Patient Safety Incident Response Plan

2023

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Foreword

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as "a foundation for change" and as such, it challenges us to think and respond differently when a patient safety incident occurs.

Des Shiels – CEO and Senior Responsible Officer for implementation of our Patient Safety Incident Response Plan

Whether part of the Healthcare Regulator (CQC), an Integrated Care Board (ICB) or as part of a Provider organisation – we are all on a journey of learning when implementing this new Framework. As a small independent provider of elective surgical care, One Healthcare is excited about this opportunity to continue our journey of review and improvement, using this whole system change to think about how we respond when an incident happens and how we can prevent recurrence.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This new NHS Patient Safety Strategy challenges us to think differently about learning and what it means for us as a healthcare organisation. This plan and associated policies and guidelines will describe how it all works within One Healthcare.

Our patient safety incident response plan sets out how One Healthcare intends to respond to patient safety incidents over the next 12 to 18 months. The plan is not a permanent rule that cannot be changed. It will be reviewed frequently, as a minimum on an annual basis. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents have occurred and the needs of those who have been affected.

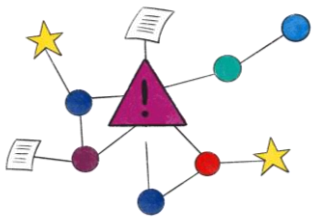
As the SRO for this implementation, I am confident that our corporate and hospital based corporate teams have worked hard over the last year to understand what this new way of thinking as to how we will adopt a more proportional patient safety response when things go wrong. We intend to enhance our engagement with both our staff and the patients affected by these events. We have undertaken several workshops over the last several months to understand our current patient safety profile. We have reviewed the last three years of our patient safety related data and feel sure we understand where our risks lie and therefore where we need to focus and target our efforts moving forward.

The patient and family voice is vital for both hospital learning from incidents and for putting actions in place to prevent them in the future. It is also key in finding closure, aiding recovery and healing of those involved in the incident together with their families.

We understand the value that Patient Safety Partners bring to under this new framework and will be working with our ICBs to see how we can recruit and effectively use this valuable insight.

*"**Accountability** can mean letting people tell their account, their story."* - Sidney Dekker

We are on an ambitious journey to ensure that One Healthcare is a safe and fair place, where everyone's voice is encouraged, valued and listened to, helping us to continually learn, inspire change and improve. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide. We look forward to the journey ahead.



Des Shiels, CEO/ Chairman
September 2023

Purpose and Scope

Purpose

This Patient Safety Incident Response Plan (PSIRP) sets out how One Healthcare will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of its work to continually improve the quality and safety of the care it provides.

This plan will help us measurably improve the efficacy of our local patient safety investigations (PSIs) by:

- Refocusing patient safety investigation towards the rigorous identification of interconnected causal factors and systems issues
- Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents
- Transfer the emphasis from the quantity to the quality of PSIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents
- Demonstrating the added value available from the above approach.

Scope

A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care. The document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2019, which sets out the requirement for this plan to be developed.

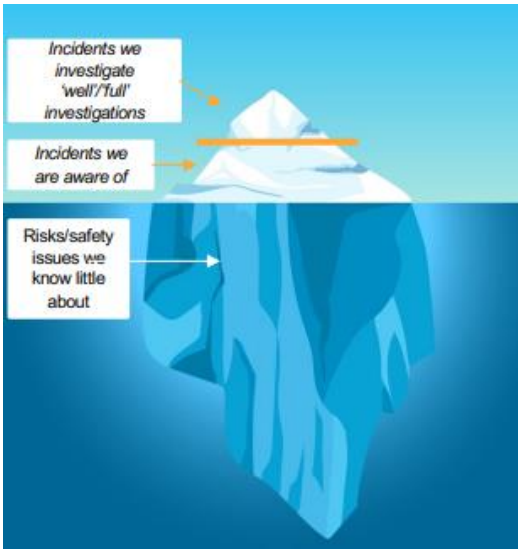
This first Patient Safety Incident Response Plan will apply to;

- One Ashford Hospital - Kennington Road, Willesborough, Ashford, Kent, TN24 0YS
- One Hatfield Hospital - Hatfield Avenue, Hatfield Business Park, AL10 9UA

There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of system learning and improvement. 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.

Responses covered in this Plan include:

- Patient Safety Incident Investigations (PSIIs)
- Patient Safety Reviews (PSRs)



Other responses to incidents exist for purposes other than learning. Examples include complaints, claims, human resource, professional regulation, coronial or criminal investigations. The aims of each of these responses differ and are outside the scope of this Plan.

To be effective in meeting their specific intended purposes, responses that are not conducted for learning and improvement are separate entities and will be appropriately referred as follows:

- Professional conduct/competence – human resource teams
- Establishing liability/avoidability – claims or legal teams
- Cause of death –coroner's office
- Criminal – police

We have developed the planning aspects of this PSIRP with the assistance and approval of the organisation's local commissioner(s). The aim of this approach is to continuously improve. As such this document will be reviewed annually to start with.

Aims and Objectives – Our Vision

Strategic aims

One Healthcare is proud to provide exceptional care, in a modern and comfortable hospital environment. In collaboration with our multidisciplinary teams, including specialist consultants, experienced healthcare professionals and support staff, the hospitals are able to maintain professionalism, effective decision making and positive attitudes to ensure excellence throughout the patient journey.

However, in complex healthcare systems, things can go wrong. We recognise the significant impact patient safety incidents can have on patients, their families and carers. We are confident that our organisations strategic objects reflect the underpinning ethos of the new Patient Safety Incident Response Framework.

Our Board (The One Healthcare Board) sets our **Strategic Objectives,** which focus on our patients, our people and our services.

Our patients

Create a culture of compassion, consistently providing safe, responsive, high quality care

Maintaining Regulatory compliance

Our people

Attract, retain and develop our staff and improve employee engagement

Providing services by staff who demonstrate our values and behaviours

Our services

Proactively seek opportunities to develop our services

Maintain financial health with appropriate investment in patient services

These align with the four strategic aims of the Patient Safety Incident Response Framework (PSIRF) upon which this plan is based.

PSIRF Strategic Aims

- **Improve the safety of the care we provide to our patients**
- **Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified.**
- **Improve the use of valuable healthcare resources.**
- **Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.**

This means that we will endeavor to:

- Act on feedback from patients, families and staff about the current problems with patient safety incident response and investigations.
- Develop a climate that supports a just culture and an effective learning response to patient safety incidents.
- Develop a local board-led and commissioner-assured architecture around patient safety investigation and alternative responses to patient safety incidents, which promotes ownership, rigour, expertise and efficacy.
- Make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents. The aim is to:
  - Make investigations more rigorous and, with this, identify causal factors and systemic improvements
  - Engage patients, families, carers and staff in investigation and other responses to incidents, for better understanding of the issues and causal factors
  - Develop and implement improvements more effectively
  - Explore means of effective and sustainable spread of improvements which have proved demonstrably effective locally.

