East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST-WIDE DOCUMENT

	Strategy / Plan
DOCUMENT TITLE	**Patient Safety Incident Response Plan**
DOCUMENT NUMBER	**ELHT/C175 Version 3.1**
DOCUMENT REPLACES	**ELHT/C175 Version 3.0**
LEAD EXECUTIVE DIRECTOR DGM	**Executive Medical Director**
AUTHOR	**Assistant Director Patient Safety and Effectiveness**

TARGET AUDIENCE	**All Trust Personnel**
DOCUMENT PURPOSE	To promote successful investigations and learning from incidents, from structured analysis of causal factors and underlying systems issues of events and near misses
To be read in conjunction with	• **C003 Incident/Accident Reporting Policy** • **C012 Incident Investigation Policy** • **C075 Openness and Honesty when things go wrong – incorporating requirements of Duty of Candour**

SUPPORTING REFERENCES	• **Patient Safety Incident Response Framework (PSIRF) 2020 https://www.england.nhs.uk/wpcontent/uploads/2020/08/200312_Introductory_version_of_Patient_Safety_Incident_Response_Framework_FINAL.pdf** • **Revised Never Events policy and framework 2018 https://www.england.nhs.uk/wp-content/uploads/2020/11/RevisedNever-Events-policy-and-framework-FINAL.pdf** • **Managing safety incidents in NHS screening programmes 2015/16 https://www.gov.uk/government/publications/managing-safetyincidents-in-nhs-screening-programmes/managing-safety-incidentsin-nhs-screening-programmes** • **PSIRF supporting guidance 2022 https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/guidance** • **Care Quality Commission, Regulation 20: Duty of Candour. Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare. Update March 2021 https://www.cqc.org.uk/sites/default/files/20210421%20The%20duty%20of%20candour%20-20guidance%20for%20providers.pdf** • **Department of Health. (2000). *An Organisation with a Memory: Report of an Expert Group on Learning from Adverse Events in the NHS*.** • **Department of Health. (2004). *Memorandum of understanding: Investigating patient safety incidents involving unexpected death or serious untoward harm: A protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health and Safety Executive*. Available at: www.dh.gov.uk and www.acpo.police.uk** • **Health & Safety Executive Website www.hse.gov.uk** • **NHS Department of Health's Confidentiality: NHS Code of Practice https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/code-of-practice-on-confidential-information**

CONSULTATION		
	Committee/Group	**Date**
Consultation	PSIRP Stakeholder Workshops	July 2023
Approval Committee	Lessons Learnt Group ELHT Quality Committee ICB Quality Committee	October 2023 November 2023 November 2023
Document ratification date	13/12/2024	
NEXT REVIEW DATE	September 2025	
AMENDMENTS	13/12/2024: the current version 3.0 of the document remains fit for purpose, i.e. it maintains the safety of patients and staff without any amendments, and is being reissued as version 3.1 until September 2025	

Contents

1. Introduction

The NHS Patient Safety Strategy was published in July 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework.

PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

This Patient Safety Incident Response Plan (PSIRP) sets out how East Lancashire Hospitals NHS Trust (ELHT) will respond to patient safety incidents over a period of 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 incidents occurred and the needs of those affected, to continually improve patient safety incident investigations (PSIIs) by:

1. Refocusing PSII towards a system analysis approach and the rigorous identification of interconnected causal factors and system issues.

2. Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

3. Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents.

4. Demonstrating the added value from the above approach.

2. Scope

There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of system learning and improvement. There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

This plan explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

Responses covered in this Plan include:

1. Patient Safety Reviews (PSRs)

2. Patient Safety Incident Investigations (PSIIs)

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

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

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

3. Aims and Objectives

This plan is based on the four strategic aims of the National PSIRF, the overarching aims and how these will be achieved through specific objectives (Table 1) and our Trust visions embodied in our work.

