DOCUMENT TYPE: **Plan**		**UNIQUE IDENTIFIER:** Plan-27	
DOCUMENT TITLE: Patient safety incident response plan		**VERSION NUMBER:** 1.1	
		STATUS: Ratified	
SCOPE: Trust Wide		**CLASSIFICATION:** Organisational	
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REPLACES: Patient safety incident response plan V1		**HEAD OF DEPARTMENT:** Sarah Cullen, Chief Nursing Officer	
VALIDATED BY: Version 1 Board of Directors Version 1 ICB Quality Committee Version 1.1 PSIRF Oversight Panel Version 1.1 Trust Management Board		**DATE:** 05 October 2023 18 October 2023 31 October 2024 06 November 2024	
RATIFIED BY: Version 1 Procedural Documents Ratification Group Chairs Approval by Michelle Durkin Version 1.1 Procedural Documents Ratification Group		**DATE:** 03 November 2023 13 November 2024	
(NOTE: Review dates may alter if any significant changes are made).		**REVIEW DATE:** 30 November 2027	

AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
1.1	16th October 2024	Addendum throughout policy, audit and monitoring section and flowchart in section 8	Policy updated to reflect new PSIRF meetings. Safety and Learning Group replaced with PSIRF Oversight Panel and Always Safety First Learning and Improvement	16th October 2024

			Group. Removed reference to PSIRF Implementation Group	
1.1	16th October 2024	Section 9	Learning Response Timeframes reviewed and definition of PSIRF MDT expanded	16th October 2024

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**
Document for Public Display: **Yes**
Evidence reviewed by Library Services

CONTENTS

1.0 Foreword

We are delighted to present our first Patient Safety Incident Response Plan (PSIRP) for **Lancashire Teaching Hospitals NHS Foundation Trust**. This plan sets out how we intend to respond to patient safety events in line with the National Patient Safety Strategy for England and the Patient Safety Incident Response Framework (PSIRF).

The PSIRF is a new and innovative approach to how the NHS responds to patient safety events. This is not a change which involves us doing the same thing. It is a cultural and system shift which fundamentally changes our thinking and response to patient safety events and how we work to prevent a safety event happening again.
Our challenge is to move the focus away from investigating safety events to produce a report because it might meet specific criteria in a framework and instead, towards an emphasis on the outcomes of patient safety incident responses that support our learning and continuous improvement methodologies to prevent safety events happening again.

Where previously we have had set timescales and external organisations have needed to approve what we do, PSIRF gives us a set of principles that we will work to and although this could seem daunting, we welcome the opportunity to take accountability for the management of our responses to patient safety events with the aim of learning and improvement.

We know that we investigate safety events to learn but acknowledge that the focus on this may have been lost due to the previous emphasis on the production of a report, as that is how we have been measured, rather than on showing how we have made meaningful changes to keep our patients safe.

Through the implementation of PSIRF we commit to meaningfully engaging with our patients, service users, families and carers to ensure that their voice is the golden thread in all of our patient safety investigations. PSIRF sets out best principles for this involvement and our move to engaging with patient safety partners will make sure that the patient voice is heard at all stages of our patient safety processes.

Our recent work in moving towards a restorative and just culture underpins how we will approach our response to patient safety events. We are an organisation who fosters a culture in which people feel they can highlight patient safety events knowing they will be psychologically safe.

PSIRF asks that we have conversations where people have been affected by a patient safety event, no matter how difficult that is, and we will continue work on how we can equip and support those affected to best hear the voice of those involved. The process of reviewing a safety event can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure, these are part of our PSIRF core objectives.

As we move into adopting this new way of managing our patient safety learning responses, we accept that we may not get it right at the beginning, however we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to. In this we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change.

Most importantly though, PSIRF offers us the opportunity to learn and improve to promote the safe, effective and compassionate care of our patients, service users, their families and carers whilst also protecting the wellbeing of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead.

2.0 Purpose

This patient safety incident response plan sets out how **Lancashire Teaching Hospitals NHS Foundation Trust** intends to respond to patient safety events over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and safety events occurred and the needs of those affected.

This document should be read in conjunction with the Trust's Patient Safety Incident Response Policy which supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how the Trust will approach the development and maintenance of effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety. One key aim of PSIRF is to ensure considered and proportionate responses to patient safety events.

3.0 Scope

This patient safety incident response plan (PSIRP) will detail the Trust's approach to responding to patient safety events and should be followed by all staff across the organisation. This plan is not a permanent tenet that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and safety events occur and the needs of those affected.

4.0 Our services

Lancashire Teaching Hospitals NHS Foundation Trust is a large acute NHS Trust consisting of Chorley and South Ribble District General Hospital, Royal Preston Hospital, the Specialist Mobility Rehabilitation Centre, Finney House Community Care Hub and a range of community and satellite services.

We serve a core population of around 395,000 people across Chorley, Preston and South Ribble as well as providing a range of highly specialist services to 1.8 million people across Lancashire and South Cumbria.

Our organisation has a workforce of approximately 9000 substantive staff, making it one of the largest employers in the region and a successful volunteers scheme, with nearly 600 volunteers providing support in a variety of roles.

Royal Preston Hospital provides a full range of district general hospital services including emergency medicine, critical care, general medicine including elderly care, general surgery, oral and maxillo-facial surgery, ear nose and throat surgery, anaesthetics, children's services, neonatal intensive care, women's health and maternity, and several specialist regional services including cancer, neurosurgery,, renal, plastics and burns, rehabilitation, and the major trauma centre for Lancashire and South Cumbria. The urgent care centre on the site is directly commissioned by the ICB and is not provided by this Trust.

Chorley and South Ribble Hospital provides a full range of district general hospital services including emergency department for adults (8am-8pm) coronary care, general medicine including elderly care, general surgery, orthopaedics, anaesthetics, stroke rehabilitation, midwifery-led maternity care, and a breast service. The urgent care centre on the site is directly commissioned by the ICB and is not provided by this Trust.
The Trust is a regional specialist centre for cancer, child neurology, disablement services, immunology, neonatal intensive care, neurosciences, major trauma, renal, respiratory, vascular and maternal medicine.

The Surgical Elective Care Hub based at Chorley and South Ribble Hospital is where patients come for day case or short inpatient surgery stays and has received the highly accredited 'NHS Surgical Hub status', meaning that our patients can be assured of the highest standards of patient care and safety, with the Getting it Right First Approach (GIRFT).

Our specialist mobility rehabilitation centre provides specialist wheelchair, prosthetic limb and orthotic services for people across the Northwest, including war veterans and is one of just nine centres of excellence in the UK.

Lancashire Community Healthcare Hub, also known as Finney House, provides residential and nursing care services in a purpose-built home. The Trust took over the lease of the building in November 2022 to become the CQC-registered provider of services, taking on all 96 beds at the facility. The first floor (Buttercup) and second floor (Meadow) allows the Trust to discharge patients from both Chorley and Royal Preston Hospitals who no longer need the specialist care provided in an acute bed, freeing up much needed space for those who need urgent and emergency medical care. There are a further 32 beds on the top floor (Orchard) which allow the Trust to continue to provide care for Local Authority or private residents. People with dementia are also looked after at the facility.