Development of this plan

In November 2022, under the guidance of the SRO and Executive Lead, our senior leadership team at both corporate and hospital level undertook a day-long orientation and planning workshop. At corporate level, this team included our CEO, Group Medical and Clinical Directors and at hospital level this included out Hospital Directors, Directors of Clinical Services and our Quality and Risk Managers.

During the planning and development phase, members of the team have attended many external webinars (NHSE and IHPN delivered) to understand the specific requirements of each of the six implementation phases. The Group Clinical Director, as the Executive Lead for PSIRF, delivered a number of internal workshops with this team, during diagnostics & discovery, governance and quality, response planning and curation phases.

During July and August 2023, a number of the newly developed Learning Response tools have been 'tested' operationally by service level staff, so that One Healthcare could adapt our toolbox, to ensure the tools are easy for staff to use and effective in identifying service gaps and future quality improvement activities.

The draft Plan was shared with the whole of the implementation team, for their input and was then ratified through our corporate level Governance Committee on 21 August 2023, where approval was given for sign-off of the final draft with the Hertfordshire and West Essex ICB.

Systems overview of One Healthcare – Our Services

We have reviewed our local systems deployed at both hospitals, to understand the people who are in involved in patient safety activities across One Healthcare, as well as the systems and mechanisms that support them.

Our Board and committee tree is structured to monitor, manage and report governance and business activity. In particular - quality, standards, processes and action plans are developed, monitored, audited, reviewed and closed through these committees. Oversight includes detailed visibility of all incidents occurring within our operational services. To date our approach has included undertaking detailed Root Cause Analysis investigations, with a review of these reports and lessons learnt being undertaken through both our hospital and corporate level Governance Committees.

PSIRF has provided an opportunity for us to review our historic incident management and service improvement processes – and to learn how we can improve.

Following the publication of the new PSIRF by NHS England in late 2022, One Healthcare established a corporate PSIRF Implementation Team. As we are a small independent sector provider, our team is small and led by our SRO – Mr Des Shiels (CEO). Further corporate leadership comes from our Group Clinical Director who also is the Executive and Oversight Lead for implementation within the organisation. Local hospital level oversight and accountability lies with our two Hospital Directors, who will be directly overseeing the work of the Learning Responders and Engagement Leads on their sites.

We offer an extensive range surgical and non-surgical treatments and procedures at our two modern, purpose-built private facility.

Procedures can either be carried out on an inpatient, day case or outpatient basis, dependent on the particular treatment. Inpatient and outpatient care including:

Audiology	Elderly care	Imaging and diagnostics	Paediatrics	Respiratory
Cardiology	Endocrinology	Neurology Outpatient only	Pain management	Spinal surgery
Colorectal surgery	Gastroenterology	Neurophysiology	Private GP services	Urology
Cosmetic surgery	General surgery	Orthopaedics	Physiotherapy	Vascular surgery
Dermatology	Oral and maxillofacial	Renal services	Podiatry	Ear, nose and throat
Gynaecology				

The hospitals also provide specialist physiotherapy and outpatient diagnostic facilities including fast-track access to X-ray, MRI, ultrasound and access to CT.

During 2022, One Healthcare has undertaken a review and consolidation of a number of its governance systems and processes. By the nature of integrated governance systems, this activity has included the strengthening of several processes that impact patient safety. This laid some ground work for the implementation of the new Framework. Activities included:

- Updating our corporate Governance Framework and Strategy;
- Assessing our compliance with the Medical Practitioner Assurance Framework and thereby being better able to evidence our compliance with the recommendations resulting from the Paterson Inquiry;
- Implementing a new assurance framework around the management of our controlled drugs and strengthening our medicines optimization strategy;
- Reviewing our risk management processes and policy and expanding our group level Risk Register;
- Enhancing our Incident investigation process, subsequent reports and sharing of lessons learnt across the organisation. We have traditionally used a Root Cause Analysis approach.

Defining our patient safety incident profile

Moving to a new approach – the national picture under PSIRF

There are many ways an organisation can respond to a patient safety incident to learn and improve. Under PSIRF Patient Safety Reviews (PSRs) include several techniques that we can now use to identify areas for improvement, including immediate safety actions and responding to any concerns raised by the affected patient, family or carer.

Different PSR techniques can be adopted depending on the intended aim and required outcome. All PSRs will be conducted locally by our own organisation.

Under PSIRF Patient Safety Incident Investigations (PSIIs) are distinct from PSRs and include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents.

While most PSIIs are conducted locally by our organisation, some may be conducted independently. Some types of patient safety incidents have been identified as national priorities and require a specific response. (See appendix A)

All patient safety incidents leading to moderate harm or above and all incidents for which a patient safety incident investigation is undertaken may trigger the Duty of Candour requirements.

Once an incident that meets the **Statutory Duty of Candour** threshold has been identified, the legal duty, as described in Regulation 20 says we must:

- Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
- Apologise. For example, “we are very sorry that this happened”
- Provide a true account of what happened, explaining whatever you know at that point.
- Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
- Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
- Keep a secure written record of all meetings and communications.

Whatever patient safety incident response approach we use, we will continue to assess each individual event as it occurs as to whether the Duty of Candour requirements apply. We monitor and track this currently.

Understanding our capacity to respond to incidents enables us to be strategic in proactively allocating resources to responding to patient safety incidents that are not included in the list of national priorities.

This section outlines our approach to understanding our available resources, it describes how we are ensuring our resources meet standards required in the National PSII standards and details how much resource we have available to proactively plan how we will respond to key risks that fall outside national priorities.

Understanding our patient safety incident response activity

We have undertaken a review of our patient safety related activity for the last three years (2020 – 2022).

We use Datix as our electronic incident management system, although other manual systems of data collection have also been reviewed, for example our separate claims and complaints processes.

