group on 01/08/2023,and was ratified by the Executive Management Group on 16/08/2023.

The policy will be reviewed initially in two years, and then every three years hereafter, by the Patient Safety Manager and the Trust Wide Governance Group.

16. Appendices

Appendix A - Guides for Staff, Outlining the Investigation Process




The investigation or learning response
These include patient safety incident investigations (PSII), incident specific investigations, thematic reviews, hot debriefs or after action reviews (AARs) as per PSIRP local priorities. The Patient Safety Team provide training, advise and support for all learning response processes.
Involvement & engagement of people affected.
The patient and/or their representative must be informed and supported to engage with PSIIs/learning responses. Their views, questions and concerns should be incorporated. Service user perspectives and questions provide valuable insight for learning.
All staff involved or affected by an incident must be supported, included in the processes and treated fairly, in line with a just restorative culture. PNA support and/or Trauma Informed Care should be considered.
Presenting at SCORG (Safety Critical Oversight and Evaluation Group)
Final learning response reports and summary reports for hot debriefs are presented to the panel for scrutiny, chaired by the Chief Medical Officer. The reports may then be signed off by the panel or further amendments or actions requested. Safety improvement plans and actions are taken forward to SQUIRE as per below.
Presenting at SQUIRE (Safety and Quality Improvement Review of Evidence)
This group oversees and supports Safety and Quality improvement plans and actions. This group reviews, provides advice and ensures that Quality Improvement methodology is used to implement improvements. The group monitors and measures progress and outcomes to establish if effective improvements have been made and sustained.

17. Equality and Human Rights Analysis (EHRA)

Title(s): Patient Safety Incident Response Framework Policy

Aims: To provide clear guidance to staff on how the Trust will respond to patient safety events. It provides an overview of the process from incident reporting, investigating using a learning response method, implementing improvement actions and monitoring the effectiveness of improvements on patient care. This work ensures that systems are in place to keep all patients safe and to learn from where things go wrong in a transparent way. The work also promotes a person-centred approach and embeds equalities at the centre of learning.

Evidence

Please summarise any evidence about how the work may impact people either positively or negatively specifically linked to their characteristics.	Mark 'X' relevant characteristics								
	Age	Disability and Carers	Race	Religion or Belief	Sex	Pregnancy or Maternity	Gender Reassignment	Sexual Orientation	Other (e.g. Armed Forces)
Positive impacts: Monitoring patient demographics in patient safety events can help to detect those who are most at risk of harm and help us to address health inequalities.	X	X	X	X	X	X	X	X	X
Negative impacts: Language, communication, technology and terminology used may create barriers for patients. Reasonable adjustments must be made to ensure patients are able to fully engage and be included in learning responses, for example, the use of interpreters, Easy Read formats.	X	X	X	X					X

Please summarise any evidence about how the work may impact people either positively or negatively specifically linked to their characteristics.	Mark 'X' relevant characteristics								
	Age	Disability and Carers	Race	Religion or Belief	Sex	Pregnancy or Maternity	Gender Reassignment	Sexual Orientation	Other (e.g. Armed Forces)

Equality Analysis

Please evaluate how the work may impact people with protected characteristics to meet the three aims (A-C) below, referencing any evidence identified above. If an aim is not relevant to your work, please explain why.

Aim A. Eliminate discrimination – Please evidence if the work could unlawfully discriminate.

Include who is discriminated (e.g. disabled adults) and how. Include detailed reasons if it is lawful.

The primary detection of patient safety events is through staff incident reporting. However, it is recognised that this may be influenced by unconscious bias across staff groups. This policy aims to mitigate this by ensuring that patient safety information and insight is taken from a range of sources ie: PALs/Patient Experience, FTSU, clinical audit, Safeguarding etc.

Aim B. Advance equality of opportunity – Please evidence if the work:

Minimises disadvantage – Does the work address any poorer outcomes for particular protected groups?

Meets different needs – Does the work meet different protected groups' social, cultural or other needs?

Encourages participation – Does the work target under-represented groups to increase involvement?