"To be widely recognised for providing Safe, Personal and Effective care"

Table 1. Overarching aims and specific objectives of the Patient Safety Incident Response Framework

Overarching Aims	Specific Objectives
Improve the safety of the care we provide to our patients.	1. Develop a climate that supports a just culture[1] and an effective learning response to patient safety incidents. 2. Respond to patient safety incidents purely from a patient safety perspective. 3. Reduce the number of duplicate PSIIs into the same type of incident to reduce waste, enable more resource to be focused on effective learning and to enable more rigorous investigations that identify systemic contributory factors. 4. Aggregate and confirm validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents. 5. Consider the safety issues that contribute to similar types of incident. 6. Develop system improvement plans across aggregated incident response data to produce systems-based improvements. 7. Better measurement of improvement initiatives based on learning from incident response.
Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified.	1. Act on feedback from patients, families, carers and staff about their concerns with patient safety incident responses in the NHS. 2. Support and involve patients, families and carers in incident response, for better understanding of the issues and contributory factors.
Improve the use of valuable healthcare resources.	1. Transfer the emphasis from quantity of investigations completed with an arbitrary

[1] A culture in which people are not punished for actions, omissions or decisions commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. Eurocontrol (2019) Just culture.

	deadline to a higher quality response to patient safety incidents, and the implementation of meaningful actions that lead to demonstrable change and improvement. 2. Develop a local board-led, commissioner and integrated care system (ICS)/sustainability and transformation partnership (STP) assured architecture around response to patient safety incidents, which promotes ownership, accountability, rigour, expertise and efficacy.
Improve the working environment for staff in relation to their experience of patient safety incidents and investigations	1. Act on feedback from staff about their concerns with patient safety incident responses in the NHS. 2. Support and involve staff in patient safety incident response, for better understanding of the issues and contributory factors.

4. Our services

ELHT was established in 2003 and is a large integrated health care organisation providing high quality acute secondary healthcare for people of East Lancashire and Blackburn with Darwen. We provide a full range of acute hospital and adult community services in the following locations:

1. Royal Blackburn Teaching Hospital
2. Burnley General Teaching Hospital
3. Lancashire Women and Newborn Centre
4. Pendle Community Hospital
5. Accrington Victoria Community Hospital
6. Clitheroe Community Hospital
7. Community locations

We are a specialist centre for: Hepatobiliary, Head and Neck and Urological Cancer Services. We also provide specialist cardiology services and Level 3 Neonatal Intensive Care. ELHT is a complex system with many interrelated components that are crucial to ensuring that everything works whilst delivering Safe, Personal and Effective care to our community. ELHT is split into 5 clinical divisions with several specialities in each:

1. Family Care
2. Surgery and Anaesthetic Services

3. Medicine and Emergency Care
4. Community and Intermediate Care
5. Diagnostics and Clinical Support

5. Defining our patient safety incident profile

A review of the PSII resource and activity (associated with patient safety incident investigations) for the period January 2021 to December 2022 has been undertaken to determine how many PSIIs can be supported during November 2023 to March 2025. This review has been undertaken alongside the Patient Safety Incident Standards to ensure that all future PSIIs are compliant with these standards.

This review has been undertaken by the Trust's Quality and Safety team with support and involvement from the Quality Improvement Team to identify the Trust's local priorities.

In summary, ELHT has identified that it can undertake 40 PSIIs Trust-wide per annum. Each lead investigator will be supported by the PSII Team's Administrator and subject matter advisors as appropriate. Further support in terms of a Family Liaison Officer will be provided by senior clinical staff within Divisions to ensure patient/family/carers are involved and kept informed of progress.

To improve our ability to deliver against PSII standards, ELHT has:

1. Assigned a team of appropriately trained Patient Safety Incident Investigators who have received system-based training on incident investigation methodologies.
2. Assigned an appropriately trained board member to oversee delivery of PSII standards and support the sign off all PSIIs.
3. Developed an incident investigation toolkit to support other Trust staff so they can review patient safety incidents where a PSII is not indicated but learning can still be identified.

