Birmingham and Solihull Mental Health NHS Foundation Trust

Patient Safety Incident Response Framework Policy

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Version number and date	**1**	**February 2024**
Ratifying committee or executive director	**Clinical Governance Committee**	
Date ratified	**April 2024**	
Next anticipated review	**April 2027**	
Executive director	**Chief Nurse for Quality and Safety**	
Policy lead	**Head of Patient Safety**	
Policy author *(if different from above)*	**As above**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Birmingham and Solihull Mental Health NHS Foundation Trust (the Trust) will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety. This policy has been developed using the national NHSE template and will be supported by a detailed Incident Reporting policy.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF.

- Inclusive and 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.

Policy requirement

PSIRF uses a "systems-based approach" to learn what risks there are for patient safety and how to respond to these to improve safety. A system-based approach recognises that healthcare takes place in a work system composed of people, tasks, equipment and the different environments in which care is provided. All these aspects of the system vary and interact with each other to produce different outcomes. By exploring how these different aspects are working together in different situations, a deeper understanding of the risks and issues facing patients and staff can be gathered, and more effective learning can be identified. Several systems based tools, for example the Systems Engineering Initiative for Patient Safety (SEIPS) will be used to support learning from patient safety events and to support responding to broad patient safety issues.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resource investigations exist for that purpose.

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1. Introduction

1.1. Rationale

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Birmingham and Solihull Mental Health NHS Foundation Trust (the Trust) will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety. This policy has been developed using the national NHSE template and will be supported by a detailed Incident Reporting policy.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF.

- Inclusive and 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.

1.2 Scope

This policy applies to all staff whether they are employed by the Trust permanently, temporarily though an agency or bank arrangement, are students on placement or are joint working through contract arrangements.

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.

PSIRF uses a "systems-based approach" to learn what risks there are for patient safety and how to respond to these to improve safety. A system-based approach recognises that healthcare takes place in a work system composed of people, tasks, equipment and the different environments in which care is provided. All these aspects of the system vary and interact with each other to produce different outcomes. By exploring how these different aspects are working together in different situations, a deeper understanding of the risks and issues facing patients and staff can be gathered, and more effective learning can be identified. Several systems based tools, for example the Systems Engineering Initiative for Patient Safety (SEIPS) will be used to support learning from patient safety events and to support responding to broad patient safety issues.

Human error is understood to be a symptom of an issue in the healthcare system, rather than a cause of an incident. When responding to incidents and safety events under PSIRF, the aim is on learning for improvement.

Other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes as those listed below and are therefore outside of the scope this policy.

- claims handling,
- human resources investigations into employment concerns,
- professional standards investigations,
- information governance concerns
- estates and facilities concern
- financial investigations and audits
- safeguarding concerns
- coronial inquests and criminal investigations
- complaints (except where a significant patient safety concern is highlighted)
- For clarity, the Trust considers these processes as separate from any patient safety investigation. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

1.3 Principles

1.3.1 Safety Culture

The Trust supports a just safety culture, supporting a fair, open, inclusive culture that abandons blame as a tool for those staff involved in patient safety incidents. The Trust conducts patient safety incident responses for the sole purpose of learning and identifying system improvements to reduce risk, this is communicated verbally and in writing to anyone that is interviewed as part of a learning response.

The Trust values the systems and processes that are in place to support a safety culture, the implementation of PSIRF is anticipated to do this further, through the new procedures and forums being implemented, which includes Restorative Culture training, safety culture questionnaires, Freedom to Speak Up Champions.

The following forums have been put in place to develop patient safety across the Trust

- Emerging Risk Group
- Local service area Patient Safety Panels
- Trust Patient Safety PSIRF oversight Group
- Patient Safety Advisory Group
- Annual Patient Safety Learning Event

1.3.2 Addressing Health Inequalities

The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust as a public authority is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. The introduction of a new interface between incident management system and the electronic clinical record will allow for protective characteristics to be analysed to give insight into any apparent inequalities.

Within our patient safety response toolkit, we will directly address if there are any features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

We will also address apparent health inequalities as part of our safety improvement work. We understand that our services provide care to significant numbers of the Core20PLUS5 population cohort identified by NHS England and Improvement (2021). we will continue to work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy. We consider this as an integral part of the future development process.

