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available to the Coroner, our commissioners, the police and other agencies if appropriate. For this reason the report does not include the patient's name or details to protect his/her privacy. The report will not be placed in their medical records.

Sometimes even after investigation there is no clear cause found or it may be that what happened couldn't have been avoided. An investigation will usually find things that we can learn from to help to improve the service that we provide.

We want to learn from what has happened and do everything that we can to make care safer for all our patients.

Contact details for advice and support

Patient Advice and Liaison Service (PALS)– provides confidential information, advice and support for patients and carers about the Trust's services.

St Richard's Hospital: 01243 831822
Worthing Hospital: 01903 285111

Trust's Patient Safety Team;
WSHFT Trust Headquarters:
01903 205111 Ext. 84583

Action for Victims of Medical Accidents (AVMA)- provide a support network and can put patients and their families in contact with other people in their area or with alternative

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organisations and support groups
www.avma.org.uk

Cruse Bereavement Care – provides information and support to anyone affected by a death.
Tel: 0870-1671677
www.crusebereavementcare.org.uk

Sussex Interpreting Service
www.sussexinterpreting.org.uk

ICAS
National Independent Complaints Advocacy Service - 0845 600 8616
Tel: 01892 540490
website www.seap.org.uk e-mail tunbridgew.icas@seap.org.uk

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"Our commitment to you when something goes wrong"

Marianne Griffiths
Chief Executive

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BN11 2DH

At Western Sussex Hospitals NHS Foundation Trust, we put our patients first.

Keeping patients safe is our most important responsibility and we want to do everything we can to ensure that we cause no harm.

Sometimes though, patients do suffer harm while in our care. This can be due to a complication of a procedure that couldn't be avoided or sometimes due to a mistake or error. For the vast majority of patients, any harm caused can be put right or is only minor in nature. A very small number of patients may suffer more serious or permanent harm.

We have given you this leaflet following our recent discussion with you because you or a member of your family has been harmed.

We have a strong philosophy of openness because we recognise that this is the way to show respect to our patients, deliver safe care and learn from any incidents that cause our patients harm.

All of our staff are trained to report any incidents - from very minor errors to more serious incidents. An investigation is then undertaken to look into what happened.

The type of investigation that we do in most cases is called Root Cause Analysis (RCA).

Root Cause Analysis

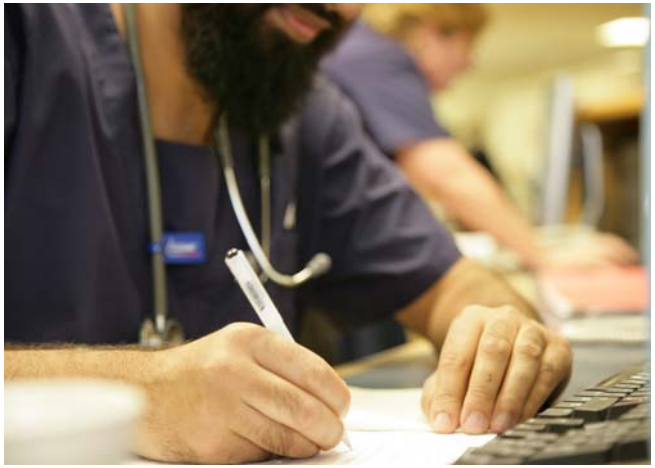
The RCA will look at the details surrounding the incident step-by-step, including for example what is written in the medical notes and what staff may remember. The report will also consider whether there were any staffing or equipment problems or training issues.

The person investigating should be able to pinpoint what caused the incident and to decide if anything could have prevented it. Actions can then be taken to try and stop it from happening again.

What does this mean for you?

A lot of information has to be obtained and it can take up to 12 weeks to investigate what happened and to produce a report.

We may not be able to provide you with answers until the whole investigation has concluded. Please be assured that we will be open and honest with you at all times, During this time, if you need support you can contact us here at the Trust or if you prefer, there are a number of independent groups. Contact details are included in this leaflet.



Once the investigation is finished, you will be able to have a copy of the report. We can either post this to you with a letter or meet with you first to go through the findings and then give you a copy of the report.

It is important to note though that because this is a formal report, it can appear a little impersonal in how it is written. This is because the report needs to be structured and factual in order to see exactly what happened. The individual patient and the impact of what happened to them is always our focus throughout the investigation

Although the RCA report is used mainly by the Trust itself, the report may also be made