PATIENT SAFETY INCIDENT RESPONSE PLAN

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Document History

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Document Status

This is a controlled document. Any printed copies of this document are not controlled.

Contents

1. INTRODUCTION

This plan supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out OSD Healthcare's (OSDH) 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.

2. PURPOSE

This patient safety incident response plan (PSIRP) sets out how OSDH will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide.

This plan supports 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.

3. SCOPE

The PSIRP is a mandatory requirement applicable to all providers or group/network of providers delivering NHS-funded care. This plan should be read in conjunction with the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which outlines the rationale for developing this plan. In collaboration with local commissioners, OSDH has obtained approval in the development of the planning aspects of this PSIRP.

The primary aim of this PSIRP is to foster a culture of learning and improvement in patient safety incident responses. It strives to enhance the effectiveness of these responses continuously. To ensure the plan's continued efficacy, it undergoes annual reviews and necessitates approval from the OSDH Board and local commissioners.

The PSIRP is specifically tailored to address patient safety incident responses with a primary focus on learning and improvement. It adheres to a systems-based approach, recognising that patient safety emerges from interactions between components within the healthcare system, rather than attributing incidents solely to individual actions or inactions. The plan intentionally avoids adopting a 'person-focused' perspective that solely attributes incidents to notions of 'human error.'

Aligned with the objective of learning and improvement, the PSIRP refrains from assigning blame or determining liability, preventability, or cause of death. Processes such as claims handling, human resources investigations, professional standards inquiries, coronial inquests, and criminal investigations serve distinct purposes in addressing these matters. These processes fall outside the scope of the PSIRP, as their aims differ from those of a patient safety response.

4. RESPONSIBILITIES

4.1 Chief Executive Officer

The Chief Executive Officer (CEO) has responsibility for:

- the effective management of all patient safety incidents, including contribution to cross-system/multi-agency reviewed and/or investigations where required.
- modelling behaviours that support the development of patient safety reporting, learning and improvement system.
- ensure that systems and processes are adequately resourced including; funding, management time, equipment and training.

4.2 Associate Director of Quality and Governance

The Associate Director of Quality and Governance (ADQG) is the lead responsible person for supporting and overseeing the implementation of PSIRF and includes:

- Ensuring processes are in place to support an appropriate response to patient safety incidents (including contribution to cross-system/multi-agency reviews and/or investigation where required).

- Oversee development and review of OSDH's PSIRP.

- Agrees sufficient resources to support the delivery of the PSIRP (including support for those affected, such as named contacts for staff, patients, families and carers where required.

- Ensures that OSDH complies with the national patient safety investigation standards.

- Establishes procedures for agreeing patient safety investigation reports in line with the national patient safety investigation standards.

- Develops professional development plans to ensure that staff have the training, skills and experience relevant to their roles in patient safety incident management.

- Act as the Being Open Lead

4.3 The Quality Surveillance Group (QSG)

The QSG is the operational group that sits weekly, and its responsibilities are to:

- Ensure that patient safety investigations are undertaken for all incidents that require this level of response (as directed by the OSDH PSIRP)

- Develop and maintains local risk management systems and relevant incident reporting systems to support the recording and sharing of patient safety incidents and monitoring of incident response processes.

- Ensure that OSDH has procedures that support the management of patient safety incidents in line with OSDH's PSIRP (including convening review and investigation teams as required and appointing trained named contacts to support those affected).

- Establish procedures to monitor/ review investigation progress and the delivery of improvements.

- Work with others to address identified weaknesses/areas for improvement in OSDH's response to patient safety incidents including gaps in resource including skills and training.

- Support and advise staff involved in the patient safety incident response.

4.4 The Corporate Assurance and Ethics Group

The Corporate Assurance and Ethics group will receive a report at each meeting of the organisation's progress against this PSIRP.

4.5 The Governance Committee

The Governance Committee has responsibility for reviewing the incident management function. The Governance Committee reports to the Corporate Assurance and Ethics Group and provides assurance on reports/evidence received. Where there are concerns about the robustness of actions identified, or the progress on implementation, the Chair of Governance Committee will seek assurances from Heads of Department that risks are being adequately addressed. Where there are remaining concerns these will be escalated to the Corporate Assurance and Ethics Group.