Table 1: Annual response activity (2020 – 2022)

Response type	Category	2020 - 2022
National priorities requiring patient safety incident investigation	Patient safety incident investigation into Never Events	2
	Mortality Reviews (including Structured Judgement Reviews)	Nil
	Incidents referred (to HSIB/Regional independent investigation teams (RIITs)/Public Health England(PHE)) for independent PSII	Nil
	Deaths of persons with learning disabilities	Nil
	Adult Safeguarding incident reviews • Safeguarding Provider Enquiry Reports • Independent Enquiry Reports • Serious Adult Case Reviews • Domestic Homicide Reviews • Joint Statutory Reviews Children's Safeguarding incident reviews • Child Safeguarding Practice Reviews • Domestic Homicide Reviews	No internal investigations 11 referrals to Local Authority Social Services teams
	Incidents in screening programmes	Nil
Patient safety incident investigations conducted locally	Coroner initiated patient safety incident investigations	1
	Serious Investigations – serious harm to patients	5
	Root Cause Analysis investigations	35
	CQC reportable incidents	9

Our current investigation process

Our current patient safety response processes relies heavily on senior clinicians, principally led by Directors of Clinical Services at each hospital. They are supported by the Quality and Risk Leads. Investigations or reviews are undertaken in their allotted management time. Our historic process has involved the use of Root Cause Analysis investigations when there has been moderate harm to service users or other concerns raised where learning can be identified. Investigations have been either concise or comprehensive, and are signed off at hospital and executive level. These reports and the learning for improvement that has been identified, are shared at our Hospital Level Governance and Medical Advisory Committee (MAC) meetings, with organisational learning achieved through sharing these outcomes at our Corporate Level Governance Committee. We did however consolidate our governance arrangements during 2022 in preparation for transitioning to the new system-based approach to incident response.

A thorough review of resources and training required to effectively implement the new Patient Safety Response Framework and to meet the requirements of the patient safety incident investigation standards has commenced but it is expected that this may take 12 – 18 months to fully achieve and embed.

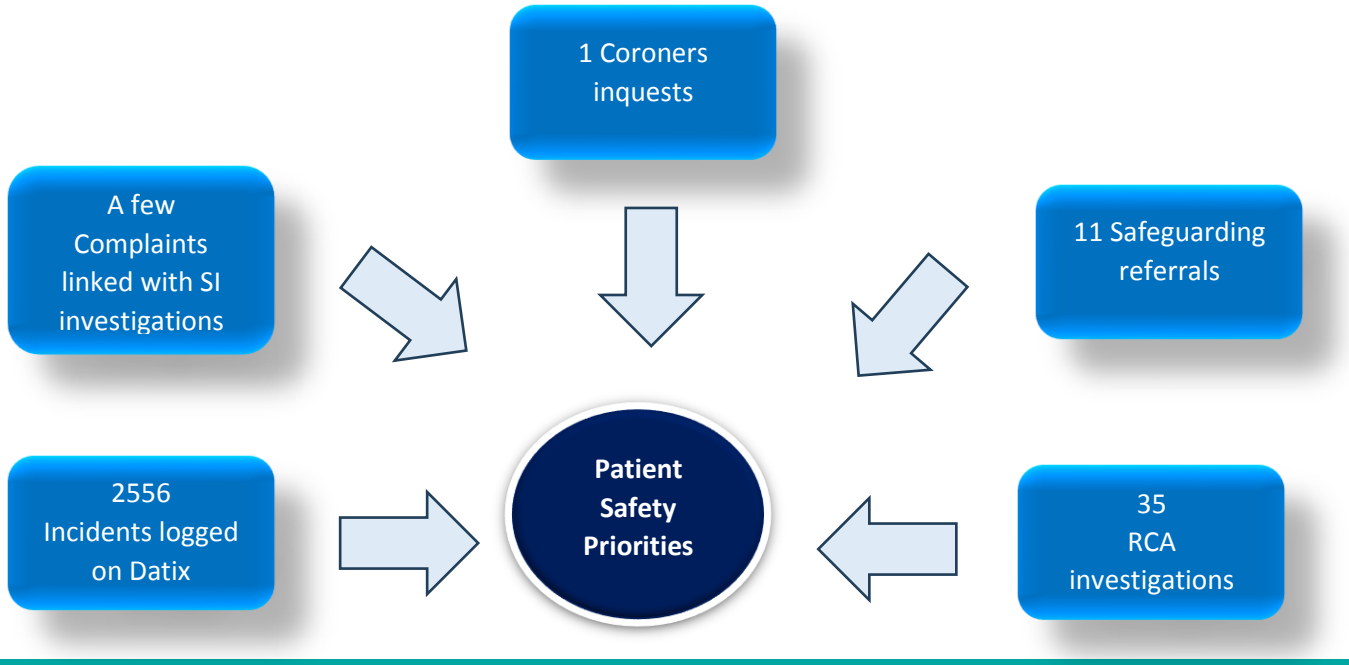
Patient safety incident response skills - gap analysis

A review of the resource and activity associated with the incident investigations for this period (2020-2022) has been undertaken to determine how many Patient Safety Incidents were reported and to anticipate how many PSII can be supported during 2023/24 and thereafter. This has involved a 2 stage process. We have undertaken a number of workshops to review the numbers and types and number of incident reviews that were undertaken and then used this data to identify our key patient safety priorities for 2023/24.

In order to meet the requirements of the new NHS National Standards for Patient Safety Investigation we will:

- Assign an appropriately trained member of the Executive Team to oversee delivery of the PSII standards and support the sign off of all PSIIs.
- Seek to ensure all relevant members of the corporate team/implementation team undertake the appropriate levels of training as specified within the National Standards.
- Ensure that for every Patient Safety Incident Investigation (national and local priorities) that a Response lead has been identified to lead the team through this specific process.
- Provide access to update training for current staff who are involved in the incident investigation function on use of updated analytical tools, use of improvement science approaches and utilization of the national report template.
- Provide access to update training for existing investigators or investigation teams/staff in specific areas
- 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
- Work with senior nursing staff and Heads of Departments to review the tools for Patient Safety Reviews (PSRs) to ensure they reflect current practice and analytical tools for the identification of all causal factors.

During 2020 – 2022 staff across the organisation were involved with:



Our Risk Profile – analysis of our patient safety data

We used a thematic analysis approach to determine which areas of patient safety activity would require our focus moving forward.

Our analysis used insights, beyond that of incidents which resulted in severe harm or death. The initial thematic review looked at patient safety activity between 2020 and 2022 from the following sources;

- Patient safety incident reports – Datix reports
- Complaints received
- Legal claims
- RCA investigations undertaken
- Notifications made to the CQC

- Quality Improvement initiatives
- Feedback from what our staff and service users have told us
- Areas of improvement identified by external assessors/auditors
- Areas of improvement identified through our internal audit processes

During this exercise we have also taken into consideration the services we provide and where demonstrated during this analysis, we indicate in the table below, into which services these patient safety priorities can be linked. This has particularly been informed by our historic CQC Inspection Reports and analysis of our incident data and complaints received.

We have determined that there are 8 patient safety priorities we will focus on for the next two years. These patient safety priorities form the foundation for how we will decide to conduct Patient Safety Incident Investigation (PSII) and patient safety reviews. The table below outlines themes identified and key risks within these themes and to which services these themes/priorities can be linked. Few of the patient safety priorities are particularly linked to any clinical specialisms.

