York and Scarborough Teaching Hospitals NHS Foundation Trust

Patient Safety Incident Response Policy

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This policy is an overarching policy for patient safety management in the Trust. The practical aspects of managing incidents are described in supporting policies and guidance:

- Incident Management Policy
- Compassionate engagement and Duty of Candour Policy
- Learning from Death Policy
- Managing and investigating incidents to and from external organisations Standard Operating Procedure

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Glossary of terms

Term/Acronym	Definition
AAR	After Action Review (AAR) is a method of evaluation that is used when the outcomes of an activity or event, have been particularly successful or unsuccessful
Arbitrary or Subjective	Chosen randomly or influenced by/based on personal beliefs or feelings, rather than on facts
Care Group	A grouping of multi-disciplinary staff working together to provide care within a certain area
CQC	Care Quality Commission – independent regulator of health and social care in England
Definitions of Harm	Unanticipated, unforeseen accidents (eg, patient injuries, care complications, or death) which are a direct result of the care dispensed rather than the patient's underlying disease
Duty of Candour	Being open and honest with patients and families when treatment or care goes wrong. The duty describes a regulatory activity to demonstrate being open
Emergent Property	A characteristic an entity (patient safety) gains when it becomes part of a bigger system
Governance Structures	System that provides a framework for managing organisations
HFACS	Human Factors Analysis and Classification System: a user-friendly, cost-effective and evidence-based approach to incident investigation, based on the goal of understanding recognized systems.
HSE	Health and Safety Executive
HSSIB	Health Services Safety Investigations Body (Previously Health and Safety Investigation Branch)
Human Error	A human error is an action or decision which was not intended that has negative consequences or fails to achieve the desired outcome
Human Factors	Factors directly related to a person eg tiredness, physical abilities and factors external to the person eg environment that have an impact upon individual performance
Inequalities data	Facts and statistics collected relating to health inequalities which are unfair. Avoidable differences in health across the population, and between different groups within society.
Integrated Care Board (ICB)	Statutory organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS
Just Culture Approach	The treating of staff involved in a patient safety incident in a consistent, constructive and fair way
MHRA	Medicines and Healthcare products Regulatory Agency
MDT	Multi-disciplinary Team – group of individuals from many disciplines. A MDT review (in the context of PSIRF) is a learning response particularly useful to understand 'work as done' and

	is used to look at specific processes or to review a complex incident not suitable for investigation. The MDT review is known locally as a pathway review.
Neonatal Death	A baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born
Never Events	A nationally recognized category of incidents that could cause harm to people that should never happen and can be prevented if mitigations are in place.
NHSE	National Health Service England
Paradigm Shift	An important change that happens when the usual way of thinking about or doing something is replaced by a new and different way
Principles of Proportionality	The least intrusive response appropriate to the risk presented
PSII	Patient Safety Incident Investigation
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SEIPS	System Engineering Initiative for Patient Safety – a framework for understanding outcomes within complex socio-technical systems.
SI	Serious Incident
SOP	Standard Operating Procedure
Stakeholder	People or groups who have an interest in what an organisation does, and who are affected by its decisions and actions.
Statistical Process Control (SPC)	A tool used to understand whether change results in improvement. It provides an easy way for people to track the impact of improvement projects.
Swarm Huddle / Hot debrief	Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. The term 'hot debrief' will be used in this organisation.

Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out York & Scarborough Teaching Hospitals NHS Foundation Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

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

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

- 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.

The PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. **Instead, organisations are now able to balance effort between learning through responding to incidents or exploring issues and improvement work.**

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all patient-facing services and departments delivering NHS care.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses, therefore, do not solely focus on the actions of individuals, or 'human error', even when these are reported to be the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Our patient safety culture

York & Scarborough Teaching Hospitals NHS Foundation Trust promotes a just culture approach (in line with the NHS Just Culture Guide) to any work planned or underway to improve safety culture. Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

The Trust encourages and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). Please refer to the *Incident Management Policy* for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame.

Patient safety partners

The Trust has established 3 roles for patient safety partners in line with the NHSE guidance Framework for involving patients in patient safety . Patient Safety Partners will

have an important role in supporting our PSIRF providing a patient perspective to developments and innovations to drive continuous improvement.