1.3.3 Patient Safety Partners

Patient Safety Partners known as Experts by Experience (EBE) Safety Partner (PSP) at BSMHFT is a new and evolving role developed by NHS England / Improvement to help improve patient safety across the NHS in the UK.

At BSMHFT, we are excited to welcome EBE Safety Partners who will offer support alongside our staff, service users and families/carers to influence and improve safety across our range of services.

The EBE Safety Partners will be supported in their role by the Lead for Recovery, service user, carer and family experience and the Patient Safety Specialist for the Trust to provide support and guidance.

EBE Safety Partners will have regular peer and one-to-one sessions with our Patient Safety Specialist and training needs will be agreed together based on the experience and knowledge of each EBE.

2: **The policy**:
This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.

Colleagues have a responsibility for ensuring that patient safety incidents are acknowledged and reported via the Eclipse incident reporting system as soon as they are identified and that staff, service user and their families are supported compassionately following a patient safety incident.

3.0 Procedure

3.1 Responding to Patient Safety Incidents

There are several mechanisms in place to allow staff, service user and the public to record patient safety incidents.

3.2 Safety incident reporting arrangements

3.2.1 Internal Process

All staff have access to the Trust incident management Eclipse. Depending on the type of incident a notification will be sent to the relevant people in that service area and/or area of expertise. An automatic feedback function is also available to staff who have reported an incident. The number of incidents reported has been growing year on year, whilst the number of causing harm to service users has remained small in comparison. This is an indicator of a good safety culture.

3.2.2 External Processes

- Via the NHSE website
- The public can a raise an incident concern through PALS
- Concerns can be raised through a complaint which may then be triangulate with the patient safety team and an incident form generated
- The public can report through LFPSE

3.3. Patient safety incident response decision-making

The PSIRF supports organisations 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, the Trust will explore patient safety incidents relevant to local context and the population we serve rather than those that meet a certain defined threshold

The Trust has arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our **PSIRF plan**

Appendix 3 takes into account all the patient safety incidents that are reported within the Trust and how they will be managed; providing internal and external stakeholders assurance that the incidents have been responded to in a proportionate way.

Each incident presented will be considered based on whether further exploration is needed due to the possibility of meeting the criteria for a Patient Safety Incident Investigation (PSII) or a Patient Safety Learning Response due to the potential for learning and improvement.

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

The Patient Safety Incident Response Plan provides a more detail on the types of learning responses most appropriate to the circumstances of the incident

The Trust has governance arrangements in place to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

All systems-based Patient Safety Incident Investigations will be carried out by a Patient Safety Manager who as part of the Patient Safety Team, will have undertaken specific training in systems-based investigation methodology.

Other learning responses can be completed by staff who have received specific training in these techniques. Training in After Action Review and Structured Judgement Review is available and can be accessed via the Patient Safety Team as is coaching in the other learning responses.

Highly prescriptive timeframes for learning responses are not helpful so the following are included as a guide only:

- Initial incident investigation – within 7 days of reporting
- Further learning response such as After Action Reviews, within 20 working days of being commissioned.
- MDT pathway reviews within 60 working days of being commissioned.
- Patient Safety Incident Investigation 90-150 days working days of being commissioned, depending on complexity

These decisions will be made in an open and transparent way by the local service area. Patient Safety Panel, who will also consider if escalation to the Trust Patient Safety Panel is required.

The Trust Patient Safety panel will have delegated responsibility for the consideration of incidents for PSII and for oversight of the outcomes of such reviews to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required.

The Quality Patient Experience Safety Committee will have overall oversight of such processes and will challenge decision making of the Patient Safety panels to ensure that the Board can be assured that the true intent of PSIRF is being implemented within our organisation and we are meeting the national patient safety incident response standards.

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

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

We are committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our service users, their families, or carers to prevent recurrence.

We recognise and acknowledge the significant impact patient safety incidents can have on staff, service users, their families, and carers.

Getting involvement right with staff, service users and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

All staff are encouraged to be open and transparent, whenever there is a concern about care not going as planned or expected or when a mistake had been made regardless of the level of harm. All staff follow the Duty of Candour Policy (C25). The regulatory aspects of Duty of Candour are to be monitored through the local service area Safety Panels and reported through our Patient Safety Advisory Group.

Service users and their families will be supported through the Patient Safety Incident Investigation process by our Family Support Officer, who will have undertaken specific training to perform this role.