4.6 Lead Investigators

- Ensure they are competent to undertake the investigation assigned to them and if not request it is reassigned.

- Undertake patient safety investigations and patient safety investigations related duties in line with latest national guidance and training.

4.7 The Being Open Lead

The 'Being Open Lead' is responsible for:

- Meeting with patient, families and carers involved in a patient safety incident to explain what has happened, the investigation taking place and provision of contact detail;
- Hearing the patient/family account of the incident from their perspective and gathering any questions they would like the review to answer;
- Ensuring that the patient has been provided with appropriate on-going support;
- Documenting the details of all discussions with the patient (and/or carer), copies of letters relating to the patient safety review ensuring this documentation is uploaded to the relevant incident record on the OSDH Risk Management System;
- Keeping in close communication with the patient, family and/or carer as per their wishes. Contact will also take place following the conclusion of the investigation to share the findings, lessons learned, and actions being taken.

4.8 Freedom to Speak Up Guardians (FTSU Guardians)

The primary responsibility of the FTSU Guardians are to provide a confidential channel for employees to voice concerns, report issues, or raise grievances related to patient safety, workplace culture, or any other matters of concern. They act as intermediaries between employees and management, ensuring that whistleblowers or those with concerns are protected from retaliation and that their feedback is appropriately addressed.

By promoting a safe environment for open communication, Freedom to Speak Up Guardians help organisations identify and rectify problems, ultimately contributing to improved patient care and a healthier workplace culture.

4.9 Heads of Department and Team Leads

- Encourage reporting of all patient safety incidents including near misses and ensure all staff in their area is competent in using the OSDH Risk Management System and are provided sufficient time to record incidents and share information.
- Provide protected time for training in patient safety disciplines to support skill development across the wider staff group.
- Provide protected time for participation in investigations as required.
- Liaise with the Governance team and others to ensure those affected by patient safety incidents have access to the support they need.
- Support development and delivery of actions in response to patient safety investigations that relate to their area of responsibility (including taking corrective action to achieve the desired outcome)

4.10 All staff

- Understand their responsibilities in relation to OSDH's PSIRP.
- Know how to access help and support in relation to patient safety incident response process.

5. OSDH SERVICES

OSDH is a private hospital located in Hemel Hempstead, established in August 2016. OSDH's regulated activities include:

1. Family planning services
2. Treatment of disease, disorder, or injury
3. Surgical procedures
4. Diagnostic and screening procedures

The hospital has 12 consultation and treatment rooms, a purpose-built gym for physiotherapy and rehabilitation, four dental suites and specialist diagnostic imaging department.

The following services are provided to patients:

- GP (General Practitioner) service

- Diagnostic imaging: including CT (Computed Tomography), MRI (Magnetic Resonance Imaging), X-ray, US, and Mammography
- Dental service: including CBCT and 3D implant diagnostics
- Outpatient minor procedures and phlebotomy
- Outpatient consultations with Consultants across a wide range of specialties
- Physiotherapy

The Day Case Unit comprised of:

- Two integrated theatres with laminar flow
- Four recovery bays
- Nine bed day case ward all of which are en-suite individual rooms

Services are supported by an onsite pharmacy.

6. STRATEGIC AIMS

The aims of this PSIRP are to:

- Enhancing Patient Safety Incident Responses: The strategic aim of the Patient Safety Incident Response Plan (PSIRP) is to enhance and optimise patient safety incident responses within the organisation. By implementing this plan, we aim to improve our ability to effectively address incidents and mitigate potential risks.

- Fostering a Culture of Learning and Improvement: A key strategic aim of the PSIRP is to foster a culture of continuous learning and improvement. We strive to create an environment where all stakeholders actively engage in learning from incidents, sharing insights, and implementing changes to prevent future occurrences.

- Embracing a Systems-Based Approach: Our strategic aim is to adopt a systems-based approach within our patient safety incident responses. By recognising that patient safety is an emergent property of the healthcare system, we focus on understanding the interdependencies and interactions among various components to identify areas for improvement.