When working with patients and staff involved in patient safety incidents a person centred approach will be taken to ensure that we identify and adjust our approach to accommodate and support individual needs and characteristics. Where a patient may not be able to be involved in an investigation, for instance due to a lack of capacity, communication or language barriers, we will liaise with the patient's NOK or representative. We will support patients to access advocacy or interpretation services if they do not have a NOK or representative.

Aim C. Foster good relations – Please evidence if the work:

Tackles prejudice – Does the work increase contact between groups to reduce negative attitudes?

Promotes understanding – Does the work educate people about groups to change negative attitudes?

Yes – this policy supports contact with both patients and staff as part of a patient safety incident learning response.

Human Rights Analysis

Mark 'X' against the relevant rights which are safeguarded (+), or breached (–) by the work:	+	–
Article 2. Right to life (e.g. The Deteriorating Patient policy, DNACPR or Clinical competencies)	X	
Article 3. Prohibition of torture, inhuman or degrading treatment (e.g. Consent or Safeguarding)	X	

Mark 'X' against the relevant rights which are safeguarded (+), or breached (−) by the work:	+	−
Article 5. Right to liberty and security (e.g. Deprivation of Liberty or Restrictive Interventions)		
Article 8. Right to respect for private and family life, home and correspondence (e.g. Confidentiality, health records, carer involvement, correspondence or staff leave)	X	
Article 9. Freedom of thought, conscience and religion (e.g. End of Life Care or Prescribing)	X	
Article 10. Freedom of expression (e.g. Patient information or Raising Concerns policy)	X	
Article 12. Right to marry and found a family (e.g. Pregnancy testing procedure)		

Monitoring

Please describe how any impacts will be monitored: (e.g. annual policy review, audit, performance metric).

The policy will be reviewed initially in two years, and then every three years hereafter, by the Patient Safety Manager and the Trust Wide Governance Group.

Outcome

Choose the final outcome(s) a-d of the analysis with an 'X' and explain the reasons in the space below:

X	(a) Continue the work	The work in this policy can be carried out.
	(b) Change the work	
	(c) Justify and continue the work	
	(d) Stop the work	

Please score any risks to equality or human rights below and update your risk register:

Consequence score:	1	x	Likelihood score:	1	=	Equality and Human Rights Risk Score:	1

Assurance Statement: I have reviewed the evidence with rigour and an open-mind and am satisfied there has been due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations, and there is compliance with Section 149 of the Equality Act 2010.

Analysis Lead(s) names: Charlotte Pearce and Deborah Johnson		Date: 24/07/2023
Ratifying committee / body: Executive Management Group		Date: 16/08/2023
Reviewer (office use):	Decision:	Date:

Improvement Plan

Description of actions	Date	Person	How will this be delivered?
Add more rows if necessary			

Send this form along with your main paperwork for consultation to sc-tr.equality@nhs.net

18. Ratification Checklist

Sections 1 – 4 of the Ratification Checklist must be completed and submitted **with the document for approval.**

All sections must be completed and submitted to the ratification group - **please note the ratification group is sighted on the ratification checklist only** therefore it should be completed comprehensively.

Executive Committee 16 August 2023

Agenda Item: 5
Policy Title: Patient Safety Incident Response Framework Policy
Policy Author: Patient Safety Lead, Patient Safety Manager and Associate Director of Quality and Safety.
Presented By: Patient Safety Lead and Patient Safety Manager
Purpose: Ratification

Checklist for Ratification		
1.	**Reason for Review:**	
	a) New Policy If it is a new policy, please summarise why there is a need for this policy.	Yes, this is a new policy. This policy has been developed as part of the implementation of the Patient Safety Incident Response Framework which takes over from the current Serious Incident Framework. Due to the substantial changes between the two frameworks this new policy was needed, and any previous policies on the Serious Incident framework will no longer be valid.
	b) Revision/update to current Policy	
	Please state **the reason** for updating, e.g. compliance with new or updated legislation	

	Please state briefly **what amendments/updates were made, what section/page number and where they can be located within the document**	
	c) Other – please state	
	d) Review date due or expired *(please state date):*	

