# Patient Safety Incident Response Policy

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| Policy first ratified: | 23/10/2024 |

| Policy Reviewed | Reviewed by Date | Next Review date |
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| New Policy<br>This policy is written in response to Patient Safety Incident Response Framework implementation in SSCH | Author:<br>Lorna Bramwells<br>Special Projects Lead | QG&R<br>October 2025<br>then 3 yearly |
| Please read in conjunction with the SSCH PSIRF Plan | | |

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# Patient Safety Incident Response Policy

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# Patient Safety Incident Response Policy

## The purpose of this document

This policy supports the requirements of the NHS's Patient Safety Incident Response Framework (PSIRF) and sets out Shooting Star Children's Hospice's (SSCH) approach to responding to patient safety incident for the purpose of learning and improving patient safety.

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

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF: (NHS 2024).

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

Using the PSIRF, reviews of safety incidents will take a more holistic, systems-based approach and move away from root cause analysis and identifying individuals or human error as a cause of the incident. The PSIRF has less focus on apportioning blame or determining liability in situations where harm was not intentional or caused by deliberate avoidance of best practice.

## What are my responsibilities?

All clinical staff and staff working in SSCH supporting services have a responsibility to report incidents and near misses on Vantage.

All volunteers who witness incidents or near misses have a responsibility to report these to their manager, who will report them on their behalf.

All clinical staff must complete the relevant mandatory training to their role. All clinical staff need to complete Level 1 of the National Patient Safety Syllabus. Staff who investigate incidents will need to complete internal training on the SEIPS approach. Staff who have a defined role relating to PSIRF learning responses, oversight or patient/family liaison must complete external training (more details can be found in the PSIRF plan).

Clinical staff may be called upon to support relevant learning responses (e.g., Involvement in a swarm huddle following a patient fall). Staff will be expected to attend and take part in these meetings in order to support information gathering and sharing, and ultimately improve patient care.

Managers reviewing Vantage incidents have the responsibility to identify if the incident would benefit from a more 'in depth' learning response.

Learning Response Leads have the responsibility to complete an appropriate learning response (as identified in the PSIRF Plan) when required. They will work with the Patient and Representative Engagement leads to ensure that patients are supported through the process appropriately.

The Director of Care is the Executive Lead for PSIRF at SSCH.

Oversight of incidents and the action plans that develop as a result will fall under the responsibility of the Senior Leadership Team Quality & Risk (SCLTQ&R) and Governance Quality & Risk Committee.

SSCH will embed a 'just culture' to avoid blame of individuals when investigating incidents. Training will be integrated into our induction programme for all staff to promote psychological safety among staff and to aid an honest and open culture for sharing (appendix 2).

# Reporting and responding to patient safety incidents

## Reporting Incidents

All staff have a responsibility to report patient safety incidents and near misses on Vantage, our incident reporting system. Volunteers should report incidents to their managers, who can submit a report on their behalf. Training will be provided on induction to all staff.

## External reporting of incidents

In addition to internal reporting of incidents, some incidents should be reported externally:

- Medication incidents involving controlled drugs

Incidents involving controlled drugs should be reported to the Controlled Drugs Local Intelligence network via CDreporting.co.uk. A quarterly occurrence report should be submitted, with additional reporting for more significant incidents / episodes of diversion. This should be submitted by the Controlled Drugs Accountable Officer or one of their deputies.

- Death of someone using the service

Deaths occurring on the Inpatient Unit, or deaths that occur at home when a regulated activity is being provided should be reported to the CQC via the 'Notifications' section of their website. This form will be completed by the staff member in attendance at the time of the death.

- Serious Injury to a person using the service

'Serious Injuries' that occur when a regulated activity is being provided should be reported to the CQC via the 'Notifications' section of their website by the head of service or Director of Care. The CQC has their own definition for serious injuries, relating to harm caused.

- Safeguarding incidents

Incidents that warrant a safeguarding concern being raised with the SSCH Safeguarding Team, whether or not related to the direct care provided by SSCH, may need to be reported to the Local Authority or allocated Social Worker. Details of how a safeguarding concern should be raised can be found in the Safeguarding Children Policy and Safeguarding Adults policy".

## Duty of Candour

When patient related incidents occur, immediate steps should be taken to support those affected. Guidance can be found in the Duty of Candour policy. Compliance is monitored through the SSCH audit plan.