- Eliminating Blame and Liability Determination: As part of our strategic approach, we aim to eliminate the culture of blame and the determination of

individual liability within the PSIRP. By shifting the focus from assigning blame to promoting learning and improvement, we create an environment where individuals feel safe to report incidents and contribute to organisational growth.

- Collaborating with Local Commissioners: We aim to collaborate closely with local commissioners in the development and implementation of the PSIRP. By seeking their input and gaining their approval, we ensure alignment with regional objectives and priorities, fostering a coordinated and cohesive approach to patient safety incident responses.

- Continuous Evaluation and Improvement: Our strategic aim involves the regular evaluation and improvement of the PSIRP. We commit to annual reviews to assess its effectiveness, make necessary adjustments, and ensure it remains in line with evolving best practices, regulatory requirements, and organisational goals.

By focusing on these strategic aims, OSDH aim to strengthen patient safety incident response capabilities, promote a culture of learning and improvement, and ultimately enhance patient safety outcomes within our organisation.

7. STRATEGIC OBJECTIVES

The strategic objectives of this PSIRP are to:

- Standardise Incident Response Procedures: Develop and implement standardised incident response procedures, ensuring that all staff members are trained and equipped to effectively respond to patient safety incidents. This objective enhances our ability to address incidents promptly and consistently.

- Establish Reporting Mechanisms: Implement user-friendly and confidential incident reporting mechanisms that encourage and facilitate the reporting of incidents. By promoting a reporting culture, OSDH increase the availability of data for analysis and learning.

- Enhance Incident Analysis and Investigation: Improve incident analysis and investigation processes by adopting robust methodologies, tools, and resources. This objective ensures a thorough examination of incidents, identifies root causes, and enables the extraction of valuable insights for learning and improvement.

- Develop Learning Initiatives: Implement learning initiatives, such as training programmes, and knowledge-sharing platforms, to foster a culture of continuous learning and improvement. By providing opportunities for staff to acquire new skills and knowledge, we empower them to contribute effectively to patient safety and incident response.

- Promote Open Communication and Collaboration: Encourage open communication channels and collaborative platforms to facilitate the exchange of ideas, insights, and best practices among staff members, patients, and other stakeholders. This objective encourages a collective approach to learning and improvement.

- Provide Resources for Professional Development: Allocate resources and support staff members in their professional development journey. This objective includes offering opportunities for specialised training, conferences, and access to relevant literature and research materials.

- Engage with Local Commissioners: Establish strong partnerships with local commissioners to ensure alignment of objectives and priorities. Regular communication and collaboration will enable the sharing of best practices and the identification of opportunities for joint initiatives and improvement efforts.

- Monitor and Evaluate Performance: Establish a robust monitoring and evaluation framework to assess the effectiveness of the PSIRP. Regularly review incident response outcomes, analyse trends, and seek feedback from stakeholders to identify areas for improvement and drive ongoing enhancement.

By implementing these strategic objectives, we will enhance patient safety incident responses, foster a culture of learning and improvement, and continually refine our practices to achieve better patient safety outcomes.

8. THE OSDH PATIENT SAFETY INCIDENT RESPONSE PLAN: NATIONAL REQUIREMENTS

It is nationally recognised that there are challenges and issues related to patient safety incident investigation (PSII) within the wider healthcare sector. Despite the dedicated and professional staff, errors and incidents can occur, leading to harm for patients and affecting the morale of clinical teams. Incidents also result in additional costs due to lost time, extra treatment, and litigation. However, it is also recognised that most incidents are caused by system design issues rather than individual mistakes.

In the past, healthcare providers have focused on investigating incidents with severe outcomes, but it was found that a more effective approach to organisational learning is needed. The openness to report patient safety issues has led to an overwhelming number of incidents requiring investigation, straining available resources and hindering the actual safety improvement work.

The current remit for patient safety incident investigation has become too broad, making it challenging to achieve the original aim of learning from incidents. Many other sectors, such as aviation adopt various approaches to incident investigation, with some using risk-based methods and others setting parameters for decision-making processes.