In addition, BSMHFT has a Patient Advice and Liaison Service (PALS). People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of the care team. Should the care team be unable to resolve the concern then PALS can provide support and advice to service users, families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing concerns to negotiate an immediate and prompt solutions.

The Trust acknowledges that staff may find being involved in an incident to be stressful and recognises that it is therefore important that staff are appropriately supported. This applies to all staff, including bank, agency and locum workers, volunteers and those on work experience.

To support staff involved in a patient safety incident, we have a range of supportive literature and the Trust has a range of psychological support systems. Details can be found on PAM website and include access to counselling and other one to one support services.

We will also be creating a set of metrics to measure how we are engaging compassionately with our staff based on the PSIRF standards, we will adapt our approach based on our learning.

3.5 Responding to cross-system incidents/issues

The ICB will help facilitate any incident that crosses more than one Trust. This encourages a more cohesive and effective method of learning from incidents that are cross systems.

3.6 Safety action development and monitoring improvement

The Trust has systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement.

The Trust will generate safety actions in relation to each of these defined areas for improvement. Following this, the Trust will have measures to monitor any safety action and set out review steps. Learning response should not describe recommendations as this can lead to premature attempts to devise a solution - safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response.

3.7 Safety Action development

Safety actions will be developed with the service area involved in that incident and be based on the recommendations of the learning response. All actions should be entered on the Trust's incident reporting action module.

All actions should be Specific, Measurable, Achievable, Relevant and Time- bound (SMART) and have Quality Improvement (QI) input. Guidance from NHSE (PSIRF) for the development of actions in provided to all learning response leads.

3.8 Safety Action Monitoring

PSII and other specific action plans will be monitored through local governance arrangements. Progress on actions will be submitted to the Patient Safety Advisory Group. Any actions which are difficult to resolve should be escalated to the Patient Safety Advisory Group.

3.9 Safety Improvement Plans

Safety Improvement Plans will be a mixture of approaches depending on the incident. The Trust may:

- Create an organisation-wide safety improvement plan summarising improvement work
- Create individual safety improvement plans that focus on a specific service, pathway or location.
- Create a safety improvement plan to tackle broad areas for improvement

Whichever approach is taken the rationale for the approach will be fully explained in the learning response process and agreed with stakeholders.

3.10 Complaints

BSMHFT recognises that there will be occasions when service users or carers are dissatisfied with aspects of the care and services provided by the Trust.

It is important to understand that there is a distinction made between complaints and concerns as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process.

The first point of contact with the Trust is the Patient Advice and Liaison Service (PALS) who will support the resolution of any concerns raised at the earliest opportunity.

Complaints are defined as expressions of dissatisfaction from a service user, their family or carer, a person acting as their representative, or any person who is affected or likely to be affected by the action, omission or decision of the Trust and requires a formal review.

The Trust is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints can be valuable aids in developing and maintaining standards of care and lessons learnt from complaints can be used positively to improve services. Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate. A copy of the complaints and concerns policy can be found here

4.0 Responsibilities

Post(s)	Responsibilities	Ref
The Chief Executive	Is the accountable officer for the Trust and has overall responsibility for ensuring that the trust has appropriate policies and robust monitoring arrangements in place	
Trust Board	The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms adhere to the roles and	

	responsibilities framework as outlined in the PSIRF documentation.	
Director of Nursing and Quality	The Executive Director for Nursing and Quality will oversee the development, review and approval of the Trust's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. To achieve the development of the plan and policy the Trust will supported by internal resources within the Patient Safety Team led by the Associate Director for IPC, Patient Safety Quality and Governance who reports to the Executive Director for Nursing and Quality	
Medical Director	Has Board delegated accountability for mortality and has responsibility to monitor, review and receive assurance on the effective implementation of national and local strategies targeted at reducing preventable mortality in accordance with patient choice, reducing adverse events, improving outcomes and quality of care for patients	
Head of Patient Safety	Under the leadership of the Deputy Director of IPC and Patient Safety has operational responsibility for the implementation of the Trust incident reporting and systems and processes and the implementation of PSIRF and ensuring that PSIRF is central to overarching governance arrangements. They are also responsible for the Trust-wide co-ordination of patient safety incident learning responses and mortality review assurance processes, including policy development, implementation and monitoring. They are a Patient Safety Specialist and provide specialist advice and support to operational teams and to the senior management team.	
Service, Clinical and Corporate Directors	Encourage the reporting of all patient safety incidents and ensure all staff in their department/division/area are competent in using the reporting systems and have time to record and share information. Also ensure that incidents are reported and managed in line with internal and external requirements and ensure that they and their staff periodically review the PSIRF and the organisation's PSIRP to check that expectations are clearly understood. The clinical leads and senior management teams will provide time for staff to attend training in patient safety disciplines to support skill development across the wider staff group. They will also facilitate time for staff to participate in patient safety reviews and investigations and ensure those affected by patient safety incidents are directed to and have access to the support they need. Clinical leads and senior managers will aid with and support	