This includes:

• Meeting with / speaking to the patient and their family / carers as soon as able to explain when something has gone wrong and the consequences of the event

• Apologising

• Taking action to put the issue right

• Following appropriate steps relating to clinical governance – e.g. incident reporting

Consideration should be given to whether the incident meets the 'notifiable event' criteria for statutory duty of candour reporting.

When incidents meet the criteria for a learning response investigation, it is important that the child / young person where possible and family / carers are involved and supported through the process. The level of involvement must be in keeping with the wishes of those affected as far as possible.

## Support for those affected by a patient safety incident

The Patient Safety Incident Response Framework (PSIRF) emphasizes compassionate engagement and involvement, offering support to patients, families, and staff, including access to investigations, learning responses, and resources to address their needs.

**Key Principles of Support**

**Compassionate Engagement**:

The PSIRF prioritizes treating those affected with compassion and understanding.

**Involvement in Investigations**:

Patients, families, and staff are encouraged to participate in investigations and learning responses to ensure their perspectives are heard.

**Access to Information**:

Those affected should be provided with clear and timely information about the incident and the investigation process.

**Support for Learning**:

The PSIRF aims to create a culture where learning from incidents is prioritized, leading to improvements in patient safety.

**Specific Support Mechanisms**

**Patient and Family Support**:

Initial Contact: Careful planning is needed for initial contact with those affected, recognizing that they may be in a vulnerable state.

Understanding and Addressing Needs: Identifying and meeting the emotional, psychological, and physical needs of those affected is crucial.

Access to Information: Providing clear and timely information about the incident and the investigation process.

Participation in Investigations: Supporting those affected to participate in investigations if they wish to do so.

Signposting to Support: Connecting people with relevant support services, such as the family support and social work team.

Learn Together: The Learn Together website provides resources and guidance for patients and families involved in patient safety incidents.

**Staff Support**:

Recognizing the Impact: Acknowledging that staff may also be affected by incidents and need support.

Access to Support: Providing access to the employee assistance program, counselling, and peer support.

Learning and Reflection: Creating opportunities for staff to reflect on their experiences and learn from incidents.

## Reviewing incidents

When an incident is logged on Vantage all clinical incidents should have an initial review using the pre-set investigation template by the assigned manager. The manager should then review the incident using the prompts on Vantage and escalate as necessary to the Head of Care within hours or on-call senior nurse and/ or on-call director out of hours. Capacity and time is allocated to staff with assigned roles, who have received training, within their job plan, ensuring adequate staff capacity and dedicated time for investigations and learning, focusing on a timely response that's completed within an agreed timeframe, maintaining a just culture and continuous improvement.

The initial investigation should be done with the System Engineering Initiative for Patient Safety (SEIPS) framework in mind, to support effective investigation (NHS 2022a). Historically, 'in depth'

investigations have been reserved for incidents leading to moderate harm, or above. In designing our local focus, we will consider the following criteria:

| Criteria | Examples |
|---|---|
| Potential for learning | • There is a potential to inform improvement<br>• Initial review suggests there may be system wide factors that have contributed to the incident<br>• Impact on quality of care, or the capacity/delivery of service |
| Likelihood for reoccurrence | • There is a persistent risk<br>• There was potential for the incident to escalate<br>• The frequency of events has been higher than usual |

All incidents will be reviewed weekly at our Patient Safety Forum (PSF) held within the Exec SITREP meeting where the learning response leads will then identify the best learning response method based on those identified in the SSCH Patient Safety Incident Response Plan.

The only exception is In-house falls or other significant incident - when a fall occurs In-house, an immediate swarm huddle occurs as the learning response method (within 24hrs of the fall occurring).

Timeframes for learning responses will remain flexible (other than for swarm huddles in response to falls or other significant incident as described above). Where possible, incident responses should be completed within one to three months of commencement. However, it is accepted that delays may occur relating to complexity of data gathering and appropriate involvement of patients and their representatives.