	Key Themes	Key risks	Link to specific services
1	**Medicines incidents**	• Medication prescribing – errors/ outside of protocol/ wrong dose or frequency • Medication administration (e.g. without valid prescription)- dose or frequency/route • Documentation issues – errors or omissions • Medication dispensing issues/error • Medication supply issues • Medication reconciliation • Communication of side effects of medication • Antibiotic prescribing relating to AMS	Across all clinical services, in particular – within inpatient wards, theatre departments and diagnostic Imaging services. Also – focus on use of Controlled Drugs across all services
2	**Infections**	• Reportable deep SSI • Outbreaks • Trends identified in wound infections - same organism/surgeon/team/location/procedure • Notifiable infections and alert organisms that require reporting to UKHSA e.g. c.diff • Cases of identified sepsis – or initiation of the sepsis pathway	This safety priority is directly lied to our surgical services, with infections being identified in our Outpatient/Inpatient and Theatre services.
3	**Communication**	• Staff behaviour/conduct (including communication with consultants and their secretaries) • Communication with staff (clinical and non-clinical) in relation to appointment cancellations or rescheduling/difficulty in accessing services or consultant • Communication in relation to expectations of treatment/outcomes or experience • Incorrect or inadequate clinical information provided	This theme was identified across most services and specialties with no particular service having excessive issues. However, communication by our consultant staff with their patients and reception staff answering patient

		• Incidents relating to telephony systems whereby patients are unable to access hospital services for help or advice	queries were an area of focus.
4	**Administration processes**	• Delays in seeing consultant (booking appointments or actual consultations) – scheduling issues • Admin processes that cause cancellation on the day of surgery	This safety priority relates to a number of internal administration processes, but in particular to those systems and processes found within our booking and scheduling teams, where appointments are booked, including within our pre-assessments service.
5	**Clinical processes**	• Delays in accessing treatment • Failures in admission processes • Failures in discharge processes • Delays in obtaining results • Issues with pre-assessment processes – delays in obtaining results, issues with anaesthetic pre-assessment reviews • Intraoperative complications – e.g. fractures, cardiac events • Complications of surgery requiring further treatment including return to theatre or transfer into NHS • Extended LOS due to delayed discharge – unfit for discharge/ theatre overruns • Moderate and sustained injury – impacting outcome and quality of life • Cancellation on the day of surgery – clinically unfit/ unavailability of equipment or consultant • Failure of emergency call bell (Ascom) system potentially compromising the deployment of emergency support to medically deteriorating patients • Failure to follow patient safety checks e.g. WHO check lists, Imaging referral risk assessment checks • VTE events	This is one of the patient safety priorities that includes a larger number of different types of events. They relate to all our clinical services, but in particular can be linked to our Outpatient/Inpatient/ Theatre and preassessment services.
6	**Imaging incidents**	• Reportable over exposures • Incorrect exposures – breach of IRMER Regulations • Incorrect laterality • Issues with referral	This priority relates specifically to our Diagnostic Imaging Services

		• Issues with Safety Checks • Image Exchange Portal (IEP) issues	
7	**Documentation**	• Failure to access/unavailability of required medical records • Errors in documentation of clinical notes e.g. incorrect demographics • Failures in consultant and nursing staff documenting care provided in medical notes	This priority relates to all documentation of clinical care and treatment – so can be linked to all clinical services
8	**Equipment related incidents**	• Issues with surgical equipment – equipment breakage – retained fragments • Incorrect or inadequate decontamination processes • Poorly maintained and serviced equipment e.g. past life expectancy - arthroscopes	This priority may be identified in any service where medical/clinical equipment is used, but the look back exercise identified issues with surgical equipment and nasal endoscopes

Improvement work

Incident Management

We use Datix, the electronic incident management platform for logging and monitoring our incidents across the organization. In 2022, in order to enhance our focus on the more in-depth analysis of this rich data source, both hospitals recruited to a new post. The Quality and Risk Lead role provides the teams with the opportunity to maintain a up-to-date real time oversight of incidents occurring within all services.

Together with the Health and Safety Lead our Quality and Risk Leads have rolled out Datix training to large numbers of front line staff. This additional resource and training has been significant in improving the reporting culture and timely management and more detailed analysis and reporting of incidents through our hospital and corporate governance systems.

Controlled Drugs

In late 2022 and early 2023, we experienced two reportable incidents involving the safe management of controlled drugs. We undertook detailed investigations into both events with the support and advice from our local CD-LINs.
These incidents instigated a thorough review of all policies, standard operating procedures and practices relating to the ordering, storage and use of controlled drugs. A number of additional checks and security measures were introduced. Additional audits were also implemented to monitor practice. Policies were then updated and circulated with staff. As this is an important area of potential risk, we have chosen to include the management and use for controlled drugs as part of our patient safety priorities moving forward as we feel there may be more to learn.

Nasal Endoscopy

In 2021, we experienced a reportable event where a nasal endoscope had not been adequately decontaminated between use on 2 patients at one of our hospitals. A detailed investigation was undertaken into the practices that lead to this event, with a complete overhaul of how the endoscopes are used. Additional staff are now involved in

supporting consultants undertaking these procedures, with 2 staff being present. The 'clean and dirty' flows that equipment follow were reviewed and changed to limit risk. Staff were provided with update training and a detailed standard operating procedure was introduced. Risk was significantly reduced which was confirmed by an independent review of the service undertaken by another Independent Sector Healthcare Provider.

In 2023, we commissioned an external expert review of our nasal endoscopy service in the sister hospital, to confirm that our practices were safe, up-to-date and aligned with best practice. A small action plan is ongoing. We will continue to monitor and focus on these services as they do have inherent risk associated with these complex processes.

VTE

Anecdotal evidence during this COVID Pandemic has shown a slight increase in VTE events in post-operative patients who have previous tested positive for the virus. One Healthcare has seen low levels of these events, with a very slight increase in incidents during the first part of 2023.

We did however identify a number of occasions where prescribers were working outside of our anaphylaxis protocols. This prompted a review of practice and protocols, which do align with both local NHS prescribing protocols and NICE guidelines.

SSI Monitoring

We are proud that we are able to report fairly low levels of post-operative infections. One Healthcare undertakes a significant number of joint arthroplasty on an annual basis. We follow nationally recommended monitoring and reporting of deep surgical site infections, which are at very low numbers.

We do also monitor all of our patients post operatively for potential superficial wound infections. Accurate monitoring within the independent sector is challenging as patients often return to primary care or NHS secondary care services. Over the last two years we have introduced a number of measures to improve the capture and analysis of this valuable data.

We undertake follow-up phone calls with 24-48 hr. of a patient discharge and also send out a 30 day patient questionnaire to capture wound infections should they develop.