To improve learning and continuous improvement in patient safety, it is recognised that we must remove barriers in healthcare and increase the quality of future PSIIs. Healthcare organisations should be conducting PSIIs purely from a patient safety perspective, reducing the number of investigations into the same type of incident, and aggregating learning from similar repeat incidents. This approach allows healthcare organisations to address common safety issues and prioritise them accordingly.

It is recognised that other incidents requiring other types of investigation and decision-making lie outside the scope of this work and will be referred to the relevant organisations e.g. professional conduct, establishing liability, or cause of death.

9. THE OSDH PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL FOCUS

9.1 Results of a review of activity

Patient safety incident investigation activity January 2020 to December 2022.

	2020	2021	2022
Never Events	0	0	0
Serious Incident Investigations	0	2	0
Other RCA Investigations	1	2	3

Incidents which have been reviewed as part of a multi-agency approach.

	2020	2021	2022
	0	2	1

9.2 Patient safety incident response skill – gap analysis

To meet the requirements of the new NHS National Standards for Patient Safety Investigation OSDH must:

- Provide an additional training programme for Executive Directors
- Provide access to update training for current staff who provide the incident investigation oversight function on use of updated analytical tools, and new Risk Management and Oversight system.
- Provide access to update training for existing investigators or investigation teams/staff in specific areas.

This will include:

- Application of updated analytical tools to support PSII
- Report writing and use of the national PSII report template
- Identify an appropriate training provider for training new investigators of PSII's to the standard required by PSIRF(e.g. minimum of two days).
- Produce new documentation for patients, families and staff members involved in patient safety incidents and ensure they are available on a public-facing area of our website

10. RISK ANALYSIS

The patient safety incident risks for OSDH have been profiled using organisational data including:

- Incident Reports: Two years of data has been reviewed and a thematic analysis undertaken.
- Risk Register: The OSDH Risk Register was reviewed, with a focus on risks related to patient safety and this was triangulated with incidents and complaint themes.
- Complaints: Complaint themes were reviewed, and a thematic analysis undertaken which was triangulated with other data sources.
- Audit outcomes and recommendations were reviewed, and the themes triangulated with other data.

With new services being delivered and existing services being extended during the next 12 months this review also highlighted areas which OSDH wished to prioritise for PSII investigations.

Key stakeholders have been consulted throughout the process and will continue to be consulted with including:

- NHS Commissioners

- Members of Staff
- Hospital Directors
- Specialist Advisors
- Consultants with active Practicing Privileges

10.1 Local patient safety risk profile

The table below lists the local patient safety risks that fall within the national priority areas.

	National Priority	Incident Type	Department
1	Never Events	All	All
2	Learning from Deaths	Where a patient death is thought more likely than not to be due to problems in care	All
3	Safeguarding Incidents	All	All

The table below identifies the criteria for defining the top local patient safety risks.

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

The current top ten local priorities/risks as identified via the analysis described above are presented in the table below:

	Incident Type	**Description**	**Department**	**Planned Response**
1	Clinical Assessment. (Diagnosis, Scans, Investigation, Tests)	Incidents reported from the Imaging service with regards to imaging of patients and sharing of results or breach of reporting timeframes.	Imaging	After Action Review

2	Infection	All instances of healthcare acquired infections, breach of IPC practices and outbreak events.	All	HCAI Review and Duty of Candour (if appropriate following discussion with lead clinician)
3	Clinical Assessment (Diagnosis, Scans, Investigation, Tests)	Failure to respond in a timely way to VTE, or NEWS risk assessments/patient deterioration resulting in harm.	Ward, Theatre, Imaging, dental, endoscopy, UTC and OPD	PSII
4	Consent, Confidentiality or Data Protection	Incidents which have resulted in a delay or other impact on patient due to documents being uploaded to wrong record.	All	Structured judgement review
5	Extravasation	Any incident of reported Extravasation	Imaging	Thematic review
6	Medication	Any incidents reported relating to prescribing, dispensing and or administrating resulting in patient harm	All	After action review and Duty of Candour (if appropriate following discussion with lead clinician)
7	Clinical Assessment. (Diagnosis, Scans, Investigation, Tests)	Incidents coming from outcome of health assessment and rapid access clinics with regards to patients timely onward referral or escalation of abnormalities	OPD	PSII