6. Understanding patient safety incident response activity

ELHT completed a review of two years data which included:

1. National priorities:
   - Never Events
   - Learning from Deaths
   - All other national priorities covered in Appendix A

2. Patient safety incident investigations conducted locally for example:
   - Independent investigations conducted locally but including/requiring a funded independent specialist
   - Incidents reported to StEIS 'coroner initiated' patient safety investigations

- Patient safety reviews (non-StEIS incidents meeting the requirements of Duty of Candour which are currently investigated by divisional teams including concise reports completed for learning).

Table 2. Annual response activity for 2022

Response type	Category	Average annual number of responses
National & Local priorities requiring patient safety incident investigation	Patient safety incident investigation into Never Events	2
	Patient safety incident investigation into deaths thought more likely than not to be due to problems in care.	9
	All other StEIS incidents (including HSIB Investigations)	32 (4)
Patient safety Responses conducted locally	Patient Safety Response manage within Division but not meeting Patient Safety Incident Response Framework criteria for a PSII (not including Pressure Ulcer Checklist)	428
	Number of Pressure Ulcer Checklists completed.	645
	Total	1073
Patient safety reviews	The Learning Disabilities Mortality Review Programme (LeDeR)	41
	Structured Judgement Review (SJR) 1	142
	SJR 2	35
	Perinatal Mortality Review Tool (PMRT)	42

7. Patient safety incident response skills - gap analysis

A review of the PSII resource and activity associated with the Patient Safety Incident Response Framework for the period January 2022 - December 2022 has been undertaken to determine how many PSIIs can be supported during 2024/25. This review was carried out alongside the Patient Safety Incident Standards to ensure that all future PSIIs are compliant with these standards.

Additionally, a review has been completed to determine the current level of resource for non-PSII related activity. This supports planning of appropriate responses using different review techniques where PSII is not indicated.

Under the Patient Safety Incident Response Incident Framework, the Trust reported 43 (including 4 HSIB Investigations) National and Local incidents that were assigned for a PSII and 1073 Patient Safety Responses. The Trust has also completed SJR, LeDeR reviews and PMRTs on deaths reported as due to underlaying conditions to identify any learning.

8. Resources for proactive planning

Under PSIRF, the Trust has commissioned a Patient Safety Incident Investigation Team who are responsible for completing all investigations relating to National and Local priorities, ad hoc complex investigations, provide investigation skills training for staff Trust-wide and disseminate any learning.

Team resources will be reviewed every 12 months.

Each PSII lead is supported by appropriate personnel including a medical/clinical adviser, Family Liaison Officer and the PSII Team's Administrator. The PSII team are responsible for leading on all national and local priority investigations, and any ad hoc complex investigations where a full PSII is required. Executive leads will be identified as and when required.

To improve our ability to deliver against PSII standards and completion of other investigations covered by PSRs and local non-StEIS incidents, the Trust has:

1. Assigned an appropriately trained member of the Executive and Non-Executive Team to oversee delivery of the PSII standards and support the sign off of all PSIIs as the Chair of the Patient Safety Incident Requiring Investigation Panel (PSIRI).

2. Invested in System Engineering Initiative for Patient Safety (SEIPS) training for the PSII Team and update training as and when required.

3. Developed incident investigation training for all staff completing PSR investigations in specific areas. This could include for example:
    - Application of updated analytical tools to support a PSR.
    - Training in identifying and understanding Human Factors including unconscious bias.
    - Development of safety improvement plans using Quality Improvement methodology and improvement science approaches.

9. Stakeholders and data inputs

The Trust used a thematic analysis approach to determine which areas of patient safety activity it should focus its local patient safety priorities on. Our analysis used several data sources and safety insights from key stakeholders.

The patient safety risk process was a collaborative process to enable us to define the top 20 patient safety risks from incident reporting and then cross-reference these from several other data sources including key stakeholders.

