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Patient Safety Incident Response Plan

2025/28

City Health Care Partnership CIC

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Contents

Introduction

The Patient Safety Incident Response Plan (PSIRP) sets out how City Health Care Partnership (CHCP) Community Interest Company (CIC) will respond to patient safety incidents during 2025-2028.

Our plan details our patient safety incident profile and the tools and methods the organisation will use to respond proportionately to patient safety incidents to support continuous learning and improvement, ensuring that there is compassionate engagement with all involved in patient safety incidents. Utilising systems-based methodologies will allow us to apply a greater focus on contributory and causal factors to identify the effectiveness of systems and where improvements are needed.

The Patient Safety Incident Response Framework (PSIRF) focuses on the following in response to patient safety incidents:

- Compassionate engagement and involvement of those affected
- Adoption of a range of system-based methods to learning from patient safety events
- Proportionate responses
- Oversight to support system improvement.

Whilst our plan sets out our priorities and approach, there may be changes during this period. We will remain flexible, consider the specific circumstances in which patient safety incidents occur, how we respond to our services and focus on the needs of those affected.

Underpinned by our governance processes, our PSIRP will support us in measuring how effective our responses are to patient safety incidents and how we can continue to learn and improve as well as creating and sustaining a safe and just culture for our staff.

The scope of PSIRF and CHCP vision

Improve the working **environment** for staff in relation to their experiences of patient safety incident response

chcp

Vision:
Lead and inspire through excellence, compassion and expertise

Mission:
Deliver high quality care through colleagues who are competent and motivated

Values:
Service and Excellence/
Equality and Diversity/
Creativity and Innovation/
Co-operation and Partnership

Improve the use of valuable healthcare resources

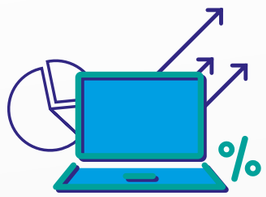
Improve the experience for **patients**, their families and carers affected by patient safety incidents

Our services

CHCP is an independent "for better profit" co-owned business providing a wide range of health and care services. We provide over 50 services to people in Hull, East Riding of Yorkshire, and Merseyside.

Operational services

- Medicines services
- Nursing and conditions
- Therapies and rehabilitation
- Care coordination hub
- Integrated urgent care
- Psychological well-being
- Sexual health
- Public health
- GP practices
- Dental services



The list is not exhaustive and further information about CHCP can be found at www.chcpcic.org.uk

Developing our patient safety incident profile

A key part of the PSIRF approach is to understand the patient safety activity CHCP has undertaken in the last year within the reporting period from March 2024-March 2025 inclusive. This will support us in how we will learn from patient safety incidents.

CHCP used a thematic analysis approach to identify our patient safety profile and our patient safety priorities.

- Analysis of learning responses
- Incidents reported via the organisation incident reporting system
- Key themes from complaints/concerns/comments/claims/inquests
- Themes from incidents with statutory requirements such as safeguarding, Learning Disability Mortality Review (LeDeR) and freedom to speak up reports
- Case-note reviews
- Staff survey results
- Health inequalities data
- Risk assessments
- Annual quality report
- National patient safety data: The number of patient safety incidents recorded in Q3 2024/25 decreased by 0.3%. In contrast the number of patient safety incidents in Q4 2024/25 increased by 0.6%. Despite the changes observed in the number of incidents recorded, the trends remain unchanged. The majority of incidents are recorded as low or no physical harm to patients in both Q3 (93.7%) and Q4 (93.7%). (See below statistics link).

[Statistics » Quarter 3 2024/25 (October to December 2024)]

CHCP patient safety profile March 2024 – March 2025 (inside CHCP care)

- Pressure ulcer cat 3/4 **0**
- Incidents **3,765**
- Medicines **952**
- Communication **484**
- Information governance **414**
- Health and safety **544**
- Reportable adult deaths **21**
- Safeguarding **81**
- Inquests **10**
- Never events **0**
- Concerns **536**
- Clinical governance **168**
- Complaints **173**
- Patient safety incident investigation **0**

Learning responses/tools

- Rapid review **15**
- After action review **15**
- MDT review internal **2**
- MDT review external **2**
- Tabletop exercise external **1**
- Service safety action plans **24**

Our safety profile themes and trends identified in our quality report show that the top three categories for incidents identified both inside and outside CHCP were pressure ulcers, medicine and communication. The top three categories (and sub-categories) reported for inside CHCP incidents continue to be medicine management, communication and clinical governance.

