			Event	Approach	Improvement
Patient Safety Event Occurs	Patient Safety Incident Investigations	National Priorities	Incidents meeting Each Baby Counts criteria	Referred to Maternity and Newborn Safety Investigations (MNSI)	Respond to recommendations from external referral agency / organisation as required
			Incidents meeting maternal death criteria		
			Child Death	Initiate child death review process	
			Death of person with learning disabilities	Reported and reviewed by Learning Disabilities Mortality Review (LeDeR) programme	
			Incidents meeting Safeguarding criteria	Reported to ELHT named safeguarding Lead for review	
			Incidents in screening programmes	Reported to NHS England (NHSE)	
			Death of patients in custody, in prison or on probation	Reported to Prison and Probation Ombudsman (PPO)	
			Incidents meeting the Never Event criteria	Patient Safety Incident Investigation Team	Create local organisational recommendations and safety improvement plans (to inform Quality Improvements)
			Incidents resulting in death	Patient Safety Incident Investigation Team	
		Local Priorities	Trust determined local patient safety priorities	Patient Safety Incident Investigation Team	Create local organisational recommendations and safety improvement plans feeding into Quality Improvements Strategy
	Patient Safety Reviews or Handler review	Divisional Level	Incident resulting in moderate or severe harm to patient	Statutory duty of candour and appropriate PSR tool	Inform thematic analysis of ongoing patient safety risks at teams, speciality, directorate, divisional and trust level
			No / Low Harm patient safety incidents	Validation of facts at local level recorded on DATIX	