Key stakeholders included:

1. Senior Managers within the Trust
2. Staff from all levels and areas
3. Commissioners
4. Patient Participation Groups and Health Watch

The Trust reviewed two years of data from January 2021 to December 2022. Data sources included:

1. Patient safety incident reports
2. Health and Safety (RIDDOR) Incidents
3. Complaints
4. Mortality reviews
5. LeDeR Reviews
6. Claims and outcome of inquests.
7. Risk assessments
8. Safety insights from key stakeholders held at two Quality Workshops

10. Our patient safety incident response plan: national requirements

National priorities are set by the PSIRF and other national initiatives. These priorities require a PSII to be conducted by the organisation.

There are three categories of national priorities requiring local PSII:

1. Incidents that meet the criteria set in the Never Events list (2018)
2. Incidents that meet Learning from Death criteria
3. Death or long-term severe injury of a person in state care or detained under the Mental Health Act.

Further detail is provided below.

10.1. Incidents that meet the criteria set in the Never Events list 2018

Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

10.2. Incidents that meet the 'Learning from Deaths' criteria;

Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

Examples include:

- Deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's mortality review tool and which have been determined by case record review to be more likely than not due to problems in care.
- Deaths of persons with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances, a PSII must be conducted in addition to the LeDeR review.
- Deaths of patients in custody, in prison or on probation where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS.

10.3. Death or long-term severe injury of a person in state care or detained under the Mental Health Act.

Examples include suicide, self-harm or assault, resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.

11. National priorities to be referred to another team

The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) are as follows:

- Maternity and neonatal incidents
- Mental health related homicides by persons in receipt of mental health services or within six months of their discharge
- Child deaths
- Deaths of persons with learning disabilities
- Safeguarding incidents
- Incidents in screening programmes
- Deaths of patients in custody, in prison or on probation

Further details are provided below.

11.1. Maternity and neonatal incidents:

- Incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Maternity and Newborn Safety Investigations Special Health Authority (MNSI) (https://www.mnsi.org.uk) (Formerly the Healthcare Safety Investigation Branch (HSIB) for investigation https://www.hsib.org.uk/maternity/)
- All cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme
- All perinatal and maternal deaths must be referred to MBRRACE

11.2. Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge

These must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)

11.3. Child deaths

- For further information, see: *Child death review statutory and operational guidance*
- Incidents must be referred to child death panels for investigation

11.4. Deaths of persons with learning disabilities

Incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

11.5. Safeguarding incidents:

Incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multi-professional investigation

11.6. Incidents in screening programmes

- For further information see: **incidents in screening programmes**
- Incidents must be reported to NHS England in the first instance for advice on reporting and investigation (NHS England regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

11.7. Deaths of patients in custody, in prison or on probation

Where healthcare is/was NHS funded and delivered through an NHS contract, incidents must be reported to the Prison and Probation

Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

See Appendix A for the planned responses to the national priorities for referral to other bodies or teams for review or PSII.

12. Our patient safety incident response plan: local focus

Locally defined responses

Through our analysis of patient safety insights, based on both the original incident review, safety insights provided by key stakeholders and using the criteria in table 3, the Trust has determined the local patient safety priorities it will focus on from November 2023 in table 4 (see below)

Table 3. Criteria for defining top local patient safety risks

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

Table 4. Top local patient safety risks

	Incident type	Description	Specialty
1	**Medication Errors**	Anticoagulant Medicine Errors	Trust-wide
2	**Discharge Planning**	Discharge between Acute hospital beds to IHSS or Care Homes	Trust-wide
3	**Safeguarding patients with Learning Difficulties**	Inappropriate use of the Mental Capacity Act	Trust-wide

Through our analysis of patient safety insights, potential for learning and improvement, systemic risk and resources available to complete PSII investigations, the Trust will complete up to 5 PSIIs on each of the local patient safety priorities in table 4.