We routinely hold a nurse-led wound clinic in one of our hospitals and are planning to role out a similar service in our other hospital. We have also implemented a detailed patient tracker, where each potential wound infection is tracked, with wound swabs taken and relevant antimicrobials prescribed. Investigations are undertaken into every potential infection.

This detailed patient tracker also allows us to identify any potential trend, so that corrective action can be taken.

Post-Operative Complication

In 2021 we identified a slight trend in patients returning to theatre for post-operative bleeding following thyroidectomy in one of our hospitals. This prompted a full review of the patient pathway for these patients, with a number of new process being implemented. A decision was made to hold patients in the post operative recovery area for 1 hour post procedure. Some additional patient 'restrictions' were also implemented, with patients having to remain NBM and at bedrest for 3 hours post op. Since these measures have been in place, we have experienced no further incidents.

How we will respond to patient safety events

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process will be a flexible approach, informed by the local and national priorities. Our objective is to facilitate an approach that involves decision making through an initial triage process – coordinated by the Response Lead, but involving the relevant people who were involved in the initial incident. This may include our medical staff and patients and their families.

Our Levels of response

National level Priorities requiring a level 1 response

National priorities are set by the PSIRF and other national initiatives. These priorities require a PSII to be conducted by the organisation. We will therefore be using this approach with the associated mandated template should we have an incident that falls within the categories outlined below (see appendix A for more detail)

- Never Events
- Learning from Deaths
- Safeguarding Incidents
- Deaths of persons with learning disabilities
- Incidents in Screening Programmes

In the event of one of our patients dying while being provided with care and treatment, a PSII will be undertaken with the case being reviewed by our Mortality Committee.

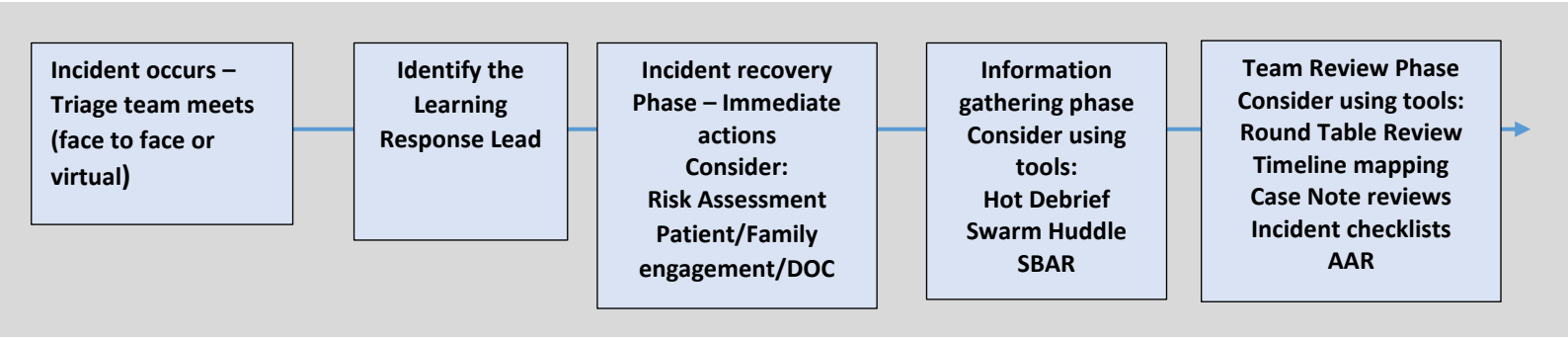
Local Priorities requiring a level 2 approach for Learning

We are changing our whole approach to the way we will be dealing with patient safety incidents. Historically we have used the well know and widely adopted Root Cause Analysis (RCA) system to investigate and write our incident reports. Our existing incident management systems include the logging of all incidents onto Datix, our electronic Incident Management system, with the local hospital senior management teams coordinating the subsequent investigations and resulting reports. A weekly review of all incidents is undertaken by the hospital senior management teams, while moderate and serious incidents that have required a RCA review are reviewed and signed off via our local hospital governance and Medical Advisory Committees. These are also shared at our corporate governance committee, so that cross organizational learning can be shared.

Our new approach will be more immediate and responsive, and also include patients and their families right at the start of the process. We intend to instigate an initial triage process, where the relevant team will gather as a patient safety event occurs. This team will have a Learning Response lead – who will coordinate the ongoing process, but will make the initial decision as to how the incident links to our PSIRP, and therefore what proportional response/ patient safety response tool will be adopted for use to gather information and identify the learning to be shared.

The diagram below sets out the process we intend to follow – but also includes the patient safety response tools we will consider at each stage. This is not a comprehensive list – as we will make full use of NHSE's toolkit, as appropriate to the incident under consideration. Cascade of learning and appropriate governance and assurance processes will also be in place,

Diagram: New patient safety incident response process



Based on our data analysis, we anticipate that there may be around 10 - 15 full Patient Safety Incident Investigations (PSIIs) undertaken during the year.

We have determined that we will use this approach when one of the following events occurs:

A National Priorities Incident
Patient safety incidents that have resulted in severe harm, these incidents would have automatically been a serious incident under the Serious Incident Framework
A reportable deep Surgical Site Infection – as defined by the UKHSA
A known case of sepsis
A reportable radiation exposure incident as per IRMER guidance
CQC notifications – if when discussion with the Regulator – the incident is deemed to warrant this level of investigation
If following engagement with the patient and their family that their concerns and needs can only be adequately addressed using this more in-depth approach.

We will also consider the following 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

Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors that result in patient safety incidents. These investigations will now analyse the system in which we work by collecting and analysing evidence, to identify systems-based contributory factors.

One of the real benefits of this new Framework is the availability of other response tools that can now be used. When

considering these review options we will still be mindful of the potential for harm.

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

Our approach to selection – proportional response

Together with the introduction of a number of new processes during the implementation of PSIRF, we will also be maintaining many of our existing and effective incident management practices. Staff log incidents on Datix, our electronic incident management system. Our Quality and Risk Managers oversee this electronic system, but it is reviewed by the hospital Senior Management Teams on a weekly basis – for review and closure of outstanding incidents.