There were 21 adult deaths reported. Of the 21 adult deaths which relate to the statutory notifications, 6 deaths although unexpected were unavoidable and 15 were within the bedded units or patient homes where the death was expected with a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form for end-of-life care and advanced care planning in place.

Analysis of learning responses

Table 1: After action review/MDT meeting's

PSIRF Category	Total	Learning themes
Pressure ulcers	5	Link to pressure ulcer tools on the patient electronic health care record. Skin/assessment. Documentation specific to dressing types and regime. Medical device equipment and advice. Holistic and risk assessment improvement. Workload and task allocation review. Referral onwards.
Information governance	2	Patient registration guidance. Mail merge process guidance. System email address monitoring. Review of video and conferencing and working from home policy.
Patient falls (health and safety)	2	Falls team referral. Mobility risk assessment. Medication reviews. Ergonomics – estates to redesign electrical points for falls equipment.
Unintended outcome of treatment or procedure (clinical governance)	4	Systems process and procurement of equipment. Patient health check template. Gp to GP transfer process. Workload – redesign clinical admin slots. Safety huddle introduction. Administration process clarity for document management and timescales.
Medication	2	Procurement of keyless/secure medication trolleys. Stock check management.
Implementation of care on patient pathway (clinical governance)	4	Overall pathway/holistic assessment and risk assessment reviews inclusive NEWS monitoring, visual patient checks, fluid input and output monitoring, health concern escalation, nutritional and dietician referral. Personalised management plans. Safety huddle introduction.

Our quality improvement and service transformation work

Through identification of themes and trends from our safety profile, existing workstreams are in place for quality improvement and service transformation work.

2024-25 transformation work identified from safety actions:

Falls

- Falls Risk Analysis Tool for the assessment of bed suitability, a tool intended for Trusted Assessors to enable the appropriate identification of beds for falls patients within the bedded units. This includes patients admitted both from hospital and home. Red/amber/green zones for clearer identification of potential fall patients.
  This tool will be used for staff to carry out an appropriate falls assessment on admission and outlined in the Management of Falls in the Bedded Units Standard Operating Procedure
- Care home testing and pilot "Safe to move triage tool"
- Stroke patients in bedded units have alarm pendants that can be worn around the neck as well as larger red buttons to alert staff when assistance is needed. Formal handover sheets have been devised alerting staff to those patients who have been identified as a falls risk
- Introduction of new falls equipment and sensor mats which will be linked to buzzer alert systems
- Daily falls huddle
- Individual patient televisions with electric cable none trip hazards
- Hull and East Riding Falls and Fracture Liaison Service lessen the risk of falls by enabling patients to make simple changes to their home providing aid and adaptions
- Respect form/Advance care planning – bespoke individualised plan to consider escalation to hospital.

Information governance

- Over the past year we have been working on the development of the Business Continuity Plan (BCP) in services covering cyber security and undertaking cyber table top exercise
- There will be an emphasis on strengthening cyber networks and educating staff on cyber scams
- Data Protection Security Toolkit achievement
- IG newsletter which is circulated by Chief Executive officer blog
- Review of our Artificial Intelligence (AI) Policy in line with Fit for the Future NHS ten-year plan - using AI as part of treatment to improve clinical outcomes, data protection assessments
- Information Security training and achieved compliance.

Pressure ulcer

- A move to community equipment services to enhance the provision of pressure ulcer care
- Implementation of patient centred care pressure ulceration pathway - the Purpose T Pressure Ulcer Risk Assessment Tool /alignment of management plans/review the integrated wound assessment templates adding SSKINg, TIME, equipment, body map, and self-management
- Incident reporting system update to include final approver pressure ulceration investigation lines of enquiry
- Organisational pressure ulcer training
- Pilot for Practice Nurses to order pressure reliving prevention equipment.