2.	**Summary**		
	This policy is being written to support the Patient Safety Incident Response Framework, which the Trust are transitioning over to in September 2023. This framework replaces the current Serious Incident framework, and therefore the current Incident Management and Reporting Policy which includes the Serious Incident framework is no longer valid. This document outlines how SCFT will respond to incidents which is outlined in our Patient Safety Incident Response plan, which sits alongside this policy, outlines our safety culture, and how we will involve patients, their families and staff within patient safety incident investigations.		
3.	**Format**		
	Has the standard SCFT template been used?	**Yes**	**Comments**:
4.	**Consultation**		

Name	**Response Y/N**	**Date (sent)**
Deborah Johnson – Patient Safety Manager	Have been supporting with the writing of this policy.	23/05/2023 & 14/07/2023
Howard Pescott - Associate Director of Quality and Safety	Have been supporting with the writing of this policy.	23/05/2023 & 14/07/2023
Alison Brown - Medical Device Safety Lead	Reviewed medical devices paragraph	11/07/2023
Mary Hammerton – Quality Development Manager	No	14/07/2023
Vasanthan Manoharan – Quality Development Lead – Assurance	Yes - comments and feedback provided.	14/07/2023
Tracey Beech – Quality Development Lead – Effectiveness	No	14/07/2023
Mary Bell – FTSU Guardian	No	14/07/2023
Joey Ramos – Claims and Inquests Senior Advisor	No – but reviewed the paragraph on claims and inquests when writing policy.	14/07/2023
Gillian McTaggart – Associate Director of Quality Improvement	No	14/07/2023
Heba Jackson – Trustwide Falls Lead	No	14/07/2023
Lorna Elliott - Senior Clinical Pharmacist and Medication Safety Officer (MSO)	No	14/07/2023
Iben Altman - Chief Pharmacist	No	14/07/2023
Adam Rezazadeh - Deputy Head of Information Governance	Yes – regarding paragraph on IG and IT	14/07/2023
Matt Pelton - Head of IT	Yes - regarding paragraph on IT and IG	14/07/2023
Lindsay Wells – Head of Information Governance	No – but Adam Rezazadeh provided comments	14/07/2023

Ian Hubbard - Patient Safety Training Lead	No	14/07/2023
Shahid Aziz - Clinical Director SCFT Urgent Care	No	14/07/2023
TVNs - Sally Jenkins, Susan Martin, Kerry Neary and Amy Sharrard	No	14/07/2023
Lisa O'Hara - Nurse Consultant Palliative & End of Life Care	No	14/07/2023
Catherine Evans - Honorary Nurse Consultant and HEE/NIHR Senior Clinical Lecturer in Palliative Care; a joint post between Sussex Community NHS Foundation Trust and King's College London	No	14/07/2023
Alison Keizer - Nurse Consultant Dementia/Delirium & Teaching Fellow	No	14/07/2023
Jackie Allt - Chief Psychologist/Consultant Clinical Psychologist	No	14/07/2023
Tracy Allan - Area Head of Nursing and Governance Children, Young People and Specialist Services	No	14/07/2023
Katie Roberts - Area Heads of Allied Health Professionals and Governance, (Adults - East locality) -	No	14/07/2023
Bethan Whittingham - Area Heads of Allied Health Professionals and Governance, (Adults - East locality) -	No	14/07/2023
Nicki Leighton - Area Head of Nursing and Governance, (Adults - East locality)	No	14/07/2023
Hannah Purser - Area Head of Allied Health Professionals and Governance, West Sussex - Bridget Winrow	No	14/07/2023
Bridget Winrow - Area Head of Allied Health Professionals and Governance, West Sussex - Bridget Winrow	No	14/07/2023
Jenefer Gillam - Head of Nursing and Governance – West Sussex Community Services	No	14/07/2023
Louise Salvi - Head of Nursing and Governance – Inpatient and Outpatient Services (West Sussex) -	No	14/07/2023
Amanda O'Boyle - Lead Diabetes Dietitian – Diabetes Care for You and Professional Lead Dietitian	No	14/07/2023
Parul Patel - Clinical Director for Dental	No	14/07/2023
David Atkins - Professional Lead for Podiatry	No	14/07/2023
John Somarib - Children's Clinical Director	No	14/07/2023
Nicky Welfare - Patient Experience Lead	No – but reviewed the paragraph on patient experience when writing policy	14/07/2023
Yvonne Martindale - Deputy Director Infection Prevention Control	No – but reviewed the paragraph on IPC when writing policy	14/07/2023
Mark Plows - Safety and Risk Manager	Has been supporting with creating this policy	14/07/2023
Russell Hite - Head of Safeguarding (Adults and Children)	No – but has reviewed the paragraphs on safeguarding adults and children when writing policy	14/07/2023
Alison Cooke - Named Nurse: Adult Safeguarding	No	14/07/2023
Georgina Colenutt - Named Nurse: Children's Safeguarding	No	14/07/2023
Corinne Nikolova - Clinical Service Manager for Wellbeing services	No	14/07/2023
Jane Mulcahy - Consultant Nurse for Children's Community Nursing & Complex Care	No	14/07/2023
Jane Rowney – Diabetes Nurse Consultant	No	14/07/2023
Alexis Judd - Professional Lead for Children's Speech and Language Therapy	No	14/07/2023
Emma Dunster - Professional Leads for Adult Speech and Language Therapy	No	14/07/2023
Theresa Samms - Professional Leads for Adult Speech and Language Therapy	No	14/07/2023