Our community services are provided in people's homes, community centres, clinics, GP Practices, community hospitals and our main hospitals.

We are the only National Institute for Health and Care Research (NIHR) Clinical Research Facility in Lancashire and South Cumbria. The Centre for Health Research and Innovation is based within the Lancashire Clinical Research Facility at Royal Preston Hospital. However, the Research team work across both the Preston and Chorley sites as well as a number of community and satellite units. The Trust is also a leading provider of undergraduate education and a leading partner in the Lancashire and South Cumbria Provider Collaborative.

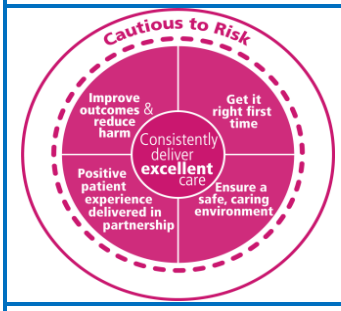
We are registered with the Care Quality Commission (CQC) without conditions to provide the following regulated activities:

- diagnostic and screening services
- maternity and midwifery services
- surgical procedures
- termination of pregnancies
- treatment of disease, disorder or injury
- management of supply of blood and blood-derived products
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- accommodation for persons who require nursing or personal care.

Our mission is to always provide excellent care with compassion and our strategic aims are:

- To provide outstanding and sustainable healthcare to our local communities
- To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria
- To drive health innovation through world class education, training, and research

These are underpinned by our four strategic ambitions which are as follows:

<table>
<tr><th>Consistently Deliver Excellent Care</th><th>Fit for the Future</th></tr>
<tr>
<td> 
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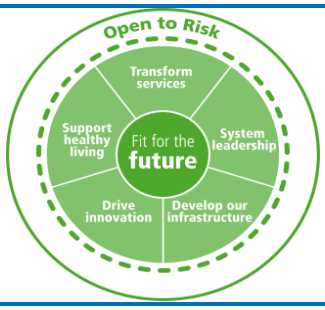
<td>Improve outcomes and reduce harm

Get it right first time

Positive patient experience delivered in partnership

Ensure a safe, caring environment</td>
<td> 
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<td>Transform services

System leadership

Develop our infrastructure

Drive innovation

Support healthy living</td>
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<tr><th>Deliver Value for Money</th><th>Great Place to Work</th></tr>
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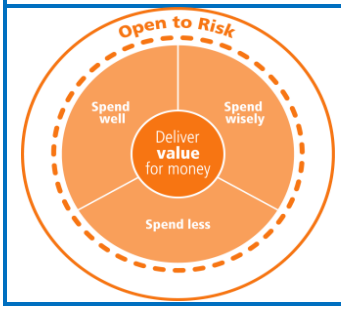
<td> 
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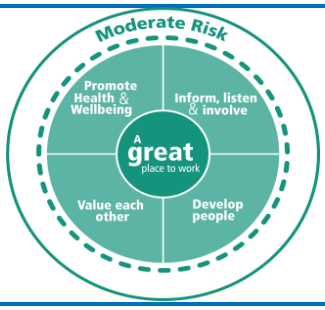
<td>Spend well

Spend wisely

Spend less</td>
<td> 
</td>
<td>Promote health and wellbeing

Inform, listen, and involve

Develop people

Value each other</td>
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</table>

We are a values-driven organisation. Our values were designed by our staff and patients and are embedded in the way we work on a day-to-day basis:

- Caring and compassionate: We treat everyone with dignity and respect, doing everything we can to show we care.
- Recognising individuality: We respect, value, and respond to every person's individual needs.
- Seeking to involve: We will always involve you in making decisions about your care and treatment and are always open and honest.
- Team working: We work together as one team, and involve patients, families, and other services, to provide the best care possible.
- Taking personal responsibility: We each take personal responsibility to give the highest standards of care and deliver a service we can always be proud.

To align specialities and services with clinical pathways and professional relationships, streamline processes and strengthen collaborative working the Trust has four clinical divisions. These are the Division of Medicine, Division of Surgery, Division of Women and Children Services and the Division of Diagnostics and Clinical Support Services and are supported by the Estates and Facilities Division and Corporate Services Division.

This highlights the variety and complexity of services provided by the Trust. It is therefore imperative for the successful implementation of the PSIRF that the plan reflects the breadth of patient safety concerns relevant to these services and that everyone is clear about how their individual role, responsibility and behaviour supports the delivery of this plan.

This will be achieved by drawing on data and intelligence to identify our PSIRF priorities (insights), by engaging with our patients, their families and carers, staff and stakeholders in our plans, equipping them with the skills and opportunities to improve patient safety throughout the whole system ('involvement') and designing and supporting programmes that deliver effective and sustainable change in the most important areas including reducing patient harms and improving our safety culture ('improvement').

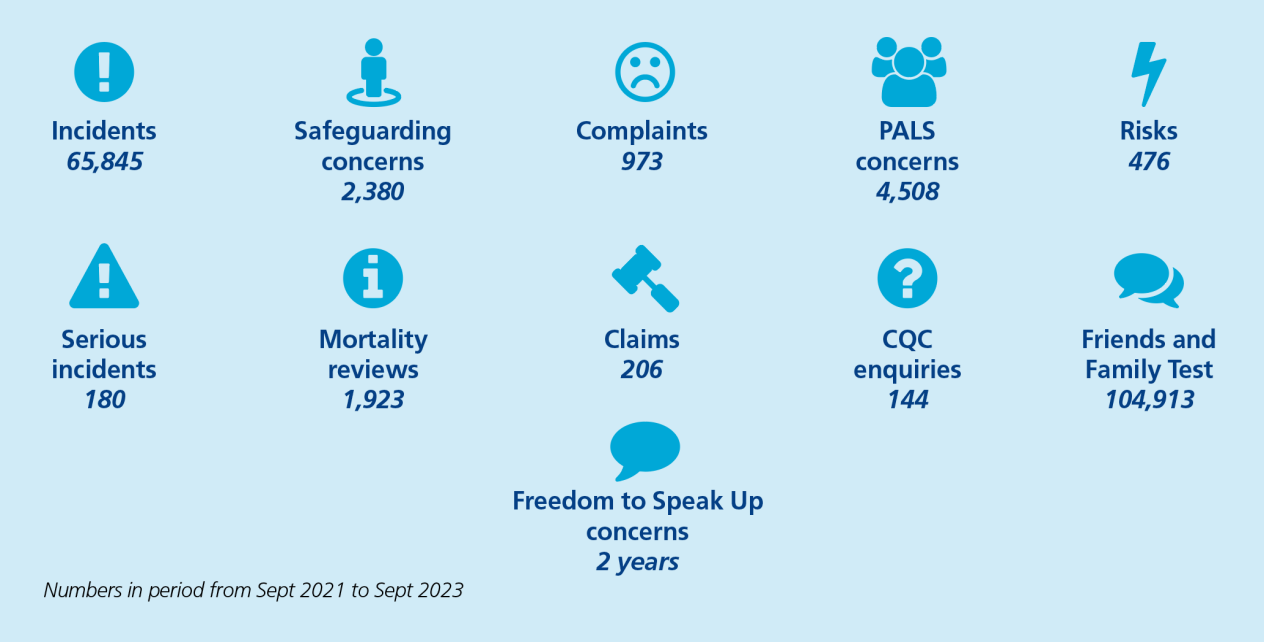
5.0 Defining our patient safety events profile

The Trust is committed to undertaking high quality learning responses following a patient safety event to ensure continuous improvement across our services and sustainable reductions in the frequency of incidents and their associated opportunity to harm our patients.