Medication

- Non-Medical Prescribing updates and training (NMP) available via our Learning Portal. Prescribing logs will be completed annually and be discussed in clinical supervision and professional development reviews with evidence to line managers
- PRN (when required) protocol document and process trial in the bedded units
- Transcribing Standard Operating Procedure to enable expansion of the number of medications that can be transcribed and the addition of palliative care medication
- NMP students learning/coursework organisational support sessions
- NMP forums for peer support, supervision and discussion which feed into NMP working group. QI, prescribing competence and data
- Introduction of Medicines Safety and Governance for Health Care Assistants (HCA)
- Retraining of staff in bedded area on Transcribing, Controlled drugs and Medicines administration. Introduction of crib sheets checklist for managers
- Introduced British National Formulary app training
- Updated all medicines training around measuring of controlled drugs (CDs) liquids using a conical measure and the meniscus line
- Re-training of all staff in Sunshine house on CDs
- Introduced second checker training for HCAs – to cover expectations, roles, and responsibilities when checking medication
- Updated transcribing training for special school
- Medicines administration training re-written in line with guidance and incident learning
- Introduction of self-locking medication trolleys and CCTV installation
- Medication keys held by one person who sign the keys in and out.

National requirements

PSIRF offers flexibility in what CHCP will appropriately and proportionately identify as incidents to investigate and allows us to prioritise improvement efforts rather than repeatedly responding to and reviewing incidents based on subjective thresholds.

CHCP acknowledge that there are nationally mandated events where a Patient Safety Incident Investigation (PSII) must be undertaken or reported via national platforms, and we will ensure that these are reported appropriately.

Table 2: National requirements that require a response:

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria **E.g., wrong site surgery, maladministration of insulin resulting in death or severe harm**	PSII	Create local organisational actions and improvement plans and feed these into the quality strategy and Integrated Quality Forum, Safe Quality Services Committee and Safety and Quality meetings
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII)	PSII	Medical examiner/Learning from deaths. Create local organisational actions and improvement plans and feed these into the quality strategy and Integrated Quality Forum, Safe Quality Services Committee and Safety and Quality meetings
Deaths of persons with learning disabilities	LeDeR	As per requirement of the case. Create local organisational actions and improvement plans and feed these into the quality strategy and Integrated Quality Forum, Safe Quality Services Committee and Safety and Quality meetings
Safeguarding Incidents where adults or children are on a child protection plan/looked after plan or a victim of wilful neglect or domestic abuse/ violence or are in receipt of care and support needs from their local authority or incidents that relate to female genital mutilation, prevent, modern slavery and human trafficking	Refer to CHCP/ Local Authority Safeguarding Lead	As per requirement of the case. Create local organisational actions and improvement plans and feed these into the quality strategy and Integrated Quality Forum, Safe Quality Services Committee and Safety and Quality meetings
Healthcare acquired infections (HCAI)	Refer to CHCP Infection Prevention and Control (IPC) Practitioners and Director of Infection Prevention and Control	As per requirement of the case. Create local organisational actions and improvement plans and feed these into the quality strategy and Integrated Quality Forum, Safe Quality Services Committee and Safety and Quality meetings.

Local focus

Our local priorities for PSII have been set out that defines patient safety incident's requiring a comprehensive investigation response (Table 3). Whereby an unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff, or organisations.

Criteria for selection of incidents within CHCP CIC care for:

a. Actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)

b. Likelihood of recurrence (including scale, scope and spread)

c. Potential for learning in terms of: – enhanced knowledge and understanding – improved efficiency and effectiveness (control potential) – opportunity for influence on wider systems improvement.

The next tables detail the different methodologies that we will use to undertake investigations and reviews including the incident types in which they can be used to support learning and improvement.

To ensure our staff are adequately trained to use these different methodologies, we have undertaken a training needs analysis. This will allow us to continuously ensure that our staff have the knowledge and skills to successfully utilise these methodologies and maximise learning opportunities.