## Developing Safety Action Plans

An outcome of the learning response review is that a safety action plan will be developed. The plan should be reviewed by the learning response lead and the relevant specialist group where appropriate (e.g. medicines management) alongside the patient safety partner and the patient / representative themselves. These actions plans will be collected into an overarching safety plan for SSCH and monitored through SLT. (Appendix 7)

SSCH will use the process for *Development of safety actions* as outlined by NHS England in the Safety Action Development Guide (2022):

- Agree areas for improvement – specify where improvement is needed, without defining

solutions

- Define the context – this will allow agreement on the approach to be taken to safety action development
- Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved
- Write the safety actions, ensuring that they follow SMART principles (see appendix 1) and have designated owner.

The planned actions will come to the SCLT Q&R prior for review before being prioritised and adopted. SCLT Q&R will review the suggested actions against the iFACES criteria (Appendix 6) and scoring rubric to help prioritise them (NHS 2022). They will also decide on any metrics that may be required to measure effectiveness of the safety action – consideration will be given to which specific measures/metrics will best demonstrate effective role out of safety action plans (for example, this may be new metrics which are not routinely captured, clinical audit or could be a qualitative measure). There may be evidence that external support may help data gathering / development of an action plan. In this case the leads will consider when external involvement may be of benefit and will seek appropriate engagement from appropriate stakeholders.

## Safety Action Monitoring

Action plans will be monitored through SCLT Q&R to assess whether actions have been implemented as planned and defined outcome measures / metrics achieved and are being sustained. If improvement is not seen / sustained then SCLT Q&R will take appropriate action to support the re-design of Safety Actions.

## Patient safety work: Existing and planned Improvement work

Analysis of PSIs has identified areas for ongoing improvement. In response we have developed an improvement plan which supports ongoing and planned areas for review and improvement.

- Redesign of incident reporting system & categories.
- Medication management
- Clinical safety assurance
- Managing challenging behaviour
- Adherence to Caldicott principles
- Ongoing CQC compliance
- Staff survey
- Emphasise and strengthen a culture of safety & a ‘just culture’

Each element has an assigned lead and is reviewed monthly in the SLT Q&R committee prior to review at QG&R for oversight.

## Responding to cross system incidents / issues

Learning response leads will also be supportive and engage with external stakeholders as and when required to support a patient safety learning / improvement response across the system. Learning responses and outcomes will be openly shared across the system through networks such as Children's Hospices Across London (CHAL) and Sharing Good Practice Forum.

## Oversight roles and responsibilities

*"When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures".*
*To achieve this, organisations must look carefully not only at what they need to improve but also what they need to stop doing (e.g., panels to declare or review Serious Incident investigations). Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control."*
(NHSE, PSIRF Guidance: 'Oversight roles and responsibilities specification and Patient safety incident response standards'- p2)
Shooting Star Children's Hospices will provide PSIRF oversight in a way that ensures improvement, rather than focuses on policy and standard compliance alone.
Alongside our local ICB structures and our regulator, the Care Quality Commission, we have specific organisational responsibilities set out within the Framework. To meet these responsibilities, we have designated the Director of Care as the executive lead for PSIRF.

## Ensuring that the organisation meets the national patient safety standards

The Director of Care will oversee the development, review and approval of the hospice's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards.

## Quality assuring our PSIRF approach and the outputs of learning responses

The Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms outlined in our Governance Framework.
Training will be monitored centrally via the Practice Education & Quality Team and monitored through SCLT Q&R. They will monitor compliance to the mandatory training from the National Patient Safety Syllabus via the learning management system, Litmos. The Executive Lead will ensure that the hospice source necessary training across the organisation as appropriate, to support the learning response leads and those leading on patient and representative engagement.

### Assuring a Just Culture

A 'just culture' is a system which avoids blaming staff when something goes wrong. It acknowledges that whilst human error can contribute to an incident occurring, there may be system wide issues that have also contributed to its occurrence.

A just culture identifies that in most cases blame of those involved should be avoided unless there is intention to cause harm or wilful avoidance of recommended practices. Avoiding blame can help to foster learning without the fear of retribution and can improve understanding of how the system works and contributed to the incident occurring.
A range of qualitative methods will be used to quality assure the adoption of Just Culture within SSCH. Direct feedback from staff via surveys and staff forums will capture whether staff feel psychologically safe, and a just culture exists (see appendix 3).

### Quality assuring the outputs of learning responses

Learning responses and their associated safety action plans will come to SCLT for sign off. Before sign off can occur, the quality of the investigation needs to be considered. For PSIIs, the executive lead will assess quality using a quality assurance tool, such as the Being Human PSII Rubric. For added assurance, external assessment from other Hospice's oversight providers may be sought.