	the development and delivery of actions in response to patient safety reviews/PSIIs that relate to their area of responsibility (including taking corrective action to achieve the desired outcomes).	
Patient Safety Managers	Incidents must be investigated and reported using the appropriate tools and techniques for the type of Patient Safety Review (PSR) required. The reviewer(s) should have completed the appropriate training for the review technique to be used. The review should be fair and thorough using the methods taught on the appropriate training courses.	
All Staff	All staff have a responsibility to highlight any risk issues which would warrant further investigation. Staff should be fully open and co-operative with any patient safety review process. All staff are required to be aware of and comply with this patient safety incident response plan. Information regarding the reporting and management of incidents is provided for new staff at corporate induction. Information for existing staff is available on the pages of the Trust intranet.	

5.0 Development and Consultation process:

Consultation summary		
Date policy issued for consultation	October 2023	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	**Date(s)**	
Where received	**Summary of feedback**	**Actions / Response**

6.0 Reference documents

- NHS England and NHS Improvement (2019), The NHS Patient Safety
- NHS England (2021), Core20PLUS5: An Approach to Reducing Health Inequalities
- NHS England (2022), Patient Safety Incident Response Framework
- NHS England (2022), Safety action development guide
- NHS England (2017), National guidance on Learning from Deaths
- NHS England (2018), Never Events policy and framework
- NHS England (2021), Never Events list 2018 (last updated February 2021

- The Equality Act (2010), Part 11, Advancement of Equality, Chapter 1 - The Public Sector Equality Duty
- NHS England, Just Culture Guide
- NHS Resolution (2023) Being fair 2 – Promoting a person-centred workplace that is compassionate, safe and fair

7.0 Bibliography:

We would like to thank the Trusts who have shared their work on NHS Future Platform for their inspiration as well as the early adopters of PSIRF

8.0 Glossary:

- PSIRF – Patient Safety Incident Response Framework
- PSII – Patient Safety Incident Investigation
- AAR – After Action Review
- QI – quality improvement

9.0 Audit and assurance:

Our Patient Safety Incident Response Plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12/18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12-18 months.

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

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Compassionate engagement and involvement of those affected by patient safety incidents	Patient safety Team	Review of engagement with Family liaison Office, feedback form for those involved in safety investigations and audit of Duty	Six monthly	CGC

		of Candour engagement		
Application of a range of system based approaches to learning from patient safety incidents	Patient Safety Team	Review of the Eclipse incident system for the number, type and trends	Quarterly	CGC
Considered and proportionate response to patient safety incidents and safety issues	Patient Safety Team	Review of the Eclipse incident system for the number, type and trends	Quarterly	CGC

18.0 Appendices:

- **Appendix 1 equality assessment**
- **Appendix 2 Harm Levels**
- **Appendix 3 Governance Process**

Appendix 1

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Policy	**Patient Safety Incident Response Framework**		
Person Completing this policy	Samantha Munbodh	**Role or title**	Head of Patient Safety
Division	Corporate	**Service Area**	Governance
Date Started	October 2023	**Date completed**	October 2023
Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.			
This policy supports the requirements of the national Patient Safety Incident Response Framework (PSIRF) and sets out BSMHFT approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety. It supports all of the strategic aims of the organisation			
Who will benefit from the policy?			
Staff, service users, carers and family members/significant other			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
In our trust, service user demographics vary: • Age 16 or less: Less than 2% • Age 25-34 and 45-54: Highest • Age 85 and plus: Approximately 4.9% • Just over 50% are women • 59.73% of our service users are white • 16.91% Asian • 7.1 % Black/Black British			

- 4.2% reported disability

  We will begin to monitor our patient safety incidents to see if people with protected characteristics are disproportionately affected.