Table 3

Incident type	Investigation response	Response links
Diagnostic incident including delay in care resulting in severe or above harm	PSII	Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Sub-optimal care of a deteriorating patient resulting in severe or above harm	PSII	Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings

Where an incident does not fall into any of the categories above an investigation and/or review method described in table 4 may be used.

Table 4: Sets out patient safety themes and investigation review options:

Incident type	Incident review method options	Learning response	Response links
Harm identified in the improvement plan and service transformation work: • **Falls** • **Pressure ulcers (category 3 and 4)** • **Medication errors** • **Information Governance (IG)**	Service SWARM After Action Review (AAR) MDT review Thematic review	One page learning response method	Update on quality improvement programmes Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Abuse/alleged abuse of adult patient by third party. Neglect, Safeguarding. **We will be guided by the Multiagency Safeguarding Hub on the level of review/ investigation and Investigating officer**	Service SWARM SAR LeDeR AAR MDT review Thematic review	One page learning response methods Statutory investigation	Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Healthcare-Associated Infections (HCAI). **We will be guided by Infection Prevention and Control Practitioners (IP&C) and Director of Infection Prevention and Control**	Service SWARM After Action Review (AAR) MDT review Thematic review	One page learning response methods Statutory investigation	Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Service level determined reviews **E.g. communication; missed appointments.** **Emergency situations**	AAR MDT	One page learning response method	Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Moderate and above harms	4 working days for Rapid Review to determine: Service SWARM AAR MDT review	One page learning response method	Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Cluster of near miss, no/low harm	Thematic review	Thematic review	Thematic review report and improvement plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Potential patient safety risks/themes	Thematic review	Thematic review	Thematic review report and improvement plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Joint/System Partner Learning	SWARM After Action Review (AAR) MDT review Thematic review	One page learning response method	Thematic review report and improvement plan Safe Quality Services Committee
Learning from best practice	AAR Thematic review	One page learning response method	Thematic review report Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings

Table 5: Description of planned response options to a patient safety incident:

Planned response to a patient safety incident	Aim
Multi-disciplinary (MDT) review	MDT reviews support learning from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of incidents either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s), to agree the key contributory factors and system gaps that impact on safe patient care.
Service Swarm huddle	To be initiated as soon as possible after an incident and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk with immediate effect to mitigate reoccurrence of the same thing happening in future.
AAR	A structured facilitated discussion of an incident, the outcome of which gives individuals involved in the incident 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. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the incident? What is the learning.

CHCP local requirements

We will continue to use existing governance structures to support the process of PSIRF. The responsibility for selection of the most appropriate level of patient safety review will be delegated to services with governance oversight and will be led locally by staff who have undertaken the PSIRF training.

PSII's for both local and national priorities will commence as soon as possible after the patient safety incident.

Duty of Candour

At CHCP every healthcare professional will be open and honest with patients their families and carers when something goes wrong with their care and offered an apology. An apology is not an admission of guilt and is the right thing to do. It also supports the learning process from identifying that things have not gone right or as planned and mitigate against recurrence.

CHCP will always apologise to patient, families, and their carers if something has gone wrong that has caused harm.

Further information can be found in our Duty of Candour Policy which is available in the document management system My Compliance.

Involvement and support for patients, their families and carers

The patient, family and carers voice are vital for learning from incidents and putting actions into place to prevent reoccurrence. They should be viewed as credible sources of information in response to any patient safety incident. Engagement and involvement will be individual and adapted to changing needs. These needs could be practical, physical, or emotional.

Discussions will be had with those affected about the structure of engagement and involvement. There will be a duty of care to everyone involved in the incident and subsequent response and opportunity provided for open communication and support. All communications will clearly describe the process and its purpose to ensure understanding.

An investigation process that is collaborative and open with information, and provides answers, can reduce the chance of litigation where they feel this is the only route to be heard.

Involvement and support for staff

Patient safety incidents are usually signs of underlying systemic issues that require wider system level action. Action singling out an individual is rarely appropriate.