### Quality assuring Safety Action Planning

The Patient Safety Forum (PSF) will support action planning by using the iFACES Rubric (appendix 6) to help prioritise planned actions. They will also ensure that actions look at the whole system.

### Quality assuring Safety Action Monitoring

The assigned leads for Safety Actions within improvement plans will report into the monthly SCLT Q&R on the progress of implementation. SCLT Q&R will assess that implemented safety actions have had the desired effect using collection of appropriate metrics (which will have previously been

defined). Sustainable change will be measured using appropriate methodology (e.g., audit at planned intervals, or statistical process control).

This will provide oversight that safety action plans are implemented to the highest standard, and in a sustainable manner. The quarterly reporting to QG&R will ensure that the Board have a continuous understanding of organisational safety and delivery of safety actions and improvement plans, including progress on completion of plans

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every year to comply with hospice guidance on policy development, alongside a review of all safety actions.

## Collaborating with the ICB and other stakeholders

Information will be shared with our ICB via contractual monitoring and via patient safety meetings for oversight and collaborative learning.

Attendance at local PSIRF networks will allow for additional collaborative learning and expertise sharing.

## Engaging and involving patients, families and staff following a patient safety incident (including Patient Safety Partner).

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if there is the compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). Our Patient and Public Engagement lead / Patient Safety Partner (once appointed) will be integral in supporting contribution to patient safety improvement projects, collaboration with safety strategies, participation in staff patient safety training, and involvement in investigation oversight groups. The role of our PSP is pivotal in ensuring that patient safety initiatives are informed by real-world experiences and perspectives, fostering a culture of safety that is truly patient-centred.

Engaging and supporting staff in incident responses will go hand in hand with developing a Just Culture at SSCH. Relevant staff at all levels will be asked to be involved in information gathering, such as after-action review meetings and MDT meetings as a way to capture what happened in an incident, and to better understand the ‘work as done’. Staff will be given time to respond and reassured throughout the incident process that involvement and engagement is done to help identify areas for change and to aid improvement. They will be reassured that processes are not punitive as we aim to support a ‘no blame’ culture.

## Monitoring and Review

This policy, alongside the PSIRF plan, will be formerly reviewed annually following implementation in October 2025 by the Exec Lead and those in oversight roles prior to further review and ratification in the QG&R committee:

- Annual review of due governance on oversight role
- Monthly then quarterly and annual review of incident investigation and analysis

Annual development of patient safety action plan with a clear process for monitoring through the senior care leadership team monthly meeting then quarterly quality, governance and risk committee that reports to the board.

## Related policies

Accident and Incident Policy

Administration and storage of medicines

Complaints and Duty of Candour Policy

Duty of Candour

End of Life Policy

Governance Framework Policy

Safeguarding Children Policy

Safeguarding Adults Policy

SSCH PSIRF Plan

Volunteer Policy

## References

NHS England (2022) Safety Action Development Guide
***https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf***
[accessed 6.9.24]

NHS (2024) The Patient Safety Incident Response Framework
***https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/*** [accessed 6.9.24]

NHS (2022a) SEIPS quick reference guide and work system explorer

***https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL-1.pdf*** [accessed 19.9.24]

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| **RATIFIED BY: QG&R** | **DATE: 23/10/24** |

# Appendices

## Appendix 1 - Glossary

**After Action Review (AAR):** 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.

**Care Quality Commission (CQC):** The regulators for health care services

**Clinical & Community Quality Assurance Committee (CCQA):** A clinical sub-committee of the Board, attended by trustees, board advisors and some staff in positions that provide oversight regarding PSIRF.

**Health Care Acquired Infection (HCAI): i**nfections that can develop as a direct result of healthcare interventions, such as medical or surgical treatments, or from being in contact with a healthcare setting. These infections cover a wide range of conditions and pose a serious risk to patients, staff, and visitors. Examples include methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.difficile).

**Infection Prevention Control (IPC):** The approach which health care settings take to prevent the transmission of avoidable infections, including health care acquired infections.

**Multidisciplinary team (MDT) review:** A discussion with multiple professionals to understand incidents and why the outcomes differed from the expected. The MDT review can be used to look at groups of incidents rather than single episodes. Can be used to understand the “work as done” when it may be more difficult to collect staff recollections.