Responses for our top patient safety risks

Local Patient Safety Risk	Proportional response
For all incidents	Incident recovery phase - We will always consider the following Immediate actions To take urgent measures to address serious and imminent: • Discomfort, injury, or threat to life • Damage to equipment or the environment. Risk assessment To assess the likelihood and severity of identified hazards in order that risks can be determined, prioritised, and control measures applied
Medicines incidents These incidents may vary in degree of severity and impact and will range from errors in prescribing, dispensing, administration or documentation	During the information gathering phase we may use a number of different tools from the NHS Learning Response Toolkit – depending on the triage teams initial assessment. These may include: • Hot debriefs • Swarm huddles • Use of the SBAR tool • Time line mapping • Observation and interviews During the Team review Phase we may make use of any of the following Learning Response Tools: • Round Table Review • Timeline mapping • Case Note reviews • Incident checklists • After Action Review • MDT Reviews

	If a serious of similar or related incidents have occurred, we will consider use of: • Thematic reviews • SHARE Debriefs – to cascade learning	
Infections These incidents may range from the more serious such as outbreaks, diagnosed sepsis or deep surgical site infections – to those with less impact such as minor wound infections.	When infection related incidents that have potential serious consequences occur such as diagnosed sepsis or deep surgical site infections, we have chosen to adopt the use of the following approach: • Undertake a full and comprehensive PSII using the national template to guide us With other incidents with potentially less serious consequences – we will consider the use of: • Hot Debriefs • Swarm Huddles • SBAR tool • Timeline mapping • Case note mapping • MDT Review If we detect any possible trends from our wound infection tracker system, we may undertake thematic reviews	
Communication related issues There may be elements of communication problems that are identified as gaps when using many of Learning Response Tools to review the 'system' within which an incident has occurred.	As with many of the other Learning Response tools – we will in principle be adopting the approach advocated within the e System Engineering Initiative for Patient Safety (SEIPS). We will be using a range of tools when responding to these types of incidents, but will be using Swarm Huddles and the SBAR tool.	
Administration processes There may a number of incidents where administration processes have failed the system. These may include incidents were there are delays in seeing consultant (booking appointments or actual consultations) – scheduling issues. They may also include processes that cause cancellation on the day of surgery	In principle – unless administration process issues are part of another more complex incident where other Learning Response Tools might be used, we will be using the following tools to review these incidents: • SBAR tool • MDT Review tool	
Clinical Process issues This is a more complex group of incidents. We will be flexible but in principle we will be using the following Learning Response Tools	Delays in accessing treatment/ Delays in obtaining results	SBAR tool
	Failures in admission and discharge processes	SBAR tool
	Issues with pre-assessment processes	SBAR tool
	Intraoperative complications – e.g. fractures, cardiac events, and also Complications of surgery requiring further treatment including return to theatre	Hot Debriefs Swarm huddles Timeline mapping AAR Round Table Reviews MDT Reviews SHARE Debrief

	Extended LOS due to delayed discharge / theatre overruns/ Cancellation on the day of surgery	SBAR tool
	Failure of emergency call bell (Ascom) system	**Immediate actions** Consider review of any relevant Risk Assessments Consider what immediate actions need to be taken to reduce risks SBAR
	VTE events	SBAR Timeline mapping Case Review
Imaging incidents This category may include a wide range of incidents from reportable incidents with serious consequences (IRMER) to those with less impact	Where we have incidents that involve radiation exposures and compliance with IRMER and are reportable – we will undertake a full PSII. With incidents that may have less impact/consequence – we may use any of the following Learning Response Tools: • Hot Debrief • Swarm Huddles • SBAR	
Documentation issues These incidents may form part of other more complex incidents or be a specific event. They may include issues such as - failure to access/unavailability of required medical records/ Errors in documentation of clinical notes e.g. incorrect demographics	As with many of the other Learning Response tools – we will in principle be adopting the approach advocated within the System Engineering Initiative for Patient Safety Framework (SEIPS). In particular we will be using the SBAR tool and even thematic reviews to understand what learning comes from these types of events	
Equipment related incidents This category includes a wide range of potential incidents – with varying degrees of impact	We will be using: • SBAR tool • Swarm Huddles • Hot Debriefs	

Learning from good care and optimal outcomes

PSIRF now recognizes:

- that outcomes in complex systems result from the interaction of multiple factors and that learning should not focus on uncovering a (root) cause, but instead should explore multiple contributory factors;
- we don't need to distinguish between care and service delivery problems. Instead, we need to explore contributory factors, including 'individual acts' in the context of the whole system.

However, in using a systems based approach and considering human factors when undertaking reviews of patient safety events, we will also be able to identify where things went well, through the use of our new Learning Response Tools.

These will guide our staff to 'walk-through' events, detecting where parts of the system actually supported the prevention of error. Many of our tools use SEIPS (Systems Engineering Initiative for Patient Safety) which will facilitate this process.

Safety 1 and Safety 11

In light of increasing demands and growing system complexity, we should all be adjusting our approach to patient safety. Historically One healthcare, in common with many healthcare providers has considered safety as the absence of accidents and incidents. Therefore we have adopted what is termed a Safety-I approach, where safety is defined as a state where as few things as possible go wrong. This approach presumes that things go wrong because of identifiable failures or malfunctions of specific components:

- technology,
- procedures,
- the human workers and
- the organisations in which they are embedded.

The purpose of accident investigation in Safety-I is to identify the causes and contributory factors of adverse outcomes, however it does not stop to consider why human performance practically always goes right. Things do not go right because people behave as they are supposed to, but because people can and do adjust what they do to match the conditions of work. As systems become more complex, these adjustments become increasingly important to maintain acceptable performance. Our challenge for safety improvement is therefore to understand these adjustments—in other words, to understand how performance usually goes right in spite of the uncertainties, ambiguities, and goal conflicts that pervade complex work situations. We will seek to move towards ensuring that we understand how 'as many things as possible go right', which is now known as a Safety-II approach.

Using this approach the purpose of our learning responses will include an understanding of how things usually go right, since that is the basis for explaining how things occasionally go wrong. We will seek to understand how everyday actions achieve improved safety.

Our way forward under this Patient Safety Incident Response Plan is to combine the two ways of thinking under the Safety-1 and Safety -11 approaches. Many of our new Learning Response tools include prompts for staff to look for what goes right, to focus on frequent events and to maintain a sensitivity to the possibility of failure in our systems and processes.

During the review stage of our new Learning Response and Quality Improvement processes, we will also be looking for specific trends that demonstrate where good practice has been instrumental in maintaining system safety. These will also be shared with our teams during debriefs and at our governance and assurance meetings.

Emerging incidents and commonalities

At level 3 response we may identify emerging categories of incidents that do not currently form part of this Plan. We may also identify commonalities between the various categories of incidents or even see a larger volume of low/no harm incidents where we feel there is still learning to be gained from further review.

This new Framework provides us with the options of a flexible approach, with an extensive toolkit to assist us in gathering information and learning from patient safety reviews. In the 'unexpected' category of incident, that isn't currently reflected in this Plan, we will assess which proportional response may lead us to the best opportunity for learning and improvement.

We will be adopting the approach of thematic review to try and understand any commonalities and where to focus our quality improvement activities moving forward.

Learning responses to multi-organisation, or cross-system patient safety incidents.