By treating staff fairly, the NHS can foster a culture of openness, equity and learning where staff feel confident to speak up when things go wrong. (See NHS England "Being Fair" link below).

NHS England » Being fair tool: Supporting staff following a patient safety incident

The personal and professional impact that a patient safety incident can have on staff can be detrimental; providing them with appropriate support is crucial. We will identify support for our staff and have clear signposting to pathways to achieve this.

We will continue to promote a "just culture" and an open reporting culture where staff are without fear of being blamed. We will ensure that we are consistent and fair when staff report an incident or is providing their insights into care of a patient for investigation. We will actively encourage a safe space to discuss the incident, explore the system in which they work and listen openly without judgement.

CHCP's policy on involving staff and the support available to them can be found on the document management My Compliance.

Patient safety partners

The NHS Patient Safety Strategy (July 2019) recognises the importance of involving patients, their families and carers and other lay people in improving the safety of NHS care and this is a priority for the NHS.

Patient Safety Partners (PSPs) are patients, carers, family members or other lay people who join and work in partnership with organisations and its staff to improve its patient safety culture. With aspiration of recruiting to PSP by 2028 to ensure compliance with the National Patient Safety Strategy. This will be achieved through PSPs being embedded within the organisational Integrated Governance Strategic Framework, engaging PSPs within our established committees, groups, and forums or equivalent, where they can provide appropriate challenge, contribute to the development of organisational policies, and play a crucial part in how patient safety issues should be managed. We will engage proactively with our Service User Voice (SUV) existing members to promote the PSP role and welcome the opportunity to work with them in improving safety.

Our Quality Improvement approach

Our key function is to embed a culture of continuous Quality Improvement (QI) rooted in evidence-based, high-quality care working across systems and teams to facilitate support, tools, and resources.

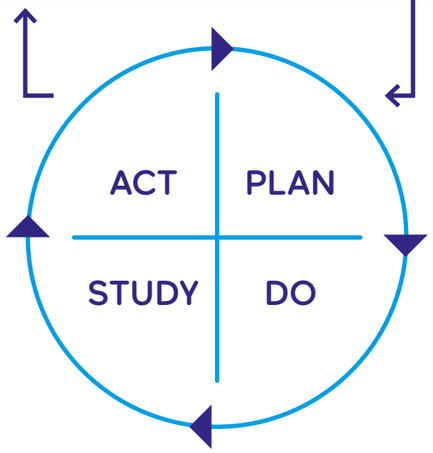
The methodology we use is the Plan, Do, Study, Act (PDSA) Model for improvement to support our QI programmes. We are committed to continue QI programmes and implement QI programmes arising from patient safety investigations, identification of themes as well as improvement priorities.

Model for improvement:

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in an improvement?



Oversight governance structure

Oversight under PSIRF focuses on engagement and empowerment rather than more traditional command and control. We will work in collaboration with our commissioners and regulators where oversight will enable us to demonstrate continuous improvement rather than compliance against Key Performance Indicators.

In collaboration with our ICB colleagues, CHCP are committed to delivering on the following standards:

- Policy, planning and oversight: Our patient safety incident response policy which describe the systems and processes to facilitate learning and improvement following a PSII.
- Competence and capacity: Learning response leads, those leading engagement and involvement as well as those in oversight roles will have specific knowledge and experience. They will apply human factors and system thinking principles to gather information from a wide range of sources.
- Engagement and involvement of those affected by patient safety incidents: Those affected by PSII's will be led by individuals with a specified level of training. Duty of candour principles will be upheld.
- Proportionate response: Patient safety learning responses will begin as soon as possible after the incident has been identified and are conducted for the sole purpose of learning, identifying improvements that reduce risk, prevent reoccurrence which do not determine liability or blame.

Internal and external oversight structure is described below:

Humber and North Yorkshire (HNY) Safety Improvement from Learning Outcomes Group (SILOG)

Reporting Arrangement: This group will report into HNY ICB PSIRF oversight meeting. HNY ICB PSIRF oversight meeting reports formally, with a chairs report, to the HNY ICB Patient Safety Committee. The Chairs report from HNY ICB PSIRF meeting will include a summary of activity in the SILOG.