8	Patient falls	Any incident of a patient fall that lead to injury.	Ward	After action review.
9	Clinical Results (Diagnosis, scans, investigation & tests)	Incidents of patient recalls for imaging.	Imaging	Structured Judgment review
10	Consent, Confidentiality or Data Protection	Incidents relating to health records and consent issues resulting in harm to patient or organisation.	All	After action review and Duty of Candour (if appropriate following discussion with lead clinician)

10.2 Locally defined Responses

The table below defines the criteria for selecting risks for PSII response

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

Systemic risk	Complexity of interactions between different parts of the healthcare system

Based on the analysis and selection criteria described above, local priorities for PSII have been set by OSDH for the period 01.10.2023 to 01.10.2024

The priorities have been agreed at the OSDH Corporate Assurance and Ethics Group, and the Hertfordshire and West Essex ICB and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board, through their approval of this Plan.

Findings from the same narrowly specified incident types will be analysed for commonalities and opportunities for system improvement.

	Incident type	Description	Response type	Number of responses (if PSII)
1	Medication	Any incidents reported relating to prescribing and or dispensing resulting in patient harm	After action review	-
2	Extravasation	Any incident of reported Extravasation	Thematic review	-
3	Clinical Assessment. (Diagnosis, Scans, Investigation, Tests)	Incidents coming from outcome of health assessment and rapid access clinics with regards to patients timely onward referral or escalation of abnormalities	PSII	2
4	Clinical Assessment (Diagnosis, Scans, Investigation, Tests)	Failure to respond in a timely way to VTE, or NEWS risk assessments/patient deterioration resulting in harm.	PSII	2
5	Clinical Assessment. (Diagnosis, Scans, Investigation, Tests)	Incidents reported from the Imaging service with regards to imaging of patients and sharing of results or breach of reporting timeframes results.	After action review	-

10.3 Approach to local PSII selection

The OSDH Risk Management Oversight System will be utilised to alert the Governance team to when incidents are recorded matching the types identified for PSII.

Incident Description	Review	Sampling technique
Any incidents reported relating to prescribing and or dispensing resulting in patient harm	• After action review of 4 incidents. • Currently monitored at the Medicines and Medical Gases Quarterly Meeting	One incident per calendar quarter.
Any incident of reported Extravasation	• Thematic review of 20 incidents • Currently monitored at the Governance Committee and Clinical Audit and Effectiveness Group	Five per calendar quarter
Incidents coming from outcome of health assessment and rapid access clinics with regards to patients timely onward referral or escalation of abnormalities	• PSII • None yet occurred but would be monitored at the Governance Committee	All
Failure to respond in a timely way to VTE, or NEWS risk assessments/patient deterioration resulting in harm.	• PSII • None yet occurred but would be monitored at the Governance Committee	All

Incidents reported from the Imaging service with regards to imaging of patients and sharing of results or breach of reporting timeframes.	• After action review of 4 incidents • Currently monitored at the Governance Committee and Clinical Audit and Effectiveness Group	1 per calendar quarter.

10.4 Stages of the Patient Safety Investigation

The table below outlines the different stages of the investigation process and the resource required for each patient safety investigation. The exact resources required will depend on the specific incident.

Investigation stage	Responsibility
1. Plan the Investigation	
Appoint investigators who are trained, competent, have secure protected time and sufficient support. Inform and engage with the patient/family and staff involved in agreeing scope.	Quality Surveillance Group Lead Investigator
2. Gather and map the information (**What** happened)	
Identify the WHO, WHERE and WHEN of the incident. Identify WHAT happened. Map the incident timeline from the clinical record, incident report and/or complaint letter. Add further detail and achieve mutual understanding via meetings/interviews with the patient/family and staff involved	Lead Investigator