  We will ask our board to commission a data dashboard which will produce more accurate information

Does the policy significantly affect service delivery, business processes or policy?
How will these reduce inequality?

We will review our data as part of Incident Response Plan to help determine our safety priorities

Does it involve a significant commitment of resources?
How will these reduce inequality?

To support this function we would require a dashboard which helps us understand our data, as manual collection s timely

Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)

Yes

Impacts on different Personal Protected Characteristics – *Helpful Questions:*

Does this policy promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*	*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*

Please click in the relevant impact box and include relevant data

Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age			X	We will be monitoring the safety incidents that occur by age
Including children and people over 65				

Is it easy for someone of any age to find out about your service or access your policy? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			X	We will be monitoring the safety incidents that occur by age
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender			X	We will be monitoring the safety incidents that occur by gender
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your policy?				
Marriage or Civil Partnerships			X	We will be monitoring the safety incidents as they occur
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity			X	We will be monitoring the safety incidents as they occur
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity			X	We will be monitoring the safety incidents as they occur
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief			X	
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				

Sexual Orientation			X	
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment			X	
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your policy or service?				
Human Rights			X	
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
		X		
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the policy does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**				
Action Planning:				

How could you minimise or remove any negative impact identified even if this is of low significance?
We will be sharing on findings with our emerging risk group and local safety panels who will determine the most appropriate and proportionate learning response
How will any impact or planned actions be monitored and reviewed?
It is intended that we will monitor safety incidents through our emerging risk group
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
This will be shared through our Patient Safety Advisory Group
Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

Appendix 2 – Definitions for Level Of Harm

Previously in the NHS, harm grading included psychological harm as well as physical harm within one measure. Following feedback from staff, patients and families, physical and psychological harm have been separated out and each can now be recorded in the LFPSE service.

Where practical, it is good practice to discuss the level of harm with the patient affected and to consider the patient's perspective on the harm definitions stated below.
The full definitions of the harm gradings are as follows:

Physical harm
No physical harm
No physical harm

Low physical harm
Low physical harm is when **all of the following** apply:
• minimal harm occurred – patient(s) required extra observation or minor treatment
- did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit
- did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication
- did not or is unlikely to affect that patient's independence
- did not or is unlikely to affect the success of treatment for existing health conditions.

Moderate physical harm
- Moderate harm is when **at least one** of the following apply:
- has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention
- has limited or is likely to limit the patient's independence, but for less than 6 months
- has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

Severe physical harm
- Severe harm is when **at least one** of the following apply:
- permanent harm/permanent alteration of the physiology
- needed immediate life-saving clinical intervention
- is likely to have reduced the patient's life expectancy
- needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions
- has limited or is likely to limit the patient's independence for 6 months or more.

Fatal (previously documented as 'Death' in NRLS)
You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

Psychological harm
Please note that when recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available.

No psychological harm
Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.