**Patient Safety Incident Response Framework (PSIRF):** The NHS’s approach to handling patient safety incidents. This approach replaces the previous Serious Incident Framework and represents a significant shift in how the NHS responds to incidents.

**Patient Safety Incident Investigation (PSII):** An in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.

**Patient Safety Forum (PSF):** A weekly meeting within Exec Sitrep which review all incidents and provides decision to support PSI methodology. The meeting is attended by those in a position to provide PSIRF oversight, and PSIRF executive lead.

**Quality Governance and Risk (QG&R):** A quarterly committee at Board level that provides oversight for clinical issues, incidents and development at SSCH. It is chaired by a Care Trustee.

**SCLT Q&R:** A monthly committee that provides oversight for clinical issues, incidents and

development at SSCH. It is chaired by the Director of Care who is the PSIRF Executive Lead.

The committee has responsibility for developing safety action plans following a learning response, particularly PSIIs.

The meeting is attended by those in a position to provide PSIRF oversight, the learning response lead, the engagement lead (to represent the perspective of the patient / family) and the Patient Safety Partner.

**Swarm Huddle:** A meeting that occurs immediately after an event happens. Staff 'swarm' to the site to quickly analyse what happened and how. They decide what needs to be done to reduce risk.

**System Engineering Initiative for Patient Safety (SEIPS) Framework:** A framework that helps you understand how a multifactorial work system may have contributed to a process (work as done) and the eventual outcome.

**Thematic Analysis:** Collating themes from similar incident reviews / observations to identify common themes that may contribute to the risk of those incidents occurring again.

**Vantage:** Electronic platform used to log and investigate incidents / safety issues

## Appendix 2 – SEIPS

**System Engineering Initiative for Patient Safety (SEIPS) Framework**

SEIPS is a framework for understanding outcomes within complex socio-technical systems.

Gains an insight into 'work as done'. The SEIPS framework acknowledges that work systems

and processes constantly adapt

(see arrows in Figure 1).

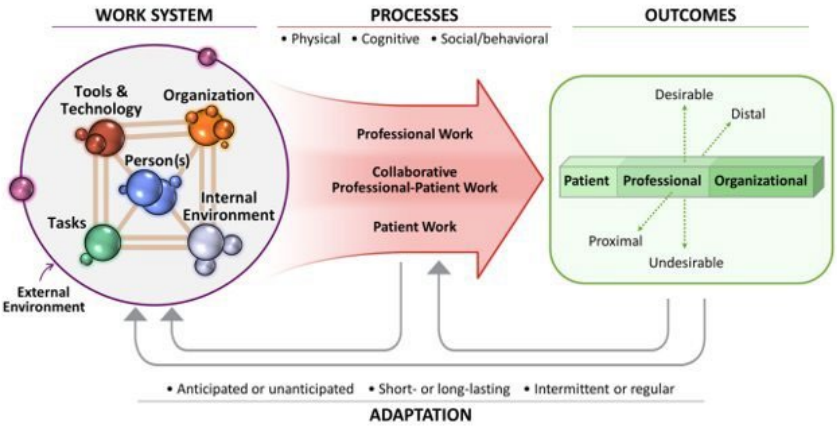
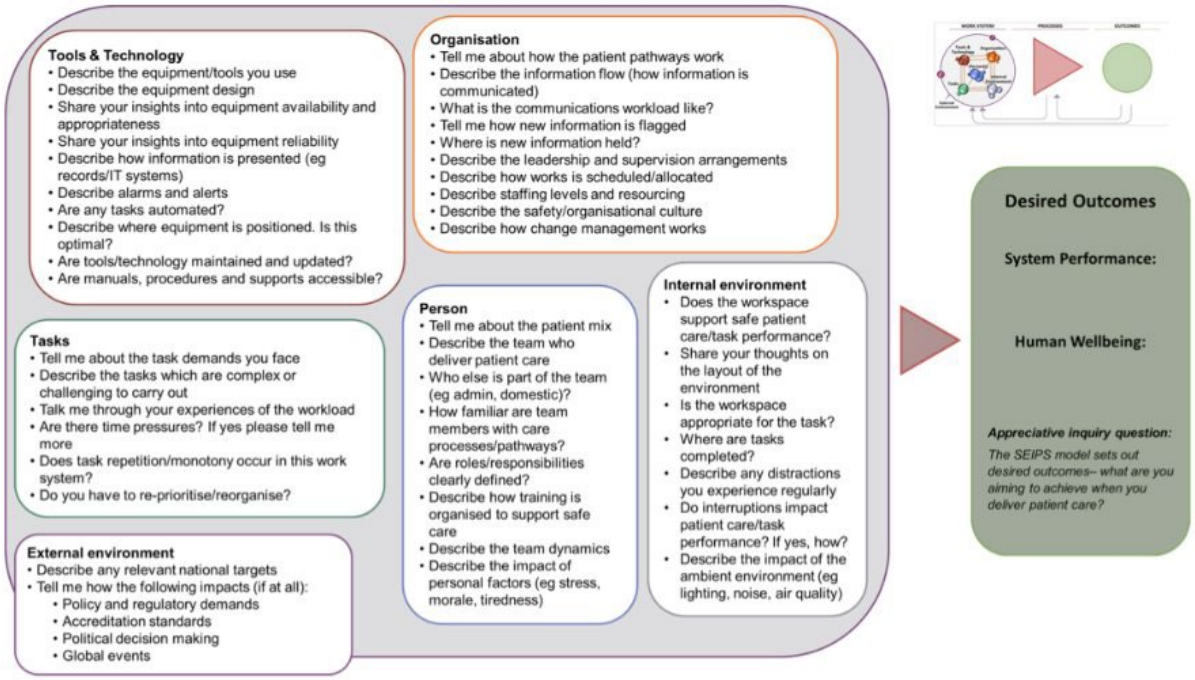