5.	**Dissemination/Implementation Process**
	This policy will be published on the Trust's intranet site "The Pulse" with links to the policy on the service specific intranet page of Patient Safety. It will also be published in the regular communications for policy review forums. A link to the policy will also

	be shared via the external Trust website, alongside the SCFT Patient Safety Incident Response Plan. SCFT offers translations of all essential leaflets for patients in all major languages, plus Braille, easy read, large print, and audio formats.		
6.	**Cost/Resource Implications**		
	Does this policy have any cost and/or resource implications?		**No**
	If Yes:		
	Please provide details of the cost/resource implications: e.*g. training, equipment, additional staff*		
	Has this been agreed by the accountable Director? Name: Job title: Date:		**Y/N**
7.	**Approval**		
	Please state the name of the Group that has approved this document?	Name: Trust Wide Governance Group	
	Date of Group Approval:	Date: 01 August 2023	
8.	**Equality Analysis**		
	Has the Equality and Human Rights Assessment (EHRA) form been completed by the author and sent for review to the Equality and Diversity team?	**Yes**	Comments:
	Has the Equality and Diversity Team reviewed the policy and signed EHRA form? *The authors are not required to send EHRA for review to E&D Team unless there are queries.*	**Yes/No** (please delete)	Comments:
9.	**Quick Guide**		
	If there is a Quick Guide for this policy, has it been reviewed?	**No**	Comments: No current quick guide.
10.	**Patient Focus**		
	To ensure that all SCFT policies/procedures are consistently patient focused, have you detailed the benefits of the policy/procedure to SCFT users/patients?	**Yes**	Comments:
11.	**Review**		

	Please state the timescale for review:	The policy will be reviewed initially in two years, and then every three years hereafter, by The Trust Wide Governance Group and the Patient Safety Manager.

Decision, Outcome & Recommendations

(to be completed after ratification)

For completion by the Chair of the Group or Committee considering ratification.		
Is the Committee / Group satisfied and assured that due process has been followed in order to produce or review the Policy?	**Yes**	Comments:
Is the Committee / Group satisfied and assured with the consultation on the Policy?	**Yes**	Comments:
Does anybody (group or individual) else need to be consulted prior to ratification?	**Yes**	Please state who: Claire Turner - Consultant in Public Health
Other Comments		
Outcome: **Was the Policy ratified?**	 **Yes**	
Other comments: Including strengths and good practice.		
Additional actions required for ratification: Must be SMART	Ratified, but subject to minor changes around the EHRA and section 4.3 “Addressing health inequalities”.	
Signature of Chair: **Print Name:** Siobhan Melia **Job Title:** Chief Executive		**Date:** 16/08/2023