Table 5. Criteria for selecting risks for PSII response

Criteria	Considerations
Potential for learning and improvement	• Increased knowledge: potential to generate new information, novel insights, or bridge a gap in current understanding • Likelihood of influencing: healthcare systems, professional practice, safety culture. • Feasibility: practicality of conducting an appropriately rigorous PSII • Value: extent of overlap with other improvement work[2]; adequacy of past actions
Systemic risk	• Complexity of interactions between different parts of the healthcare system

Table 6. Planned responses for top local patient safety risks

	Incident type	Description	Response type	Number of responses (if PSII)
1	**Medication Errors**	Anticoagulant Medicine Errors	Full PSI Investigation	5
2	**Discharge Planning**	Discharge between Acute hospital beds to IHSS or Care Homes	Full PSI Investigation	5
3	**Safeguarding patients with Learning Difficulties**	Inappropriate use of the Mental Capacity Act	Full PSI Investigation	5

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process will be a flexible approach, informed by the national and local priorities. Our objective is to facilitate an approach that involves decision making through a triage process at the Trusts weekly Complex Case meeting to identify National and local priorities and potential for learning and improvement and system risks.

See Appendix A for the planned responses to the local priorities for referral to other bodies or teams for review or PSII.

13. Timescales for PSIIs

Where a PSII is required (as defined in this Plan for both local and national priorities), the investigation will start as soon as the Investigation Approach /Terms of Reference has been agreed with the Division in which the incident took place and in agreement with the patient and/or family / carer.

The Trust aim to complete all PSIIs within 4 months from the date the Investigation Approach / Terms of Reference has been approved.

In exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended timeframe will be agreed between the ELHT and the patient/family/carer.

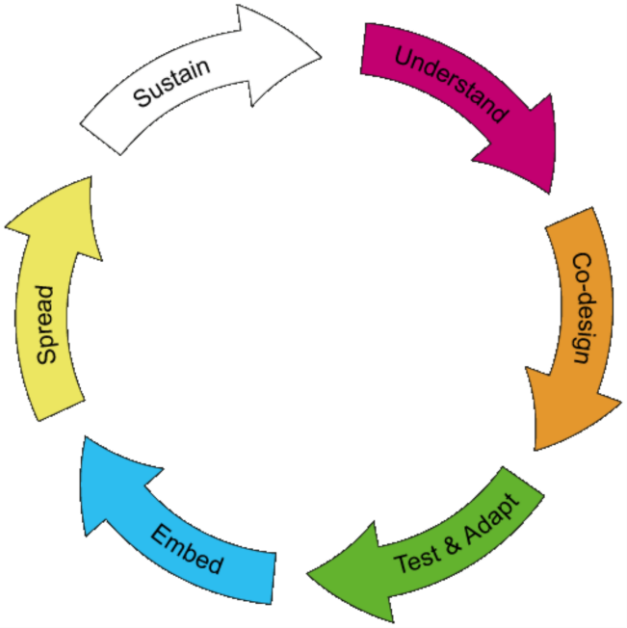
All PSIIs should take no longer than six months. A balance will be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

14. Mechanisms to develop and support improvements following PSIIs

The Trust has developed a robust approach to continuous learning and improvement. *'Improving Safe, Personal and Effective Care'* (SPE+) is our Improvement Practice of understanding, designing, testing and implementing changes that lead to improvement across the Trust. We work with our partners across Pennine Lancashire to provide better care and outcomes for our patients, staff and communities by using a six-stage approach to improvement which brings together the improvement principles of the IHI Model for Improvement and Lean.

This approach is summarised below:



The development of our Improvement Practice is being supported through our involvement in the national NHS Improvement and NHS England Vital Signs Programme.

Our improvement priorities are directly informed by our patient safety priorities, identified from patient safety incident investigations and identification of themes, as well as by key operational and pathway improvement priorities from across the organisation and wider Integrated Care Partnership, in line with national requirements. We have a comprehensive set of agreed improvement programmes spanning:

- Quality – key quality of care priorities
- Operational delivery – non-elective pathways
- Operational delivery – elective pathways
- Operational delivery – outpatient pathways
- People – delivery of our people strategy

Our Quality Improvement programme currently comprises of:

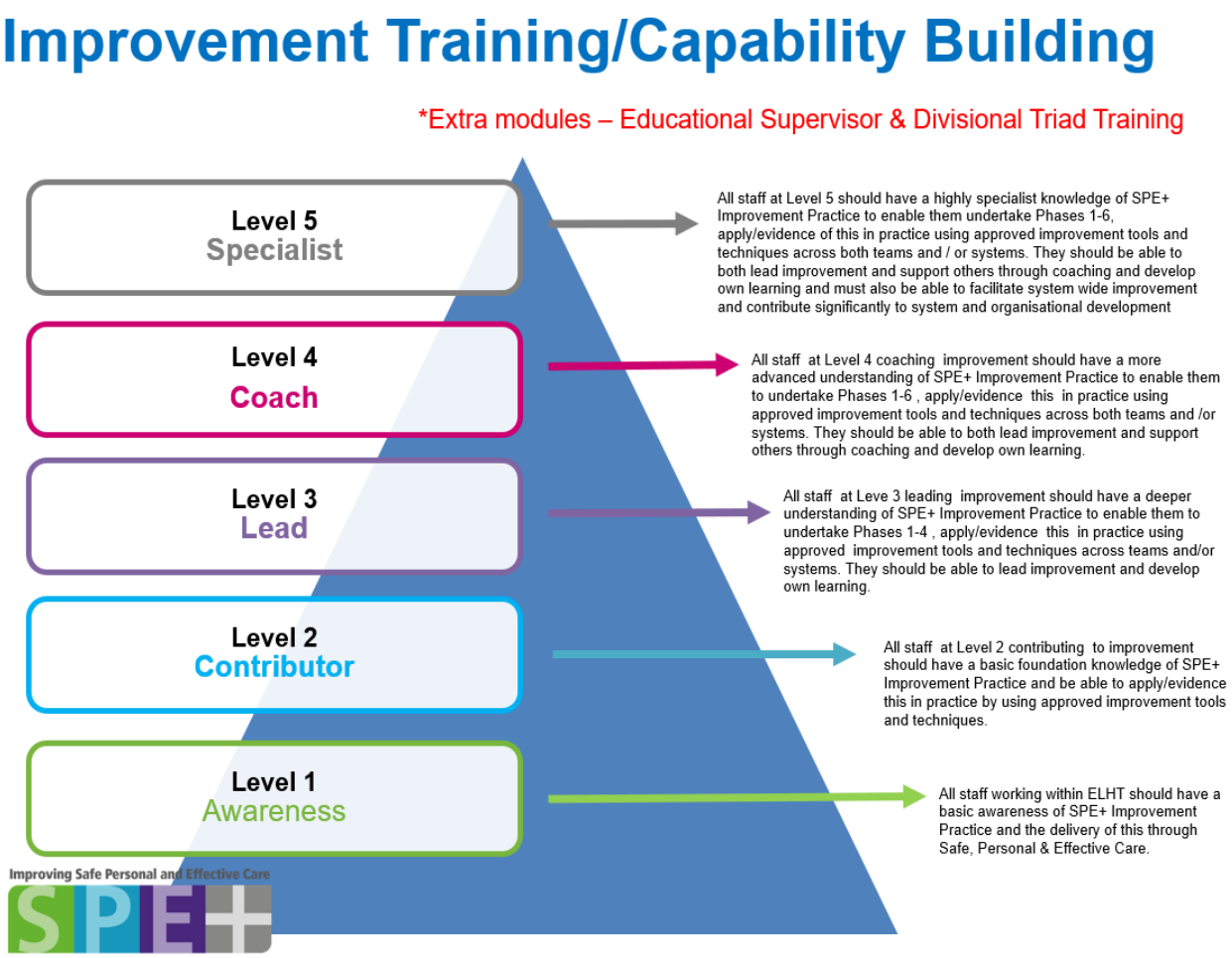
- Trust-wide harms reduction priorities (falls, SAFER surgery, deteriorating patient, medication errors, maternity/neonates and hand hygiene)
- Other key improvement priorities arising from national reports/audit, incidents and complaints e.g. nutrition and hydration, End of Life care
- Directorate and Divisional quality improvement projects
- Quality improvement (QI) projects for clinicians in training

We have an active Improvement Register with over 240 live Improvement projects currently ongoing.