The national PSIRF sets out the opportunity for us to ascertain own local highest risk areas, and to ensure both investigation focus, and improvement resource is directed towards those areas of greatest risk and therefore need. These local priorities sit alongside national priorities that require continued focus, for example, safety events that meets the criteria of a 'never event'.

5.1 Data Sources

The Trust recognises that in order to truly understand its patient safety profile it must review data from a variety of sources. A core element of the development of our PSIRP was to undertake a retrospective analysis of a minimum of two years of data, to include previously reported safety events and data sets such as claims, complaints and information from any relevant surveys. The summary below provides an overview of the sources and numbers of data analysed between September 2021 and September 2023.



The results from the retrospective analysis output identified twenty two patient safety event themes as potential areas for further investigation.

5.2 Stakeholder Engagement

The twenty two patient safety event types were circulated to a stakeholder group with representation from a range of groups and professions including staff, patients and external partners. Groups represented included patient groups (e.g., Healthwatch), governors, equality, diversity and inclusion ambassadors, workforce teams, a range of governance professionals, nurses, medical staff, allied health professions, the Integrated Care Board (ICB) and other key stakeholders.

The table gives an overview of the groups that took part in the stakeholder engagement with a total of 43 individuals taking part.

Group Represented	Numbers of people
Lancashire and South Cumbria ICB	1
Patient Safety Team	2
Infection, Prevention and Control	1
Senior Medical and Nursing Leadership	3
Corporate Governance Professionals	7
Divisional Governance Professionals	8
Patient Experience Team	3
Pharmacy	2
Equality, Diversity and Inclusion Representative	1
Clinical Placement and Support Team	1
Continuous Improvement Team	1
Safeguarding Team	1
Critical Care Outreach Representative	1
Workforce and Organisational Development	1
Divisional Management Team	4
Patient Representative	2
Patient Forum Representative	1
Healthwatch Representative	1
Governor Representative	1
Allied Health Professions Leadership Team	1

At the engagement session, stakeholders were invited to score the identified themes, using the criteria below to determine which local priorities would invoke the greatest amount of learning to improving patient safety.

Criteria	Considerations
Likelihood of Harm	Staff were required to review the likelihood of harm based on a scale of 1 (Rare) – 5 (Almost Certain) Staff were required to consider the frequency of previous events in addition to the probability of events occurring in the future.
Impact of Harm	Staff were required to review the likelihood of harm based on a scale of 1 (Insignificant) – 5 (Catastrophic) Staff were advised to consider both the physical and psychological impact of harm if an incident was to occur.
Confidence in Existing Improvement Work	Staff were required to review the confidence in existing improvement work on a scale of 1 (Extremely Confident) – 5 (No Confidence at All) Staff were made aware of existing improvement work in relation to identified themes and were asked to consider their effectiveness.
Potential for New Learning	Staff were required to review the potential for new learning on a scale of 1 (No Potential for Learning) – 5 (Significant Potential for Learning) Staff were asked to consider what the potential for learning was within each identified theme.

**criteria adopted from University Hospitals Morecambe Bay*

The full scoring guidance is available in Appendix 1.

The scoring was undertaken by individuals via a Microsoft Forms survey and the results subsequently analysed. From the analysis, a priority order emerged based on potential for learning.

The themes were then considered in further detail using previous quantitative and qualitative analysis to identify five key themes. Although some themes had a greater potential for learning, there were several themes where opportunities for learning could be considered as part of a different theme. From this exercise, five local priorities emerged.

When identifying the final five local priorities where possible, the Trust considered:

- any elements of the data that told us about inequalities in patient safety,
- pathways, processes or systems that cross-cut our services,
- existing improvement programmes and
- any new and emergent risks relating to future service changes and changes in demand that the historical data did not reveal.

5.3 Local Priorities

Through our analysis and stakeholder engagement, the Trust has determined 5 patient safety priorities. These priorities will be the focus of the Trust's Patient Safety activity over the next 12-18 months but will be reviewed sooner if appropriate.

These patient safety priorities form the foundation for how the Trust will decide to conduct Patient Safety Incident Investigations (PSII) and other appropriate patient safety reviews.

The Patient Safety Priorities and rationale for selecting them are detailed as follows:

No.	Local Priorities	Rationale
1	Delayed recognition of a deteriorating patient, due to gaps in monitoring (including all pregnant women)	- 'Earlier recognition of deterioration' identified as high potential for learning in stakeholder engagement. - Potential to identify learning related to: • Communication between staff/teams

No.	Local Priorities	Rationale
		• Delays in treatment • Failure/incomplete/insufficient monitoring of patient • Nutrition and hydration fluid balance • Maternity incidents • Communication – incorrect or insufficient monitoring which were all identified as other top areas with potential for learning. - Relates to pathways, processes or systems that crosscut our services.
2	Delayed, missed or incorrect cancer diagnosis	- 'Delay in diagnosis' identified as high potential for learning in stakeholder engagement. - Potential to identify learning related to: • Communication between staff/teams • Delays in treatment • Communication – incorrect or insufficient monitoring which were all identified as other top areas with potential for learning. - **Focus on cancer diagnosis based on quantitative and qualitative feedback and insight of data.** - Relates to pathways, processes or systems that crosscut our services.
3	Prescribing or administration error or near miss of anticoagulation medication	- 'Medication errors-administration and prescribing' identified as high potential for learning in stakeholder engagement. - Potential to identify learning related to: • Communication between staff/teams • Delays in treatment • Communication – incorrect or insufficient monitoring which were all identified as other top areas with potential for learning. - **Focus on anticoagulation based on quantitative and qualitative feedback and insight of data.**

No.	Local Priorities	Rationale
		- Relates to pathways, processes or systems that crosscut our services.
4	Adverse Discharge due to gaps in communication or misinformation	- 'Discharge' 'Communication between staff/teams incomplete' and 'Communication-incorrect or insufficient information' identified as high potential area learning in stakeholder engagement. - Relates to pathways, processes or systems that crosscut our services.
5	Delay in responding to a critical pathology finding	- 'Diagnostic incidents, including missed diagnosis' identified as high potential for learning in stakeholder engagement. - Potential to identify learning related to: • Communication between staff/teams • Communication – incorrect or insufficient monitoring which were all identified as other top areas with potential for learning. - **Focus on pathology findings based on quantitative and qualitative feedback and insight of data. There is also an existing continuous improvement programme of work related to radiology findings and hence the decision to focus on pathology findings.** - Relates to pathways, processes or systems that crosscut our services.