**Figure 1.**
SEIPS 2.0 model.

**Figure 3. SEIPS work system explorer questions**



## Appendix 3 - A Just Culture

**What is a Just Culture?**

A 'just culture' is a system which avoids blaming staff when something goes wrong. It acknowledges that whilst human error can contribute to an incident occurring, there may be system wide issues that have also contributed to its occurrence.

A just culture identifies that in most cases blame of those involved should be avoided unless there is intention to cause harm or wilful avoidance of recommended practices. Avoiding blame can help to foster learning without the fear of retribution and can improve understanding of how the system works and contributed to the incident occurring.

**How will Shooting Star Children's Hospice foster a Just Culture?**

### Mandatory training

Level 1 of The National Patient Safety Syllabus will become part of mandatory training for all clinical staff. This module covers avoidance of inappropriate blame and creating a culture that prioritises safety and is open to learning about risk and safety.

### Patient safety as part of the induction programme

All new starters in clinical teams will have training as part of their induction programme. This meeting will help to explain the Hospice's approach to Just Culture, incident investigation and patient safety. Staff will be introduced to the oversight structure to understand how change and improvements are facilitated as well as SEIPS training to gain an understanding of a systems approach.

### Vantage reporting

All staff complete training on the use of Vantage, to encourage open and transparent reporting. In training and induction, staff are encouraged to report near misses as well as incidents that occur to encourage improvement.

### Learning response methodologies

The identified learning response methodologies will support the development of a Just Culture as they move away from individual blame. Data gathering for a number of the methods (e.g. Swarm huddles, MDT meetings) focus on group opinion and discussion, helping to move away the focus away from an individual's actions.

### Feedback of incident outcomes and actions

Outcome of incident reviews will be fed back to all staff rather than just those involved, in order to limit the focus on blame, and instead focus on the potential for improvement. Feedback will be done via safety huddles, team meetings, bulletin and emails

### Collection of staff feedback via staff surveys and the staff forum

The outputs of staff feedback routes will be monitored for comments around the theme of psychological safety, just culture and incident reporting. These routes include staff surveys, staff forums, team meetings and exit interviews This will help with providing assurance on how a Just Culture has been adopted by the organisation.

### Freedom to Speak Up Guardians

There is an established Freedom to Speak Up pathway, with guardians in post at SSCH. This will allow for anonymous 'whistle blowing' or alerting to areas of concern. Freedom to Speak Up submissions will be monitored by the SCLT for areas where improvement work may be needed.

### Inequity in the workforce

It is a well-documented issue that inequity within healthcare exists. Staff from ethnically diverse backgrounds are more likely to experience discrimination and face disciplinary action. We acknowledge that unconscious bias may contribute to the way some staff are treated. As an organisation, we will record the demographic data of any clinical staff facing disciplinary action / processes. Oversight of this will be provided by the Director for People & Culture.