Moving forward under PSIRF, should an incident occur that will require a review of systems and processes across a number of organisations (either private or NHS), we will work collaboratively with our colleagues and commissioners to agree the proportional Learning Response that will be adopted, and how the review process will be lead. The response should be led by the organisation best placed to investigate the concerns. This may depend on capability, capacity, or remit. Our ICB commission colleagues will be supporting all stakeholders involved and our learning responses will need to examine the care provided throughout the specific care pathway as opposed to focusing solely on the part of the pathway most proximal to the incident. We will actively engage with partner organisations that provided care to the patient(s) involved where that care may have played a role in the incident being examined.

Our look-back exercise to analyze our last 3 years of patient safety data and those investigations that had been undertaken, demonstrated that cross organisational joint investigations, undertaken with partner organisations, will be rare. However, where a patient safety incidents occurs on one of our sites, the learning gained following a review/investigation is not only shared with the staff at the site where the event occurred, but is also shared at the sister site through our corporate governance and assurance processes. In principle, learning response outcomes are discussed at our monthly Cross Site Governance Committee and then cascaded to the hospital teams by our senior management teams.

Timescales

Where a PSII is required (as defined in this Plan for both local and national priorities), the investigation will start as soon as possible after the patient safety incident is identified.

We anticipate that PSIIs will ordinarily be completed within one to three months of their start date. In exceptional circumstances, a longer timeframe may be required for completion of a PSII. In this case, any extended timeframe will be agreed with the patient/family/carer. No PSII should take longer than six months.

We hope to ensure that a balance will be drawn between conducting a thorough PSII, 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 information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

When our teams are using any of the other Learning Response Tools, we will again start fact finding as soon as possible after the incident, with timescales being agreed by the initial triage team as to when the team review and sign off phase of the process needs to be completed.

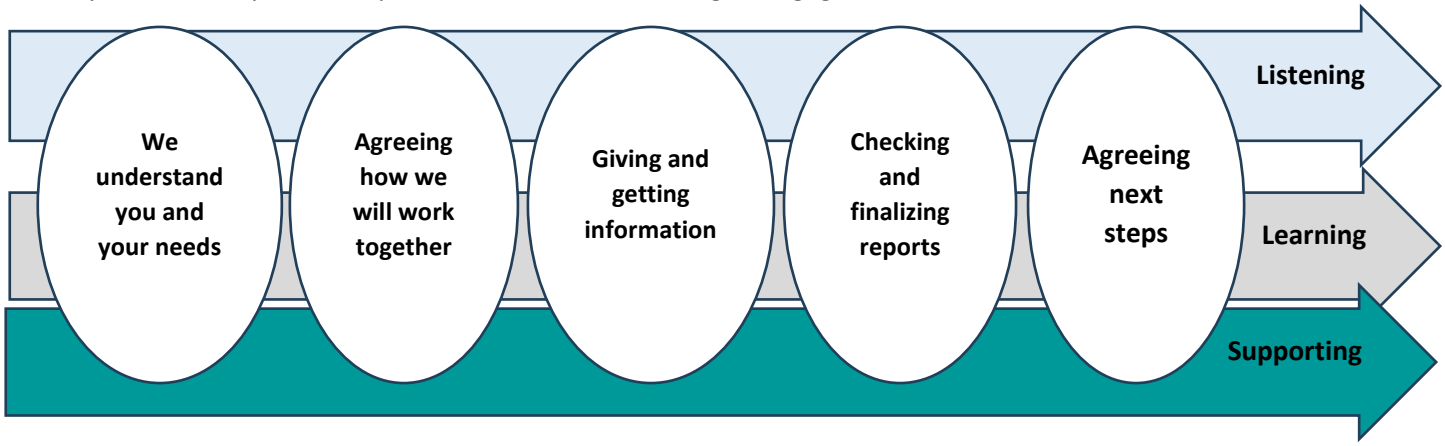
Involving Patient, families and carers when an incident has occurred

Compassionate engagement and involvement of those affected by patient safety incidents is central to PSIRF. One Healthcare is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned. We recognise the significant impact patient safety incidents can have on patients, their families and carers. We aim to continually demonstrate a Restorative Just Culture.

'When we think about the outcomes of accidents or other untoward events, what differentiates healthcare from other industries are the patients.' Thus, when patients suffer harm there is another aspect of culture that must be developed – a proper, humanistic response to them and their families'

Fatal Solutions 2022

We have identified Engagement Leads at each hospital, with the Directors of Clinical Services taking this lead. Involvement has been in principle, part of investigations policy and process for some time, but we wish to now engage at a much earlier stage of the process, to understand the needs of those involved, to prevent compound harm, and repair relationships while facilitating healing. They will be undertaking the required training to ensure they have the required competencies to ensure meaningful engagement.



We understand that those affected by a patient safety incident may have a range of needs (including clinical needs) as a result and these must be met where possible. This is part of our duty of care. Engaging with those affected by a patient safety incident substantially improves our understanding of what happened, and potentially how to prevent a similar incident in future. In our engagement activities with patients/families and carers we will be adopted the principles advocated in the Patient Safety Incident Response Framework supporting guidance – '*Engaging and involving patients, families and staff following a patient safety incident',* namely*:*

- Providing apologies that are meaningful
- Ensuring that each approach is individualised
- Being mindful that timing is sensitive
- That those affected are treated with respect and compassion
- That we ensure guidance and clarity are provided
- Making sure that those affected are 'heard'
- That our approach is collaborative and open
- Recognising that subjectivity is accepted
- Understanding that we need to strive for equity

As previously stated, we will continue to make sure that our requirements under Regulation 20 – Duty of Candour will be met and monitored closely.

Engagement, signposting and support

Patients, their families and carers may need to be signposted to support at any point during their engagement or involvement in the learning response. As part of our new processes we will endeavour to understand their individual needs as soon as possible following an incident. We plan to roll out the use of the National Institute for Health and Care research (NIHR) co-designed new guidance to make investigations more human and meaningful for those involved, and support better organisational learning. In this way we hope to ensure that those affected by a patient safety incident have clear information about the purpose of any learning response, and what to expect from the process.

We plan to make sure that we take account of and act on feedback that we receive during the learning response process. Where patients request, we will involve them in the production of investigation reports and they will be

provided with the final version. The incident response lead will provide patients and their families with the chance to go through the report with them.

We realise that we may not always be able to meet every expectation. When we can't meet the patient/families expectations, we will give clear and meaningful explanations as to why this was not possible.

Involving and supporting staff

We know that we can learn more from the staff who have been involved, when an incident occurs and we intend to implement a patient safety response approach that include more staff, including medical staff, immediately following and event. This moves away from the historic approach as used under RCA investigations, where staff may either never get to participate in information gathering and review or only do so very late in the process.