6.0 Our patient safety incident response plan: national requirements

In addition to the five local patient safety priorities, the Trust must comply with the following national patient safety event response requirements.

No.	National Priorities	Action Required	Lead Body for response
1.	Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally Led PSII.	The Trust
2.	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally Led PSII.	The Trust
3	Incidents meeting the Never Events criteria 2018, or its replacement.	Locally Led PSII.	The Trust
4	Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. Locally-led PSII may be required.	As decided by the RIIT

5	Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place HSSIB will investigate the following maternity safety incidents; • Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life. • Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days). • Potentially severe brain injury diagnosed in the first seven days of life and the baby was diagnosed with grade III hypoxic–ischaemic encephalopathy; or was therapeutically cooled (active cooling only); or – had decreased central tone, was comatose and had seizures of any kind. • • Maternal deaths: death while pregnant or within 42 days of the end	Refer to HSSIB or SpHA for independent PSII. Where such an investigation is undertaken, a separate local patient safety learning response is not required. However, organisations should complete Duty of Candour requirements (ahead of handover to HSSIB for further involvement of patients/families in the investigation) as set out below, and report on the relevant incident reporting system(s) as described below. Organisations must also take any immediate actions identified as necessary to avoid and/or mitigate further serious and imminent danger to patients, staff and the public. In relevant cases, the organisation should also use the Perinatal Mortality Review Tool (in parallel with and with the assistance of HSSIB as it works through its independent investigation).	HSSIB (or SpHA)

	of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).		
6	Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel.	Child Death Overview Panel
7	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this.	LeDeR programme
8	Safeguarding incidents in which: • Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. • Adults (over 18 years old) are in receipt of care and support needs from their local authority. • The incident relates to FGM, Prevent	Refer to local authority safeguarding lead. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	Refer to the local designated professionals for child and adult safeguarding

	(radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence		
9	Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programme.	The organisation in which the event occurred
10	Deaths in custody (e.g., police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare organisations must fully support these investigations where required to do so.	PPO or IOPC
11	Domestic homicide	A domestic homicide is identified by the police usually in partnership. with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the	CSP

		statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs.	

7.0 Our patient safety incident response plan: local focus

The Trust will be flexible with its investigative approach, informed by the national and local priorities detailed within this plan. An established 'Daily Triage' group will triangulate events captured through a variety of routes (i.e., incidents, complaints etc.) and agree the most appropriate response based on the potential for learning, improvement and systemic risk.

National Guidance recommends that 3 – 6 investigations per priority are conducted.

The table below details the number of Patient Safety Incident Investigations (PSII) which will be undertaken for the Trust's identified priorities:

No	Priority	Planned response	Number of PSIIs
1	Delayed recognition of a deteriorating patient, due to gaps in monitoring (including all pregnant women)	Patient Safety Incident Investigation (PSII)	5
2	Delayed, missed or incorrect cancer diagnosis	Patient Safety Incident Investigation (PSII)	5
3	Prescribing or administration error or near miss of anticoagulation medication	Patient Safety Incident Investigation (PSII)	5
4	Adverse Discharge due to gaps in communication or misinformation	Patient Safety Incident Investigation (PSII)	5

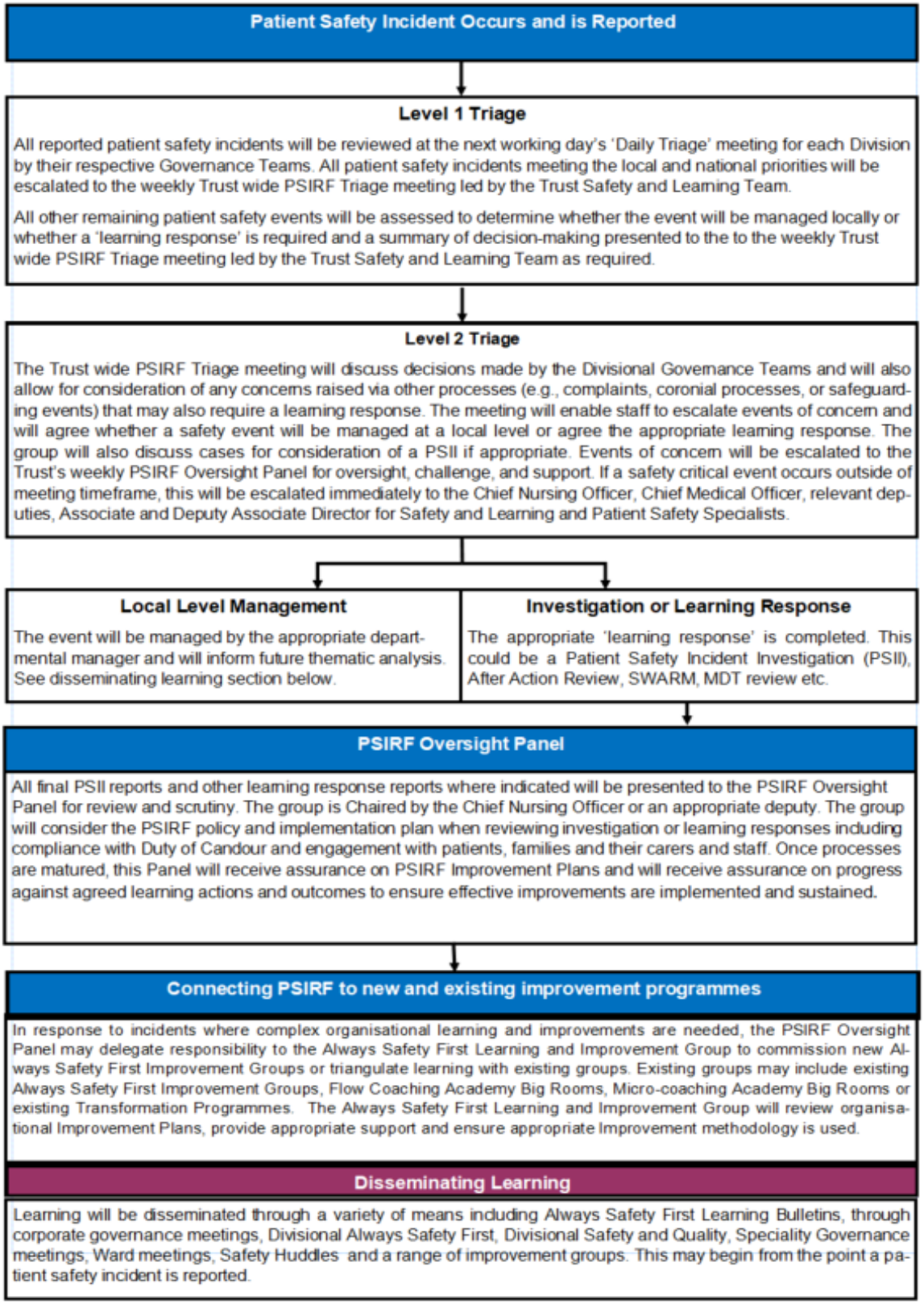
5	Delay in responding to a critical pathology finding	Patient Safety Incident Investigation (PSII)	5

Safety events which previously met the Serious Incident Framework's definition of a 'serious incident' do not need to be routinely investigated using the PSII process.