HNY Quality Committee
HNY Patient Safety Committee
HNY ICB PSIRF Oversight Meeting

SILOG

SILOG will maintain relationships with the Place Quality Groups in HNY and the System Quality Group.

Learning from SILOG proactive harm reduction/ safety improvement will be shared internally

External ICB Representation

Learning from Patient Safety Incident Meeting

Meet monthly

Oversight of completed PSII and learning responses/QI plans/QI data

Executive Board:

Overall responsibility, assurance, and sign off.

Safe Quality Services Committee:

To provide Executive Board oversight of all PSIRF related activity.

Assurance on QI programmes.

Monitors risks.

Integrated Quality Forum:

Escalates to Safe Quality Services Committee.

Monitors risks.

Updates on ongoing PSIRF development, systems and quality priorities.

Receive assurance patient safety review completion.

Safety and Quality Forum:

Summary of incidents/service improvements.

Operationalise learning from incidents.

Patient Safety Oversight Meeting:

Meet weekly

Co-opt operational services.

Oversee all learning responses, QI programmes.

Review moderate and above harm incidents, level of investigation, shared learning.

Review development of PSIRF.

Patient Safety Specialists

In 2024 Our Patient Safety Specialists (PSSs) have completed the Patient Safety Syllabus programme delivered by Loughborough University in collaboration with NHS England Workforce, Training and Education.

The programme is delivered through a blended learning programme which covers all content of the NHS Patient Safety Syllabus level 3 and 4. This was the first cohort and modules included unpacking system issues, managing patient safety risks, understand the culture, legal, and regulatory factors, involving those affected and designing solutions.

Our PSSs support CHCP CIC governance in ensuring that reviews, management, investigation and monitoring of learning from incidents. They work closely with patient safety incident reporting and investigations in supporting the timely and appropriate reporting, recording, investigating and coordination of incidents. They are responsible for ensuring risks and trends from incidents are escalated through the risk management process. Any learning is included in our Quality Reports and reported to Safety and Quality Forums, Integrated Quality Forum, Safe Quality Service Committee and The Executive Board.

Glossary

CQC – Care Quality Commission

The CQC regulates all the health and social care services in England

LeDeR – Learning Disabilities Mortality Review

LeDeR is a national service improvement programme looking at the lives and deaths of people with a learning disability and autistic people. The programme aims to improve care, reduce health inequalities, and prevent premature mortality.

Never Event – Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at national level and have been implemented by healthcare providers

PDSA – Plan, Do, Study and Act model for improvement

PSII – Patient Safety Incident Investigation

A system-based response to a single patient safety incident or cluster of incidents for learning and improvement and to understand any system factors that contributed to the incident. Typically, a PSII includes four phases: planning, information gathering, synthesis, and interpreting and improving

PSIRF – Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRP – Patient Safety Incident Response Plan

CHCP plan – In response to the framework. It describes what is being done to prepare for "go live" with PSIRF and what comes next. These have been developed by analysis of local data.

SILOG – Safety Improvement from Learning Outcomes Group

SIF – Serious Incident Framework

Framework to manage reporting of serious incidents. Is being replaced by PSIRF.

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Kurdish
ئەگەر حەز دەکەیت ئەم بەڵگەنامەیەت بە زمان یاخود شێوازێکی دیکە بەدەست بگات وەک شریتی دەنگ، چاپی گەورە یاخود برایل (هەڵنوقیو)، تکایە تەلەفۆن بکە بۆ 01482 347649.

Mandarin
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Arabic
"إذا كنت ترغب في الحصول على هذه الوثيقة بلغة أخرى أو بتنسيق مختلف مثل شريط صوتي، أو طباعة بحروف كبيرة أو بطريقة "برايل"، يرجى الاتصال على الرقم: 01482 347649".

Russian
Если вы хотите получить этот документ на другом языке или в другом формате (на аудио кассете, большим шрифтом или шрифтом Брайля), пожалуйста, позвоните по 01482 347649.

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