Our future improvement priorities will be directly informed by implementation of the PSIRF, providing us with an opportunity to streamline and prioritise future improvement activity.

Our improvement priorities are supported by a specialist team of improvement practitioners, our Improvement Hub. The team provides support, facilitation and coaching for improvement activity across the Trust as well as providing a range of training/development opportunities to build capacity and capability at all levels. Our approach to supporting improvement is tailored to support the needs of each priority e.g. facilitation of large-scale improvement events, patient safety collaboratives, utilisation of a six-week improvement burst methodology, providing coaching and support for small scale projects.

Last year we supported over 200 staff in participating in improvement training, ranging from Lean basics awareness (two-hour course), an introduction to QI course (3 hours) and Practice Coach training (3 days). Work has been undertaken to revise our Improvement Practice training offer to full align to the 6-phase SPE+ improvement methodology. This is depicted below:



We are in the process of developing a comprehensive Improvement Network, across the organisation and wider Integrated Care Partnership to bring together colleagues involved in improvement to support shared learning and spread and celebration of success.

We measure improvement activity benefits in terms of Delivery, Quality, Cost and People (morale of both staff and patients), focussing on key process, outcomes and balancing measures. We are developing a series of dashboards to enable ongoing monitoring and assurance on key improvements that can be demonstrated and continued after formal improvement work has been completed to ensure there is ongoing delivery of the improvement identified and implemented. This will also support review and adaption of actions wherever the desired outcome is not being delivered.

Appendix A: Safety Event Investigation approach

<table>
<tr><td rowspan="11">Patient Safety Event Occurs</td><td rowspan="10">Patient Safety Incident Investigations</td><td rowspan="9">National Priorities</td><th>Event</th><th>Approach</th><th>Improvement</th></tr>
<tr><td>Incidents meeting Each Baby Counts criteria</td><td rowspan="2">Referred to Maternity and Newborn Safety Investigations (MNSI)</td><td rowspan="8">Respond to recommendations from external referral agency / organisation as required</td></tr>
<tr><td>Incidents meeting maternal death criteria</td></tr>
<tr><td>Child Death</td><td>Initiate child death review process</td></tr>
<tr><td>Death of person with learning disabilities</td><td>Reported and reviewed by Learning Disabilities Mortality Review (LeDeR) programme</td></tr>
<tr><td>Incidents meeting Safeguarding criteria</td><td>Reported to ELHT named safeguarding Lead for review</td></tr>
<tr><td>Incidents in screening programmes</td><td>Reported to NHS England (NHSE)</td></tr>
<tr><td>Death of patients in custody, in prison or on probation</td><td>Reported to Prison and Probation Ombudsman (PPO)</td></tr>
<tr><td>Incidents meeting the Never Event criteria</td><td>Patient Safety Incident Investigation Team</td><td rowspan="2">Create local organisational recommendations and safety improvement plans (to inform Quality Improvements)</td></tr>
<tr><td>Incidents resulting in death</td><td>Patient Safety Incident Investigation Team</td></tr>
<tr><td>Local Priorities</td><td>◆ Medication Errors (Anticoagulant)
◆ Discharge Planning (Discharge between Acute beds to IHSS and Care Homes)
◆ Safeguarding patients with LD (Inappropriate use of MCA)</td><td>Patient Safety Incident Investigation Team</td><td>Create local organisational recommendations and safety improvement plans feeding into Quality Improvements Strategy</td></tr>
<tr><td>Patient Safety Reviews or Handler review</td><td>Divisional Level</td><td>Incident resulting in moderate or severe harm to patient</td><td>Statutory duty of candour and appropriate PSR tool</td><td rowspan="2">Inform thematic analysis of ongoing patient safety risks at teams, speciality, directorate, divisional and trust level</td></tr>
<tr><td>No / Low Harm patient safety incidents</td><td>Validation of facts at local level recorded on DATIX</td></tr>
</table>