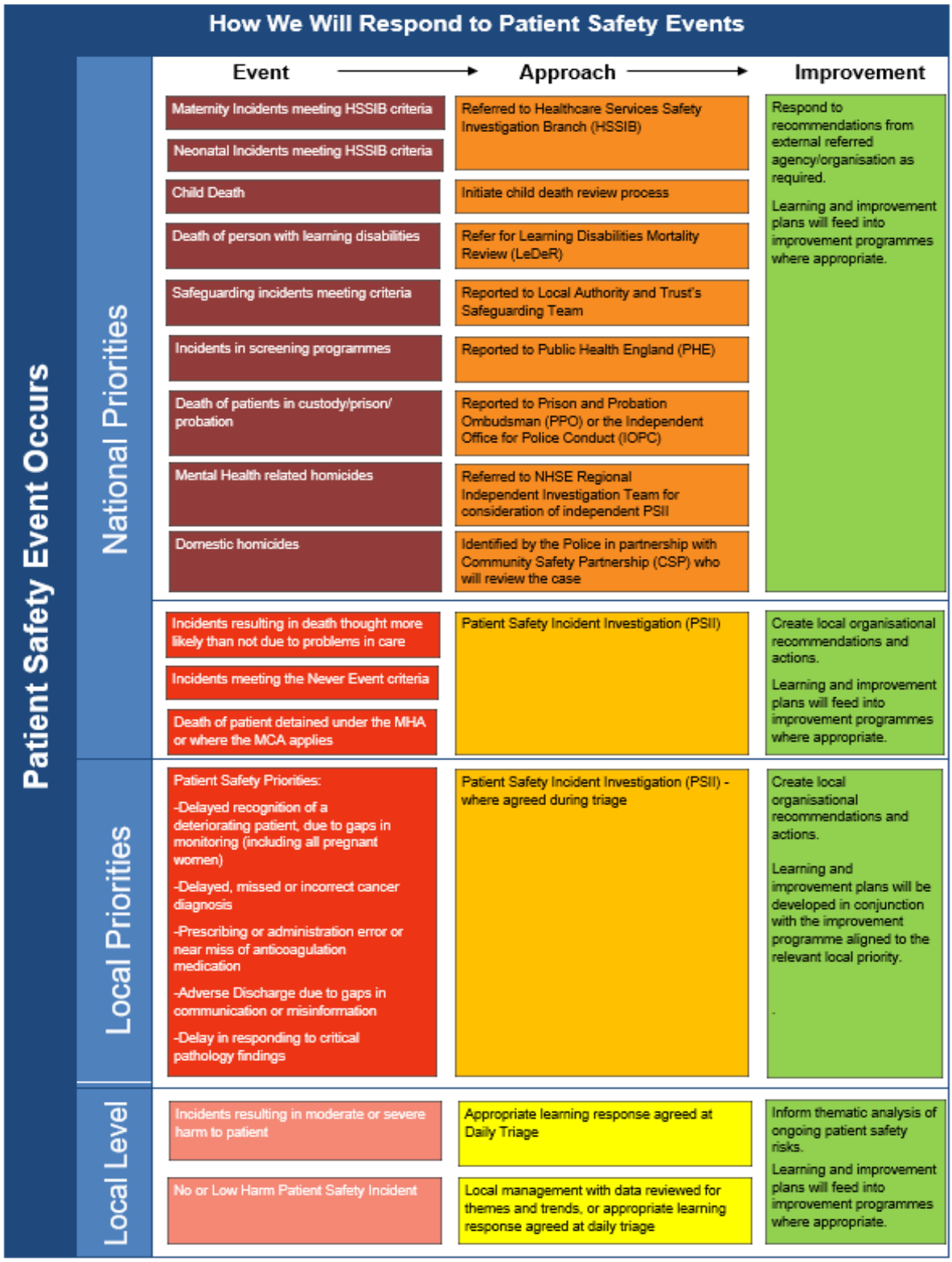
By undertaking PSII investigations for events that do not meet the criteria of the identified patient safety priorities, the Trust runs the risk of recreating the Serious Incident Framework.

8.0 How we will respond to patient safety events

The infographic below describes the governance arrangements in relation to how the Trust will respond to a patient safety event.



The infographic below describes how patient safety events assessed under the national priorities, local priorities and local level criteria will be managed and how improvement plans will be developed.



9.0 Learning Responses

Some patient safety events will not require a PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff. A clear distinction is made between the activity, aims and outputs from reviews and those from PSIIs.

The timeframes set are intended to be used as a guide and should be flexible if there are circumstances that require more in depth understanding.

9.1 Types of learning responses

The table below gives an overview of the different types of learning responses.

Type of learning response	Description	Timeframe
Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. These will be undertaken using Systems Engineering Initiative for Patient Safety (SEIPS) methodology.	To be agreed in discussion with those affected, particularly the patient(s) and/or their carer(s), where they wish to be involved in such discussions. Depending on discussions with stakeholders, to be

Type of learning response	Description	Timeframe
		completed within 3 months and/or no longer than 6 months.
Multidisciplinary (MDT) Team Review	An MDT review supports health and social care teams to identify learning from multiple patient safety incidents (including incidents were multiple patients were harmed or where there are similar types of incidents). This could include incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.	Ordinarily within 20 working days of being commissioned.
SWARM	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future	Ordinarily within 10 working days of the event being identified to allow for SWARM and documentation

Type of learning response	Description	Timeframe
		to be completed.
After action review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. **It is based around four questions:** 1. What was the expected outcome/expected to happen? 2. What was the actual outcome/what actually happened? 3. What was the difference between the expected outcome and the event? 4. What is the learning?	Ordinarily within 20 working days of the event being reported.
Thematic Review	A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative (I.e., Incident reports, Complaints data etc.) rather than quantitative data to identify safety themes and issues. Thematic Reviews can be used for multiple purposes, including: • Developing or revising our Safety Improvement Profile	As agreed by the PSIRF Oversight Panel or Divisional Management Team or relevant other

Type of learning response	Description	Timeframe
	• Aggregating information from many diverse sources of safety intelligence datasets. • Gathering insight about gaps / safety issues across a pathway or as part of an overarching safety theme to direct further analysis • Aggregating findings from multiple incident responses to identify interlinked contributory factors to inform / direct improvement efforts. • Presenting summary data to show the impact of ongoing safety improvement work.	