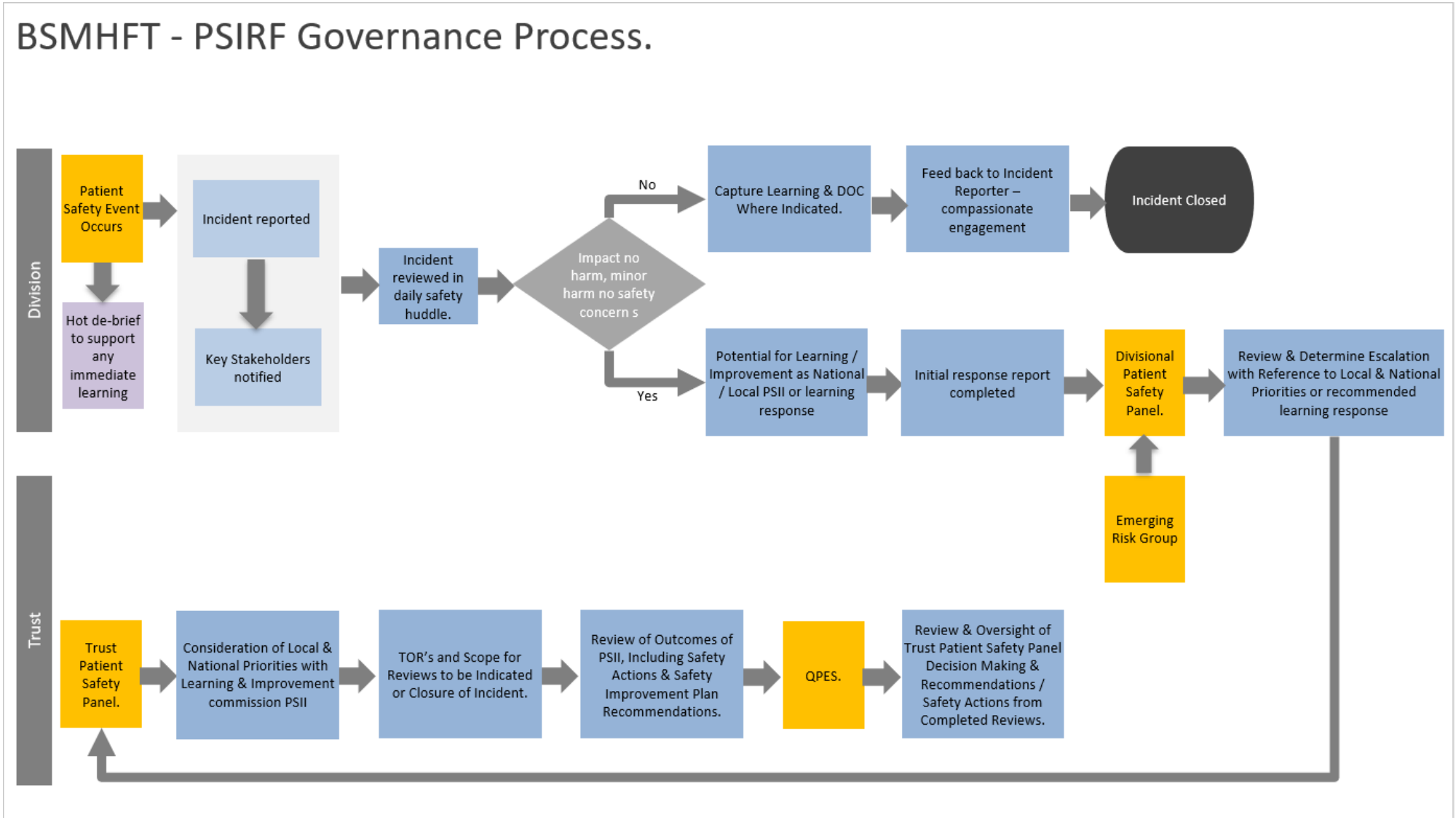
Low psychological harm
- Low psychological harm is when **at least one** of the following apply:
- distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit
- distress that did not or is unlikely to affect the patient's normal activities for more than a few days distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

Moderate psychological harm
Moderate psychological harm is when **at least one** of the following apply:
- distress that did or is likely to need a course of treatment that extends for less than six months
- distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months

Severe psychological harm
- Severe psychological harm is when **at least one** of the following apply:
- distress that did or is likely to need a course of treatment that continues for more than six months
- distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

For further information in relation to LFPSE recording of incidents and levels of harm go to: NHS England » Policy guidance on recording patient safety events and levels of harm

Appendix 3


BSMHFT - PSIRF Governance Process.
Division
Patient Safety Event Occurs
Hot de-brief to support any immediate learning
Incident reported
Key Stakeholders notified
Incident reviewed in daily safety huddle.
Impact no harm, minor harm no safety concern s
No
Capture Learning & DOC Where Indicated.
Feed back to Incident Reporter – compassionate engagement
Incident Closed
Yes
Potential for Learning / Improvement as National / Local PSII or learning response
Initial response report completed
Divisional Patient Safety Panel.
Review & Determine Escalation with Reference to Local & National Priorities or recommended learning response
Emerging Risk Group
Trust
Trust Patient Safety Panel.
Consideration of Local & National Priorities with Learning & Improvement commission PSII
TOR's and Scope for Reviews to be Indicated or Closure of Incident.
Review of Outcomes of PSII, Including Safety Actions & Safety Improvement Plan Recommendations.
QPES.
Review & Oversight of Trust Patient Safety Panel Decision Making & Recommendations / Safety Actions from Completed Reviews.