3. Identify Problems (**how** it happened and variations from what was expected to happen)	
Identify and reference good practice requirements (work as imagined) Identify the key problems arising	Lead Investigator/Subject Matter Experts
4. Analyse contributory and causal factors (**why** these key problems arose)	
Observe and discuss how work is routinely done. Search for contributory and causal factors for each key problem (deep-seated reasons WHY)	Lead Investigator
5. Write Investigation Report- with clarity, openness and in full consultation with patient/family and staff	
Write investigation report	Lead Investigator
6. Develop Recommendations and Action Plan	
Identify and develop strong systemic improvements. Develop action plan. Review effectiveness of actions/improvements in reducing or preventing repeat incidents	Lead Investigator Quality Surveillance Group

10.5 Timescales for patient safety incident investigation

10.5.1 Where a patient safety incident investigation for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified.

10.5.2 Patient safety incident investigation should ordinarily be completed within one to three months of their start date.

10.5.3 In exceptional circumstances, a longer timeframe may be required for completion of the Patient safety incident investigation. In this case, any extended timeframe should be agreed between the healthcare organisation and the patient/family/carer.

10.5.4 No local Patient safety incident investigation should take longer than six months. A balance must be drawn between conducting a thorough patient safety incident investigation, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. (Where the processes of external bodies delay access to some information for longer than six months, a completed patient safety incident investigation can be reviewed to determine whether new information indicates the need for further investigative activity.)

10.6 Nationally defined priorities to be referred for a patient safety investigation review by another team.

The nationally defined priorities for referral to other bodies or teams for review or patient safety investigation at the time of publication at the plan and relevant to the services that OSDH provide are:

- Safeguarding incidents:
  - Safeguarding incidents must be reported to the local organisations named professional/safeguarding lead manager for review/multi-professional investigation.

10.7 Nationally defined incidents requiring local patient safety incident investigation.

Nationally defined incident for local patient safety incident investigation are set by the PSIRF and other nation initiatives. These are at the time of publishing this plan:

- incidents that meet the criteria set in the never-events-list-2018
- incidents that meet the Learning from Deaths criteria that is, deaths clinically assessed as more likely than not due to problems in care.

11. SELECTION OF INCIDENTS FOR REVIEW

Some patient safety incidents will not require a patient safety incident investigation but may benefit from a different type of examination to gain further insights or address queries from patients, family, carers or staff.

Different techniques can be adopted depending on the intended aim and required outcome. OSDH will use the following techniques.

Technique	Method	Objective
Immediate safety actions	Incident recovery	To take urgent measures to address serious and imminent: a. discomfort, injury, or threat to life b. damage to equipment or the environment.
Being open' conversations	Open disclosure	To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.
Case record/note review	Clinical documentation review	To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues)
Structured Judgment Review for delays	Clinical documentation review	This approach will be used to assess delays in both thematic reviews and individual cases. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.
Debrief	Debriefing	To conduct a post-incident review as a team by discussing and answering a series of questions.
Safety huddle	Briefing	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: • improve situational awareness of safety concerns • focus on the patients most at risk • share understanding of the day's focus and priorities • agree actions • enhance teamwork through communication and collaborative problem-solving • celebrate success in reducing harm.
Incident timeline	Incident review	To provide a detailed documentary account of an incident in the style of a chronology

After-action review	Team review	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement.
Swarm Huddle	Team involvement	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
Thematic Review	Team involvement	A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative (e.g. open text contained in incident reports) rather than quantitative data to identify safety themes and issues.

Where incidents result in death the OSDH Learning from Deaths Policy GOV-07 will be activated.

12. PATIENT SAFETY INCIDENT REPORTING ARRANGEMENTS

The reporting of all incidents is essential so that, when things go wrong or could have gone wrong, we can learn and take action to reduce the risk of harm to patients and staff and improve the quality of our services.

All members of staff must report (or ensure that a colleague has reported) all incidents in which they are involved or become aware of.

Incident Reporting Systems are considered to be a major tool in the way the OSDH manage risks; their purpose is to:

- to ensure that all incidents/accidents (actual and near miss) are reported, recorded and managed.
- to prevent the recurrence of preventable adverse clinical and non-clinical events
- to provide 'early warning' of complaints/claims/adverse publicity
- to ensure that sufficient information is obtained:
    - to meet internal and external reporting requirements
    - to respond to complaints and litigation should these ensue.
    - for trend analysis which in turn is intended to facilitate the identification and 'learning of lessons' from incidents/mistakes made

The process of complying with both internal and external notification requirements for the reporting of patient safety related incidents can be found within the OSDH Incident Management Policy GOV-06.