9.2 Anticipated time commitment for completion of learning responses

The table describes the estimated time commitment for each category response type. This has been calculated using guidance from peer organisations.

Response type	Category	Time Commitment
PSII	Local Priorities defined PSIIs	**Minimum 60 hours per investigation for:** • 1 lead investigator • 1 support investigator **Up to 30 hours per investigation for:** • subject matter expertise • family liaison ***Plus*** **Up to 30 hours per investigation for:** • investigation oversight and support • administration support • interview and statement time of staff involved in the incident

		Time commitments may vary per PSII and therefore subject to further review.
PSII	National Priorities	**Minimum 60 hours per investigation for:** • 1 lead investigator • 1 support investigator **Up to 30 hours per investigation for:** • subject matter expertise • family liaison ***Plus*** **Up to 30 hours per investigation for:** • investigation oversight and support • administration support • interview and statement time of staff involved in the incident. Time commitments may vary per PSII and therefore subject to further review.
Various	Local Level	**Maximum eighteen hours per response review**

9.3 Anticipated number of learning responses

Based on a comparison of data between September 2021 and August 2023, the trust has also calculated the anticipated number of learning responses.

Response type	Category	Anticipated Number of Responses
PSII	Local Priorities defined PSIIs	25 (Based on this plan)
PSII	National	Deaths thought more likely than not due to problems in care

	Priorities	(incidents meeting the learning from deaths criteria for PSII) Approximately 22 per year based on an average of incidents graded as 'Death' and reported to Strategic Executive Information System (StEIS) over the past 2 years.
PSII	National Priorities	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria) The Trust does not currently categorise incidents in this group and therefore difficult to estimate this number.
PSII	National Priorities	Incidents meeting the Never Events criteria 2018, or its replacement. 2-4 per year based on range of Never Events over the past 2 years,
Various	Local Level	<u>Incidents Resulting in Moderate or Severe Harm to Patient.</u> ***Average Investigations Undertaken:*** The below provides an average number of investigations initiated in a financial year based on severe and moderate harm level (calculated based on the previous 2 years). 135 (72 Hour Review) 82 (RCAs) = equivalent to 217 learning responses ***Local RCAs:*** The below provides an average number of Local RCAs initiated in a financial year (based on data from the previous

		2 years). 48 (Inpatient Falls) 1 (Delay for Cancer Treatment) 148 (Clostridium Difficile) 1 (MRSA PIR) 166 (Acute Tissue Viability Cat 2 and above) 5 (VTE) 5 (Section 42 Safeguarding) 3 (Maternity Incidents – 3rd/4th degree tears and PPH >1500mls) = equivalent to 377 learning responses. Learning responses for these categories may include: • Thematic Review • PIR • MDT round table discussion • SWARM • After Action Review <u>Incidents Resulting in low or no harm</u> ***Average Investigations Undertaken:*** The below provides an average number of investigations initiated in a financial year based on low or no harm level (calculated based on the previous 2 years). 23 (Section 42 Safeguarding) 1008 (Violence and Aggression incidents) 218 (Absconding/Missing patients) 609 (Patient safety events linked to communication between staff/teams)

		24 (Maternity Incidents – 3rd/4th degree tears and PPH >1500mls) = equivalent to 1882 learning responses* *However, in line with PSIRF it is likely that for 'violence and aggression' and 'patient safety events linked to communication between staff/teams', the Trust will undertake a series of thematic reviews where appropriate. Due to the broad categorisation of this incidents, the Trust will also consider as part of the triage process whether categorisation of the incidents reported are appropriate. Learning responses for these categories may include: • Thematic Review • PIR • MDT round table discussion • SWARM • After Action Review The numbers of anticipated thematic reviews under PSIRF are difficult to estimate at this current time.

The table above does not capture learning responses for those patient safety events that may need to be reported externally that do not fit into the current PSIRF national and local priorities criteria. The table is also based on data at the time of producing this incident response plan and likely to be subject to some variation. Therefore, it is anticipated that the number of learning responses managed at local level may be higher than the numbers currently estimated above**.**

9.4 Capacity assessment

To ensure learning responses are conducted in line with the PSIRF professional standards and to understand the organisation's capacity to respond to patient safety events, a skill mix review has been undertaken. This has been supported by an analysis of the numbers and training of staff with a specific role in patient safety incident responses, as well as how other staff will be expected to support such responses.

10.0 Our patient safety improvement approach

The Trust is committed to ensuring PSIRF implementation is intrinsically linked to the Trust's programmes of improvement so that learning outcomes utilise evidence-based improvement methodology to create sustainable change in the delivery of safe care for our patients and to build on the existing culture of continuous improvement within the organisation.

In line with the Trust's Continuous Improvement Strategy, improvement programmes at Lancashire Teaching Hospitals NHS Foundation Trust are organised at macro (system and organisation), meso (pathway) and micro (individual ward and department) levels.

Where opportunities for learning are identified from PSIIs or other learning responses, these will be connected to improvement programmes of work if appropriate. This will not only be undertaken reactively when things have not gone well but also proactively whilst considering the principles of Safety II by learning from things that have gone well and exploring how more of this can be achieved. Where existing improvement programmes of work do not exist, the PSIRF Oversight Panel will determine whether a new improvement programme is required. The PSIRF Oversight Panel may delegate this responsibility to the Always Safety First Learning and Improvement Group.

Once learning has been identified from Patient Safety Incident Investigations, each local priority will have an associated improvement programme. These programmes will be co-designed with frontline teams who are delivering the services with a patient and staff focused outcome at their core and will have an aim, driver diagram, project outline, recognised continuous methodology, baseline measures and measurement and evaluation plans. The programmes will also be tailored to fit the circumstances of the programme utilising a variety of approaches such as: Break Through Series Collaborative to individual support, guidance and coaching maximising the use of technology where appropriate to help achieve the greatest benefit.

At the point that an improvement need has been identified, improvement plans will be co-produced with members from the associated improvement group, including patients,

carers and families and staff with support from the continuous improvement teams if required to identify outcome measures and actions to then be shared.

Once processes are matured, the PSIRF Oversight Panel will receive assurance on PSIRF Improvement Plans relating to the Trust's Patient Safety Priorities and will receive assurance on against agreed learning actions and outcomes to ensure effective improvements are implemented and sustained.

11.0 Transition to PSIRF

The implementation of PSIRF will commence on 06 November 2023 in a phased approach following Board and ICB approval. There will be a period of transition from the previous Serious Incident Framework and the new PSIRF with a plan for full implementation of PSIRF expected by the 31 March 2024.

To ensure successful implementation of the PSIRF policy and plan, the Trust has engaged and will continue to engage with a number of stakeholders including patients, families, carers and staff, other acute Trusts within the ICS to capture learning, the Care Quality Commission (CQC), our regulators, the ICB who are responsible for approving this plan and ensuring collaborative work across the local ICS and a range of advocacy groups such as Healthwatch.