A Patient Safety Partner (PSP) is involved in the designing of safer healthcare at all levels in the organisation. This means maximising the things that go right and minimising the things that go wrong for patients when they are receiving treatment, care and services from us. PSPs will use their lived experience as a patient, carer, family member or a member of the local community to support and advise on activities, policies and procedures that will improve patient safety and help us to deliver high quality care.

PSPs will work alongside staff, volunteers and patients, attend meetings (face-to-face and online), be involved in projects to co-design developments of patient safety initiatives, and join (and participate in) key conversations and meetings in the Trust focusing on patient safety. They will have a mind-set for improving outcomes, whilst representing the patient, carer, family view and ensuring committee/meeting members are “walking in the patients’ shoes”.

Full role descriptions are provided for PSPs along with any support requirements they may need to maximise their opportunities for involvement and ensure they are fully supported and enabled.

Addressing health inequalities

As a large provider of acute and community services, the Trust has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the control of the health care system, for example our education system; employment levels; pay and conditions; and availability and quality of housing.

Through our implementation of PSIRF, we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to our Trust Board and partner agencies on how to tackle these. The more holistic, integrated approach to patient safety under PSIRF will require the Trust to be more collaborative with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda.

Our engagement with patients, families and carers following a patient safety investigation must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / compassionate engagement process.

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

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

Involving Patients & Families

The Trust recognises the importance of and is committed to involving patients and families following patient safety incidents, engaging them in the investigation process and fulfilling the duty of candour requirements. It is recognised from experience and research that patients and families often provide a unique and important perspective to the circumstances around patient safety incidents, and / or may have different questions or needs to that of the organisation. This policy therefore reinforces existing guidance relating to the duty of candour and 'compassionate engagement' and recognises the value of involving patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved. Further guidance in relation to involving patients and families following a patient safety incident is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/#heading-2
See also the Trust's *Compassionate engagement and duty of candour policy*.

Guidance for families involved in investigations can be found on the Learn Together page Investigation resources – learn-together.org.uk. These resources have been created following a national research project involving the Trust.

Involving Staff, Colleagues and Partners

Similarly, involvement of staff and colleagues (including partner agencies) is of paramount importance when responding to a patient safety incident to ensure a holistic and inclusive approach from the outset. Again, this reinforces existing guidance such as our incident management policy, though it is recognised this approach must not be restricted to only those incidents that meet a threshold of harm or predefined categories. We will continue to promote, support and encourage our colleagues and partners to report any incident or near-misses, with a shift in focus to incidents, or groups of incidents, which provide the greatest opportunities for learning and improvement.

It is recognised that this new approach will represent a culture shift for the organisation which needs to provide support and guidance utilising the principles of good change management, so staff feel 'part of' rather than 'done to'. We will therefore ensure regular communication and involvement through our communication framework and our wider organisational governance structures.

It is also recognised that staff and colleagues need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame. We will continue to closely monitor incident reporting levels and continue promote an open and just culture to support this.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

As a Trust we welcome this approach so we can focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improving safety. It is also recognised that our planning needs to account for other sources of feedback and intelligence such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. PSIRF guidance specifies the following standards that our plans should reflect:

- A thorough analysis of relevant organisational data
- Collaborative stakeholder engagement
- A clear rationale for the response to each identified patient safety incident type

They will also be:

- Updated as required and in accordance with emerging intelligence and improvement efforts
- Published on our external facing website

Our associated patient safety incident response plan (PSIRP) will reflect these standards and will be published alongside this overarching policy framework.

Resources and training to support patient safety incident response

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. It is therefore essential that as an organisation we evaluate our capacity and resources to deliver our plan. The PSIRP provides more specific details in relation to this including the number of comprehensive investigations that may be required for single or small groups of incidents that do not fall into one of the broader improvement workstreams/priorities.

Currently the Patient Safety Team has the following working time equivalent posts to support and facilitate the PSIRF framework:

- 1 x Patient Safety Specialist
- 1 x Patient Safety Lead
- 1 x Patient Safety Facilitator
- 1 x Datix Manager
- 2 x Medical Devices Officers
- 2 x Administrators
- 0.2 x Datix Admin Support

There is also a pool of trained investigators who can undertake comprehensive investigations, though the majority have a substantive clinical or governance role, so therefore must be allocated time within job plans to complete investigations. Again, our PSIRP will detail more specifically which incidents will require a comprehensive investigation with an indication of how many of these we expect to complete in a year.