13. PROCEDURE TO SUPPORT PATIENTS' FAMILIES AND CARERS AFFECTED BY PSI's

OSDH is open with patients and relatives when errors are made and ensures that the principles of Being Open and Duty of Candour (DoC) are applied and adhered to.

This is integral to the response to incidents, complaints, legal and safeguarding processes. Being open is part of a 'just" culture required of all healthcare providers and is fundamental to being a learning organisation.

The 'Being Open Lead' is the key contact for communications with patients, families and carers during a patient safety incident review.

The 'Being Open Lead' is responsible for:

- Meeting with patient, families and carers involved in a patient safety incident to explain what has happened, the investigation taking place and provision of contact detail;
- Hearing the patient/family account of the incident from their perspective and gathering any questions they would like the review to answer;
- Ensuring that the patient has been provided with appropriate on-going support;
- Documenting the details of all discussions with the patient (and/or carer), copies of letters relating to the patient safety review ensuring this documentation is uploaded to the relevant incident record on the OSDH Risk Management System;
- Keeping in close communication with the patient, family and/or carer as per their wishes. Contact will also take place following the conclusion of the investigation to share the findings, lessons learned and actions being taken.

OSDH is firmly committed to continuously improving the care and the services provided. There will be occasions when actions do not meet the expectations of patients, family members or carers. On these occasions OSDH aims to achieve a satisfactory resolution to concerns, comments and complaints and to learn from them to reduce the likelihood of recurrence.

National sources of support services are:

www.iscas.org.uk
Independent Sector Complaints Adjudication Service provides independent adjudication on complaints

www.patients-association.org.uk
The patients Association is an independent patient charity campaigning for improvements in health and social care for patients.

https://www.ombudsman.org.uk/
Parliamentary and Health Service Ombudsman makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

https://www.citizensadvice.org.uk/
Citizens Advice Bureau provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/
Learning from deaths – information for families explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy
The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints process.

14. PROCEDURES TO SUPPORT STAFF AFFECTED BY PSI'S

It is essential that with any PSI the staff involved are genuinely supported throughout the entirety of the process. It is well documented that staff that are involved in such incident are potentially a 'second victim' and clear procedures to ensure and escalate the appropriate support is pivotal to the developed PSIIRF.

In keeping with the ethos of 'just culture' staff should be informed as soon as possible that an incident they have been involved in is to be investigated as a PSI. Significantly a clear explanation of the 'how's and whys' the incident is to be investigated needs to be explained in a transparent way to ensure the staff are confident that the investigation is fair and appropriate.

The initial acknowledgement to staff is important and can 'set the tone' of the perceived investigation to follow in the eyes of the staff. Rather than being too prescriptive the initial contact should be based on 'best for staff' utilising local management knowledge of said individuals. A verbal and 'face to face' discussion with the staff should always be followed up with an 'individualised' written response to follow.

Key components that should be explained to staff at the onset and indeed reinforced in written follow up:

- Just culture
- Emphasis is on identifying organisational learning
- Staff to be provided with a copy of the national PSII standards to which the investigation will be completed
- Emphasis that their input / questions and contribution is pivotal to any investigation
- Shared understanding of the potential stress associated (staff should absolutely be provided with written evidence of support options available)
- Clear time frames explained (avoid the possible concern that periods of 'no news is bad news')
- Emphasis that there is no hidden agenda, transparency is key.
- Regular 'touch base' periods built into any investigation.
- Draft reports to be shared with staff to encourage feedback and promote the ethos of transparency.
- Final report to be shared and debrief arranged as required.

15. FREEDOM TO SPEAK UP

OSDH staff can contact their Freedom to Speak Up Guardians using the shared email address FTSUGuardian@osdhealthcare.co.uk, or by contacting the Guardians directly on their personal OSDH email or in person.