It is recognised the implementation of PSIRF will require continued review, reflection and learning across the NHS. This document is intended to be evolving in nature and sets out the pertinent parts of the implementation process. -

12.0 AUDIT AND MONITORING

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings /	Group / committee / individual responsible for ensuring

				monitoring report and act on findings.	**that the actions are completed**
Entire Document	Report	Associate Director of Safety and Learning or appropriate deputy	Quarterly Report	Safety and Quality Committee	PSIRF Oversight Panel
Entire Document	Report	Associate Director of Safety and Learning or appropriate deputy	Annual	Trust Board	Safety and Quality Committee/ PSIRF Oversight Panel
Learning Responses	Report	Associate Director of Safety and Learning or appropriate deputy	Weekly	PSIRF Oversight Panel	PSIRF Oversight Panel

13.0. TRAINING

TRAINING Is training required to be given due to the introduction of this policy? Yes
The Trust has committed to ensuring that we fully embed the PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen. A summary of the training requirements can be found in the PSIRF Policy.

14.0. DOCUMENT INFORMATION

ATTACHMENTS	
Appendix Number	Title
Appendix 1	Assessment criteria for identifying local priorities.
Appendix 2	Equality, Diversity & Inclusion Impact Assessment Form

OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library
RMP-C-278	Patient Safety Incident Response Policy
RMP HS 114	Adverse Incident Reporting, Management and Investigation Policy and Procedure
TP-149	Duty of Candour
SOP-394	Complaints Policy and Procedure
HRP-02	Raising concerns at work policy and procedure – freedom to speak up
TP-96	Work Related Incidents and Staff Debrief and Support Policy.
See Adverse Incident Reporting, Management and Investigation Policy for links to other Associated Documents	

SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full** Checked by Library ET 03/11/2023	
Number	References
1	Patient Safety Incident Response Framework (NHS England, 2022)
2	Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident (HSSIB, Learn Together and NHS England, 2022)
3	Regulation 20: Duty of Candour (CQC, 2022)
4	A Just Culture Guide (NHS England)

DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	Definition
AAR	**After Action Review** A learning response tool consisting of a structured facilitated discussion of an event/incident
CQC	**Care Quality Commission** Independent regulator for health and social care in England
CSP	**Community Safety Partnership** Statutory partnerships of organisations who work together in an area to reduce crime and the fear of crime, anti-social behaviour, alcohol, and drug misuse and reducing re-offending
Core20PLUS5	**Core20PLUS5** A national NHS England approach to inform action and reduce healthcare inequalities at both national and system levels, focused initially on the experience of adults, but has now been adapted to apply to children and young people
DHR	**Domestic Homicide Review** A review into the circumstances around a death of a person following domestic abuse
HealthWatch	**HealthWatch** A health and social care champion service who obtain the views of people about their needs and experience of local health and social care services
HSSIB	**Healthcare Services Safety Investigation Body** The independent national investigator for patient safety in England
ICB	**Integrated Care Board** A statutory organisation who are responsible for developing a plan for meeting the health needs of the local population, managing the NHS budget, and arranging for the provision of NHS services in a geographical area
ICS	**Integrated Care System**

	Partnerships of organisations which come together to deliver joined up health care services and improve the lives of people who live in the area
IOPC	**Independent Office for Police Conduct** A non-departmental public body in England and Wales who are responsible for overseeing the system for handling complaints made against police forces in England and Wales
LeDeR	**Learning Disability and Mortality Review** A service improvement programme for people with a learning disability and autistic people who look at key episodes of health and social care the person received that may have been relevant to their overall health outcomes
LFPSE	**Learning from Patient Safety Events** The new national NHS service for the recording and analysis of patient safety events
LTHTR	**Lancashire Teaching Hospitals NHS Foundation Trust**
Magnet4Europe	**Magnet4Europe** A four-year Horizon project that aims to improve mental health and wellbeing among health professionals in Europe
MDT	**Multi-Disciplinary Team** A group of staff from different areas in healthcare
NRLS	**National Reporting and Learning System** The current national central database for recording and analysing patient safety incident reports
PALS	**Patient Experience and Liaison Service** The Trust's team which provides support for patients, families, and carers
PPO	**Prison and Probation Ombudsman** A public body that carries out independent investigations into complaints and deaths in custody
PSIRF	**Patient Safety Incident Response Framework** A new and innovative approach to the way the NHS responds to patient safety incidents/events.
PSIRP	**Patient Safety Incident Response Plan** The plan which sets out how NHS organisations intend to respond to patient safety incidents/events under PSIRF
PSP	**Patient Safety Partners** The role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisations' governance and management processes for patient safety
PSII	**Patient Safety Incident Investigation**

	A learning response tool which is undertaken when an incident or near miss indicates significant patient safety risks and the potential for new learning
Safety I	**Safety I** Identifying causes and contributing factors in patient safety events as the focus point in an attempt to stop them occurring
Safety II	**Safety II** Considering variations in everyday performance to understand how things usually go right
SEIPS	**Systems Engineering Initiative for Patient Safety** A methodology for understanding outcomes within complex socio-technical systems
SIF	**Serious Incident Framework** The current process by which the NHS ensures serious incidents are identified, investigated, and learned from to prevent the likelihood of similar incidents happening again. This framework will be replaced by PSIRF
SOP	**Standard Operating Procedure** A guide/step by step instructions compiled by an organisation to help staff to carry out routine tasks/processes
SpHA	**Special Healthcare Authority** An authority who provides a health service to the whole of England, not solely to a local community
STP	**Sustainability and Transformation Partnership** Where local NHS organisations and Local Authorities draw up shared proposals to improve health and care in the areas they serve

CONSULTATION WITH STAFF AND PATIENTS

Enter the names and job titles of staff and stakeholders that have contributed to the document

Name	Job Title	Date Consulted
NMAHP group	Senior Nurses, Ward Managers, AHP leads	20/9/23
Visually Impaired Forum	Patients	22/9/23
Clinical Reference Group	Senior Clinicians	25/9/23
Patient Experience and Involvement Group	Staff, Patients and Advocacy Services	26/9/23
Carers forum	Patients	27/9/23
Cancer Forum	Patients	3/10/23
Dementia Strategy Meeting	Staff and Patients	5/10/23
EDI forum	Staff	9/10/23