All staff are required to complete mandatory patient safety training which covers the basic requirements of reporting, investigating and learning from incidents. The national patient safety syllabus training at level 1 (awareness) is available via the Trust Learning Hub. It is expected that operational managers will involve all relevant staff in more routine / low risk incident reviews, though further advice and guidance can always be provided by the Patient Safety Team if required. It is important that the organisation seeks regular feedback from colleagues with regard to investigating and learning from incidents and considers whether any additional or bespoke training is required, either more widely or targeted at specific staff groups or individuals.

Our patient safety incident response plan

Our plan (PSIRP) sets out how we intend to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

The PSIRP is based on a thorough analysis of themes and trends from all incidents from 2019-2022 (including low harm, no harm and near misses), complaints and concerns, learning and recommendations from Serious Incidents (conducted under the previous framework), mortality reviews, legal claims and inquests, risks and risk registers and feedback from staff and patients. The priorities identified in the PSIRP will be regularly reviewed against quality governance reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

Reviewing our patient safety incident response policy and plan

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

Updated plans will be published on our website, replacing any previous versions.

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

Responding to patient safety incidents

PSIRF guidance states:

"Where an incident type is well understood – for example, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness – resources may be better directed at improvement rather than repeat investigation (or other type of learning response)."

(PSIRF supporting guidance, Guide to responding proportionately to patient safety incidents. NHSE 2022)

Patient safety incident reporting arrangements

Patient safety incident reporting will remain in line with the Trusts Incident Management Policy. It is recognised that staff must continue to feel supported and able to report any incidents, or concerns in relation to patient safety, to promote a system of continuous improvement and a just and open culture.

Operational managers and governance teams will ensure any incidents that require cross system or partnership engagement are identified and shared through existing channels and networks, and that partnership colleagues are fully engaged in investigations and learning as required. Likewise, we will ensure we are responsive to incidents reported by partner colleagues that require input from the Trust, primarily by directing enquires to the relevant clinical teams or colleagues and seeking assurance that engagement, information sharing and learning has been achieved, or taken forward.

Certain incidents require external reporting to national bodies such as HSSIB, HSE, RIDDOR and MHRA. Please refer to the Trusts SOP for *Managing and Investigating Incidents to and from External Organisations* for full details and guidance.

Patient safety incident response decision-making

As explained above, reporting of incidents should continue in line with existing Trust policy and guidance. The Trust also has governance and assurance systems to ensure oversight of incidents at both a Care Group and Organisational level. Governance teams work with clinical and operational managers to ensure the following arrangements are in place:

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends or clusters of incidents within a specific service
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risks and issues (eg – CQC concerns)
- Identification of any incidents requiring external reporting or scrutiny (eg – Never Events, Neonatal deaths)
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures

The Patient Safety Team, with support from a Business Analyst, also provide regular reports to quality and safety committees using statistical process control (SPC) analysis on a monthly basis to identify and track emerging themes and trends outside of normal variation. This information will be reviewed regularly against our identified priorities in the PSIRP to determine whether any shift in focus is required, which will be agreed by the Quality Oversight Group if required.

Following the introduction of PSIRF a Patient Safety Incident Review (PSIR) to determine any further investigation or escalation will not be required. Completing a PSIR will effectively 'double up' a review which is not in the spirit of PSIRF. Instead Care Groups will have the authority to determine the response it considers most appropriate. Guidance on selecting these responses will be available to all Care Groups within the suite of supporting materials; and discussions at the weekly Quality and Safety Group will provide a 'sounding board' as the new processes become embedded. The principles of

proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under the Trust's PSIRP. This may sometimes mean no further 'investigation' is required, especially where the incident falls within one of the improvement themes identified in the PSIRP.

It is recognised that some incidents may still require a case based comprehensive investigation, like a Serious Incident investigation under the old framework. The criteria for such will be defined in policy and guidance. Where this is the case, reference must be made to available investigatory capacity and resources as detailed in the PSIRP.

Timeframes for learning responses

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

"The first step when embarking on a process to learn and improve after a patient safety incident is to make efforts to understand the context and develop a deep understanding of work processes. It can be tempting to rush to identify what needs to change, but this cannot be done without understanding work as done, and the system factors that influence this. A thorough understanding of the work system can be gained using a learning response method such as investigation, multidisciplinary team review or after action review, supplemented with a system-based framework to guide thinking (eg SEIPS, Yorkshire Contributory Factors Framework, HFACS, etc)." (NHSE PSIRF Guidance: Safety Action Development, p17)

One of the most important factors in ensuring timeliness of a learning response is thorough, complete and accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team. These principles are set out in the current incident reporting guidance but must be reinforced through the PSIRF.

The PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident. Highly prescriptive timeframes for learning responses may not be helpful so the following are included as a guideline only:

- Learning response **hot debrief / swarm huddle** – as soon as possible, preferably before the end of the shift when the incident occurred
- Review of Datix incident report - within 5 working days of reporting

- Learning response **after action review** – within 10 working days of the event
- Learning response **pathway review** – within 50 working days of event or identification of a theme needing further exploration
- Learning response **Patient Safety Incident Investigation**: 60-120 working days depending on the complexity

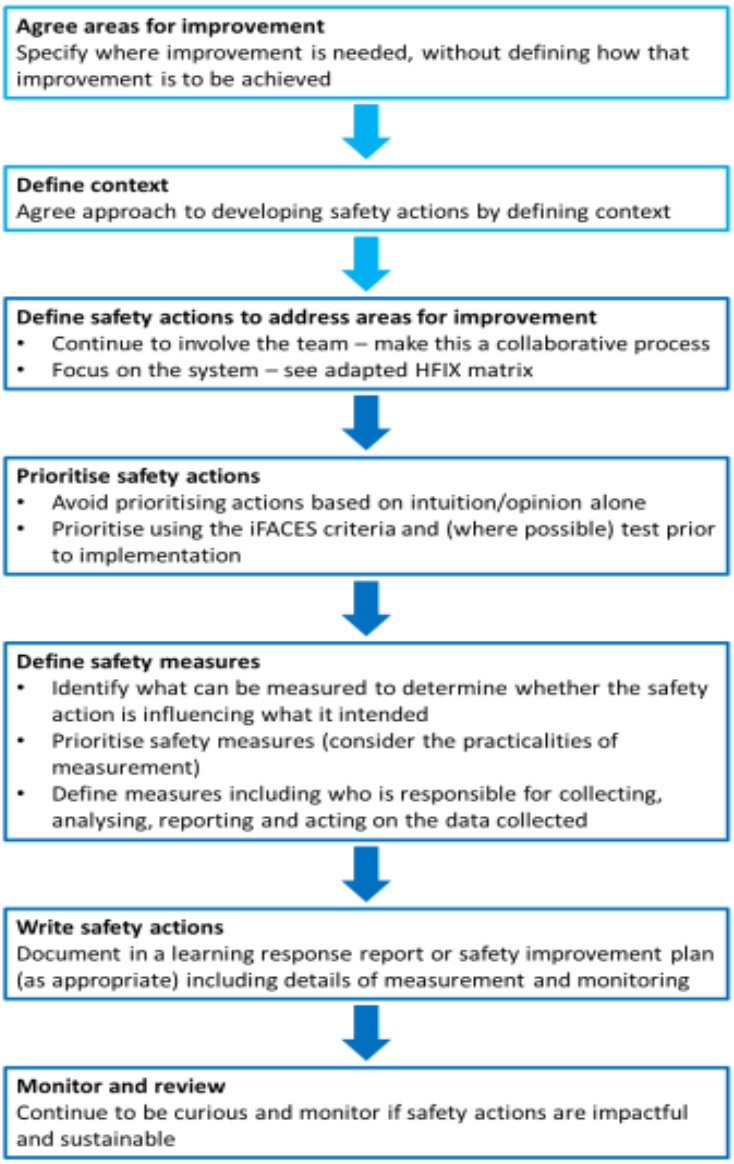
A toolkit of learning response types is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

Safety action development and monitoring improvement

PSIRF moves away from the identification of 'recommendations' which may lead to solutionising at an early stage of the safety action development process.

"Learning response methods enable the collection of information to acquire knowledge. This is important, but it is only the beginning. A thorough human factors analysis of a patient safety incident does not always translate into better safety actions to reduce risk. You must move from identifying the learning to implementation of the lessons. Without an integrated process for designing, implementing, and monitoring safety actions, attempts to reduce risk and potential for harm will be limited."