## Appendix 4 - Patient Safety Partners

Patient safety partners are members of the public (sometimes who have experienced our care first hand) who can contribute to the management of safety processes at SSCH. They will help to bring a different and important perspective to the table when reviewing incidents and deciding on how to improve patient safety issues.

We will aim to source 1 patient safety partner to support patient safety work at the Hospice.

Key functions of the patient safety partner include:

• Assisting in the development of action plans in response to incident reviews / learning

responses.

• Helping to develop patient safety information resources.

• Assisting in the sharing of learning in response to incident reviews with staff

As we embed the role in SSCH we appreciate there may be emerging adaptations to the role and we will review accordingly ensuring that they are adequately trained. The patient safety partner will be a volunteer at the hospice as this is an unpaid role. The patient safety partner will be managed by the Head of Hospices Services who will support them to access local patient safety partner networks where available to non-NHS independent organisations.

## Appendix 5 - Addressing Health Inequalities

At Shooting Star Children's Hospice's we acknowledge that nationally, some clinical errors and incidents disproportionately affect some minority groups. With this in mind we aim to review the demographic data to see if any groups are more at risk of having a safety incident occur to them.

As part of the work relating to the patient safety incident response framework, we will begin

collecting demographic data in relation to the occurrence of incidents to help us identify

if there are health inequalities in the incidents that occur. This will be reported at SCLT QG&R and a review instigated if any emerging themes become apparent.

## Appendix 6 - iFACES scoring rubric

**Table 3: iFACES criteria and scoring rubric**

| Criterion | Low | Medium | High |
|---|---|---|---|
| | 1 — 2 — 3 — 4 — 5 | | |
| Inequality<br>Does the intervention ensure fair treatment and opportunity for all? | The intervention is not accessible to the diverse population that will use it. | The intervention accommodates some inequalities but further investigation is needed. | Inequalities are reduced by this intervention. |
| Feasibility<br>Can the change be implemented relatively easily or quickly? | The intervention does not exist today nor is it likely to become available in the near future; it is highly impractical and not suitable for your organisation. | The intervention exists but is not readily available or will require modifications to better fit the context in which it is intended to be used. | The intervention is readily available and could be implemented in a relatively short period of time without much effort. |
| Acceptability<br>Will those being impacted by the intervention readily accept the change? | The intervention will not be tolerated by those it impacts. People are likely to consistently resist the change and attempt to work around the change. | The intervention will be tolerated by those it impacts. There may be moderate resistance but attempts to undermine the change will not be wide spread. | The intervention will be readily accepted by those it impacts. People are likely to welcome the change and make every attempt to ensure it works. |
| Cost/Benefit<br>Does the benefit of the intervention outweigh the costs? | The cost of the intervention is exorbitant relative to its minimal expected impact on safety and performance. | The intervention is moderately expensive but cost could be justified by its expected benefit. Return on investment (benefits) is relatively equal to cost. | The cost of the intervention is nominal relative to the expected impact on safety and performance. |
| Effectiveness<br>How effective will the intervention be at eliminating the problem or reducing its consequences | The intervention will not directly eliminate the problem or hazard and it relied heavily on wilful compliance with the change and/or requires humans to remember to perform the task correctly. | The intervention reduces the likelihood of the problem or hazard occurring but relies in part on human memory and/or wilful compliance with the change. | The intervention will very likely eliminate the problem or hazard and it does not rely on wilful compliance with the change or require humans to remember to perform the task correctly. |
| Sustainability<br>How well will the intervention last over time | The impact of the intervention will diminish rapidly after it is deployed and/or will require extraordinary effort to keep it working. | The benefits of the intervention may have a tendency to slowly dissipate over time and will require moderate efforts to maintain its benefits. | The impact of the intervention will persist over time with minimal efforts being required to maintain its benefits. |

***https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf***

## Appendix 7

Safety Action Plan - example

| Date | Vantage Reference | What happened | Immediate Safety Actions | Key learning points | **Action** (SMART – specific, measurable, achievable/action-related relevant, timely) | **Lead responsible** (Job titles) | By when | Review | Outcome |
|---|---|---|---|---|---|---|---|---|---|
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