Safety and Quality Committee	Executives, Non Executives, Senior Leaders	29/9/23
Board of Directors Public Meeting	Directors and Public	5/10/23
Sarah Cullen	Chief Nursing, Midwifery & AHP Officer	15/09/2023
Emma Ashton	Divisional Midwifery Director	15/09/2023
Joanne Connolly	Divisional Nursing Director	15/09/2023
Lisa Elliott	Divisional Nursing Director	15/09/2023
Catherine Gregory	Deputy Chief Nursing Officer	15/09/2023
Rachel Sansbury	Divisional Nursing Director	15/09/2023
Kate Smith-Probert	Deputy Divisional Nursing Director	15/09/2023
Jacqueline Murray	Deputy Divisional Nursing Director	15/09/2023
Cathy Owen	Divisional Clinical Governance Lead	15/09/2023
Rachel Moxham	Divisional Clinical Governance Lead	15/09/2023
Clare Shaw	Compliance & Governance Officer	15/09/2023
Emma Holden	Safety and quality matron for maternity	15/09/2023
Karin Colbeck	Divisional Clinical Governance Lead	15/09/2023
Sarah Howarth	Divisional Clinical Governance Lead	15/09/2023
Joanne Lambert	Deputy Divisional Nursing & Midwifery Director	15/09/2023
Simon Regan	Associate Director of Risk & Assurance	15/09/2023
John Howles	Associate Director of Patient Experience & Engagement	15/09/2023
Anne Kirkham	Head of Community Services	15/09/2023
Katy Clay	Governance & Risk Manager	15/09/2023
Michelle Durkin	Deputy Associate Director of Safety & Learning	15/09/2023
Michael Stewart	Deputy Medical Officer	15/09/2023
Claire Granato	Chief AHP	15/09/2023
Lauren O'Brien	Deputy Director of Education	15/09/2023
Christopher Taylor	Head of Training Performance & Compliance	15/09/2023
Arnab Bhowmick	Deputy Medical Officer	15/09/2023
Lousie Gracie	Deputy Divisional Nursing Director	15/09/2023
Gareth Price	Chief Pharmacist	15/09/2023
Caroline Marshall	Associate Director of Patient Safety, ICB	19/09/2023
Kimberley Ciraolo	Patient Safety Manager, ICB	19/09/2023
Louisa Graham	Deputy Director of Workforce & OD	18/09/2023
Kate Holt	Organisational Development & Culture Lead	18/09/2023

Amanda Davis	Head of Diversity & OD	18/09/2023
Jennifer Carroll	Continuous Improvement Clinical Fellow	18/09/2023
Kurt Bramfitt	Senior Associate Director of Continuous Improvement	18/09/2023
Elizabeth Midwinter	Continuous Improvement Clinical Fellow	18/09/2023
Stuart Clough	Senior Associate Director of Continuous Improvement	18/09/2023
PSIRF Oversight Panel	Members of PSIRF Oversight Panel	24/10/2024

DISTRIBUTION PLAN	
Dissemination lead:	Hajara Ugradar/John Howles/Michelle Durkin
Previous document already being used?	No
If yes, in what format and where?	NA
Proposed action to retrieve out-of-date copies of the document:	NA
To be disseminated to:	Trust wide
Document Library	Yes
Proposed actions to communicate the document contents to staff:	• Include in the LTHTR weekly Procedural documents communication. • Document uploaded to the Document Library. • Circulate via relevant stakeholder groups.

Appendix 1 – Assessment criteria for identifying local priorities.

Likelihood of Harm

1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
This will probably never happen/recur Not expected to occur for years Probability = <0.1% (<1 in 1000)	Do not expect it to happen/recur but it is possible it may do so. Expected to occur at least annually. Probability = 0.1 – 1% (1 in 1000 to 1 in 100)	Might happen or recur occasionally Expected to occur at least monthly Probability = 1 – 10% (1 in 100 to 1 in 10)	Will probably happen / recur but it is not a persisting issue Expected to occur at least weekly Probability = 10 – 50% (1 in 10 – 1 in 2)	Will undoubtedly happen/recur, possibly frequently Expected to occur at least daily Probability = >50% (more than 1 in 2)

Impact of Harm

1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention Increase in length of hospital stay by 1-3 days.	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days	Major incident leading to long-term incapacity/disability Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Confidence in Existing Improvement Work

1 Extremely Confident	2 Very Confident	3 Some Confidence	4 Low Level of Confidence	5 No Confidence at All
You are aware of existing improvement work. The improvement work had eradicated patient safety events.	You are aware of existing improvement work. The improvement work has almost eradicated patient safety events/or significantly reduces these. However, I these do occasionally occur.	You are aware of some existing improvement work. The improvement work has made an impact and significant events have reduced but do continue to happen but are significantly less frequent.	You are aware of some existing improvement work. The improvement work has resulted in some reduction in patient safety events but significant events continue to happen.	You are not aware of any existing improvement work. You are aware of existing improvement work but patient safety events continue to happen at a similar rate/severity.

Potential for New Learning

1 No Potential for Learning	2 Slight Potential for Learning	3 Some Potential for Learning	4 Low Level of Confidence	5 Significant Potential or Learning
The theme is well known throughout the Trust and the Trust has exhausted all improvement / learning opportunities.	The theme is well known throughout the Trust and the Trust has existing improvement measures in place which are addressing the learning from this theme.	The theme is known and there may have historically been improvement work that made an impact. However, this was not sustained.	The theme is known but there is no existing improvement work or no evidence that existing improvement work is having an impact.	The theme is unknown and there is no pre-existing improvement work within the Trust.

Appendix 2 - Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Corporate			
Lead Assessor	Hajara Ugradar			
What is being assessed?	Impact of document on equality.			
Date of assessment	18/10/2023 (reviewed 16/10/2024 and still appropriate)			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☒
	Service Users	☒	Staff Inclusion Network/s	☒
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☒
	Please give details:			

1) What is the impact on the following equality groups?			
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups		**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments:** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?	
Race (All ethnic groups)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.	
Disability (Including physical and mental impairments)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.	
Sex	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing	

		safety improvement actions and this will inform our system learning and improvement priorities.
Gender reassignment	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Religion or Belief (includes non-belief)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Sexual orientation	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Age	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Marriage and Civil Partnership	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Pregnancy and maternity	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.
Other (e.g. caring, human rights, social)	Positive	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions and this will inform our system learning and improvement priorities.

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	In our response to PSIRF, we will consider any features of an incident which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to a particular population group, including all protected characteristics. We will also consider this when constructing safety improvement actions

	and this will inform our system learning and improvement priorities.

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.** ➢ This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups ➢ This should be reviewed annually.

ACTION PLAN SUMMARY		
Action	**Lead**	**Timescale**
NA	NA	NA

HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	√	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	√
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	√	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	√
3. The NHS aspires to the highest standards of excellence and professionalism.	√	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	√
4. The patient will be at the heart of everything the NHS does.	√	4. Provide support and opportunities for staff to maintain their health, wellbeing and safety.	√
5. The NHS works across organisational boundaries.	√	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.	√
6. The NHS is committed to providing best value for taxpayers' money.	☐	6. To have a process for staff to raise an internal grievance.	√
7. The NHS is accountable to the public, communities and patients that it serves.	√	7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	√

WHICH AIMS OF THE TRUST APPLY? Click here for Aims	Tick those which apply	WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions	Tick those which apply
1. To offer excellent health care and treatment to our local communities.	√	1. Consistently deliver excellent care.	√
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria.	√	2. Great place to work.	√
3. To drive innovation through world-class education, teaching and research.	☐	3. Deliver value for money.	☐
		4. Fit for the future.	√