The following diagram summarises how safety actions should be developed and overseen:



A Quality Improvement approach is valuable in this aspect of learning and improvement following a patient safety incident learning response. It will therefore be necessary to ensure close links are developed and maintained with the Quality Improvement Team so their expertise and guidance can be utilised when developing the learning response and safety actions. This approach is recognised within the Trust and considerable work has taken place to educate colleagues in the principles of QI methodology. PSIRF therefore provides an opportunity to strengthen this and for the QI and Patient Safety functions to work more closely together.

Safety actions arising from a learning response should follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and thought must be given to monitoring and measures of success. Further guidance on this can be found in NHSE

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

Monitoring of completion and efficacy of safety actions will be through organisational governance processes with oversight at Care Group level reporting corporately to the Quality Oversight Group. The Patient Safety Team will maintain an overview across the organisation to identify themes, trends and triangulation with other sources of information that may reflect improvements and reduction of risk.

It is important that monitoring of completion of safety actions does not become an end in and of itself, but rather a means to improve safety and quality outcomes and reduce risk. The Trust must therefore develop governance systems focused more on measuring and monitoring these outcomes, utilising subjective as well as objective measures.

Safety improvement plans

As referred to throughout the policy, the Trust has developed a Patient Safety Incident Response Plan (PSIRP) that clarifies what our improvement priorities are. The PSIRP details how we will ensure patient safety incidents are reviewed in a more holistic and inclusive way, to identify learning and safety actions which will reduce risk and improve safety and quality.

These themes, as detailed in the PSIRP, are based on an extensive analysis of historic data and information from a range of sources (eg: incident trends, complaints, mortality reviews, risk registers, legal claims and inquests) and feedback from staff and patients. Each theme will have its own improvement plan utilising QI methodology, where appropriate, to determine what the key drivers are to patient safety risks, how improvements can be made and how these can be monitored for completion and effectiveness. Whilst the PSIRP identifies the broad organisational priorities, it is recognised there may be more specific priorities and improvements identified at a Care Group, Specialty and Sub-specialty level, which although will not form part of the overarching plan, can still be approached utilising the more holistic and inclusive PSIRF approach. The Patient Safety Team will provide support and guidance, as required, to services and Care Groups in this regard. The QI team can also assist in these improvements and identify where there is overlap with existing and developing QI programmes across the Trust.

The Trust has reviewed governance processes and taken account of the PSIRF guidance so it is clear how the PSIRP improvement priorities will be overseen through Care Group and Corporate governance structures and processes. The organisational charts are shown within the PRIRP. Care Group and Specialty level improvements will be managed locally with assurance and reporting to Care Group, then, Corporate oversight and assurance committees to provide 'ward to board' assurance.

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 (eg 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)

Responsibility for oversight of the PSIRF for provider organisations sits with the Trust Board. The Executive Leads are the Medical Director and Chief Nurse who hold joint responsibility for effective monitoring and oversight of PSIRF. The 'Responding to patient safety incidents' section above also describes some of the more operational principles that underpin this approach.

The Trust recognises and is committed to close working, in partnership, with the local ICB and other national commissioning bodies as required. Representatives from the ICB will sit on PSIRF implementation groups. Oversight and assurance arrangements will be developed through joint planning and arrangements must incorporate the key principles detailed in the guidance above, namely:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Policy, planning and governance

- Competence and capacity
- Proportionate responses
- Safety actions and improvement

As referred to above, it is important that under PSIRF there is a paradigm shift from monitoring of process, timescales and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients. It should be noted that similarly the ICB's role will focus on oversight of PSIRF plans / priorities and monitoring progress with improvements. There will no longer be a requirement to 'declare' a serious incident and have individual patient safety responses 'signed off' by commissioners. However, they will wish to seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety.

The metrics, measures (objective and subjective) and evidence of improvement are linked intrinsically with the terms of reference, driver diagrams and intentions of each improvement group (PSIRF priorities or otherwise), as per best practice according to QI methodology. Monitoring via the committee structures shown in the PSIRP, supported by graphical outcome data (also shown in Board reports), will enable the effectiveness of improvement plans to be evaluated.

Complaints and appeals

Any complaints relating to this guidance, or its implementation can be raised informally with the Trust Patient Safety Specialist, initially, who will aim to resolve any concerns as appropriate.

Formal complaints from patients or families can be lodged through the Trust's complaints procedure at https://www.yorkhospitals.nhs.uk/contact-us/patient-experience/complaints/