Concerns can be raised with Guardians either openly, where everyone involved will know the identity of the person raising the concern, confidentially, where only the Guardian will know the identity of the person raising the concern and will not share it without their consent or unless legally obligated, and anonymously, where no one will know the identity of the person raising the concern and their concern will be carried forward by the Guardian on their behalf.

16. MECHANISMS TO DEVELOP AND SUPPORT IMPROVEMENTS FOLLOWING PSIIS

At the conclusion of a Patient Safety Incident Investigation (PSII) the final report will be submitted to the QSG for discussion and agreement of the system improvement plan. The improvement plan will be agreed in collaboration with any existing plans in place. The Governance Team will facilitate cascade of relevant information across the organisation through various mediums including.

Improvement plans will be shared with the relevant Heads of Department to enable delivery of actions, monitoring, and evaluation of improvement outcomes. The Corporate Assurance and Ethics Group will be provided with update reports on progress.

The Governance Committee will have oversight and undertake monitoring of all improvement plans created following a PSII. The Governance Committee reports to the Corporate Assurance and Ethics Group. The group promote a positive culture of continuous learning and improvement.

Monitoring with audit should be undertaken when improvement plans are complete to ensure that changes are embedded and continue to deliver the desired outcomes. When changes have led to measurable improvements then these will be shared and implemented with other areas of the organisation and peer organisations, the following techniques can be used:

Technique	Method	Objective
Process audit	Audit	To determine whether the activities, resources and behaviours that lead to results are being managed efficiently and effectively, as expected/intended
Outcome audit	Audit	To systematically determine the outcome of an intervention and whether this was as expected/intended
Clinical audit	Outcome audit	A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes.
Risk assessment	Proactive hazard identification and analysis	To determine the likelihood of an identified risk and its potential severity (e.g., clinical, safety, business).

17. COMPLAINTS AND FEEDBACK

Patient experience and feedback offer learning opportunities that allows us to understand whether our services are meeting the standards we set and addressing patients' expectations and concerns. With these objectives very much in mind, we take all patient and stakeholder feedback very seriously, clearly identifying any lessons and using these to improve our service.

18. LEARNING FROM POSITIVE CARE AND FEEDBACK

When OSDH receives positive feedback from patients or customers, or staff members identify episodes of positive care OSDH will not only celebrate these successes but also analyse the underlying factors that contributed to the positive experience. By examining what went well, identifying best practices, and recognising

the individuals or teams responsible, the organisation can reinforce those behaviours and strategies.

Additionally, sharing these success stories and best practices across the organisation at the Patient Experience Quarterly Group can inspire others to replicate them, leading to a ripple effect of positive improvements. Moreover, positive feedback should be used as a source of motivation and affirmation for employees, reinforcing their commitment to delivering high-quality care or service.

Positive feedback is also shared at the monthly staff forum and on the morning situation report.

19. ASSOCIATED DOCUMENTATION

- Policy for the Managing and Reporting Incidents GOV–10
- Duty of Candour Policy CORP-06
- Complaints Management Policy CORP-05
- Patient Safety Incident Response Policy GOV-08

20. EQUALITY IMPACT ASSESSMENT

	Yes/No	Comments
1. Does the policy affect any group less or more favourably than another on the basis of:	No	
Gender	No	
Race	No	
Ethnic Origins	No	
Nationality	No	
Culture	No	
Religion or Belief	No	
Sexual Orientation	No	
Age	No	
Disability - learning disabilities, sensory, impairment and mental health problems, physical disabilities	No	This policy will be available electronically so the font and background colour can be adjusted to accommodate visual impairment.
2. Is there any evidence that some groups are affected differently?	No	
3. If you have identified potential discrimination, are there exceptions valid, legal and/or justifiable?	No	
4. Is the impact of the policy likely to be negative?	No	
5. If so can the impact be avoided?	N/A	
6. What alternative is there to achieving the requirements of the policy without impact?	N/A	
7. Can the impact be reduced by taking different action?	N/A	
8. Please list any staff training on equalities issues arising from this assessment.	N/A	

Completed by: Corrie Sellers, Associate Director of Quality and Governance Date: 31 January 2024

Equality Impact Assessed As (please highlight e.g.): Low Medium High