All staff with knowledge of the events being reviewed will be encouraged to actively participate in the learning response. That may be through participating in a Hot Debrief or Swarm Huddle, submitting written information or even doing a walkthrough of the environment in which the incident occurred. They will be encourage to join in with team reviews and debrief meeting.

Review teams will agree with staff and patients, the timescales for feedback of progress and findings in accordance with the type of review method being utilised. All contact with staff will involve the collection of their account of the events and also their views and opinions on how systems can be improved.

'An atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior' James Reason 1997

Staff are an integral part in helping us to understand 'work as disclosed' and 'work as done'. Things do not go right because people behave as they are supposed to, but because people can and do adjust what they do to match the conditions of work. As systems continue to develop and introduce more complexity, these adjustments become increasingly important to maintain acceptable performance. The challenge for safety improvement is therefore to understand these adjustments

One Healthcare is committed to the principles of the NHS Just Culture Guide for ensuring the fair, open and transparent treatment of staff who are involved in patient safety incidents. We are embedding these principles in to our procedures for the review of incidents. Our annual staff survey provides us with a high-level over view of staff views in relation to their voices being heard and acted upon. Although the survey questions do include elements of a safety culture, as an organisation we are planning on undertaking a more targeted staff survey to gain a better understanding of staff views in relation to our 'safety-culture', especially in assessing the impact the introduction of the new processes under PSIRF has had.

We recognise the significant impact being involved in a patient safety incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place.

Occupational Health

All of our staff have access to Occupational Health Services, to access support that may be needed.

Health & Wellbeing

The health and wellbeing of our staff is a key priority for One Healthcare. If we don't look after ourselves and our colleagues, we cannot deliver safe, high quality patient care. Our staff, and their families, have access to our online staff support programme – WeCare (via Canada Life). This service looks after their wellbeing with a 24/7 UK-based online GP, mental health counselling, a get fit programme, legal and financial guidance, plus much more. Staff can use their phone, tablet or desktop, to have 24/7 access to thousands of experts, all from the comfort of their own home. The Mental Health Support programme helps staff to prevent burnout, tackle major life events or learn to deal with stress and anxiety, which can also be an outcome of involvement with serious patient safety events.

Freedom to Speak Up

Our Freedom to Speak Up network provides a confidential service for staff if they have concerns about the organisation's response to a patient safety incident. Our Group Clinical Director is the organisations Freedom to Speak Up Guardian who is supported by a small number of FTSU Champions based within the hospitals.

Roles and Responsibilities

Within One Healthcare we have clear roles and responsibilities in relation to our response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents

All Staff

Everyone has a role in keeping people safe. We can all make a difference. All staff have a responsibility to highlight any risk issues which would warrant further investigation. Staff should be fully open and co-operative with any patient safety review process. All staff are required to be aware of and comply with this patient safety incident response plan. It has been shared with the hospital teams. Information regarding the reporting and management of incidents is provided for new staff at hospital level induction.

> "Restorative Just Culture aims to repair trust and relationships damaged after an incident. It allows all parties to discuss how they have been affected, and collaboratively decide what should be done to repair the harm"
>
> Sidney Dekker – Restorative Just Culture

SRO

Our PSIRF Implementation team is led by our CEO who acts as the Senior Responsible Officer (SRO), ensuring that the this implementation project meets its objectives, delivers the required outcomes, and realises the required benefits.

Executive Lead

Our Group Clinical Director is our PSIRF executive lead and has the overarching responsibility for quality and patient safety, including ensuring an effective organisational response to incidents. This role holds responsibility for ensuring that we meet the national patient safety incident response standards, but also needs to ensure that PSIRF is central to our overarching safety governance arrangements. Overseeing our patient safety incident reporting and our learning response data.

The Group Clinical Director also acts as our Corporate level Oversight lead. She will ensure that investigation findings, safety actions, safety improvement plans, and progress are discussed at the board level and at all relevant sub-committees.

Oversight Leads

Our Hospital Directors at each site, supported by their local leadership teams, provide an additional level of oversight, specifically at local level. They will monitor and assure local processes, thereby ensuring:

- An adequate and appropriately trained level of local resource is in place in order to be able to effectively manage our patients safety responses;
- Oversight of local safety governance arrangements, with investigation findings, safety actions, safety improvement plans, and progress being discussed at all relevant local level committees;
- Local level quality assurance of the learning response outputs, with the PSIRF executive lead reviewing all PSII reports;
- That all safety actions are implemented in response to learning or wider safety improvement plan(s) are monitored, to check they are delivering the required improvements.

All members of the team who undertake oversight roles are working towards the standards and competencies set out in NHS England's Patient Safety Incident response standards (Version 1 – August 2022)and the Framework's supporting guidance - Oversight roles and responsibilities specification (Version 1 – August 2022).

Engagement Leads

Our Engagement Leads are key to ensure compassionate engagement prioritises and respects the needs of people who have been affected by a patient safety incident. Our Directors of Clinical Services at each site will take responsibility for this role, supported by their senior clinical team. Our Engagement Leads are currently undergoing training, as per the national syllabus, to ensure they have the required competencies to actively listen, show openness, demonstrate empathy, and create a rapport with those affected.

Learning Response leads

Our Quality and Risk Leads at each of our sites will take on the role of Learning Response Leads. However, learning responses are not undertaken by staff working in isolation. Our Quality and Risk Leads will co-ordinate the response teams, working closely with the Directors of Clinical Services to initiate the triage stage of our response once an incident has occurred. The team will then identify a specific Response Lead to steer and guide that individual incident.

Subject matter experts with relevant knowledge and skills will be involved, where necessary, throughout the learning response process to provide expertise, advice and review of draft reports. This will include members of our medical staff, who are either speciality experts, were involved in the incident or are advisers as part of our internal governance processes.

Patient Safety Partners

Patient Safety Partners often have the insight of a user of services, or even experience of avoidable harm and can therefore be instrumental in helping us to develop safety solutions following incidents. We are keen to use these useful roles to promote our openness and transparency, helping us to know what is important to patients and supporting us to consider how processes appear and feel to patients. We will value their contribution to our governance and management processes.

Successful recruitment of Patient Safety Partners is a particular challenge for small independent sector providers like ourselves and we will be liaising with our relevant Integrated Care Boards (ICBs) within Hertfordshire and Kent to explore the potential opportunities of participating in their Patient Safety Partner networks.

Coroner / Medical examiner

A coroner investigates unnatural or violent deaths, where the cause of death is unknown. The investigation may include an inquest hearing. The coroner's role is to find out who died and how, when, and where they died. The Notification of Deaths regulations require registered medical practitioners to notify the senior coroner of a death if one or more of the circumstances set out in the regulations applies, including where they "suspect" that the person's death was due to "undergoing any treatment or procedure of a medical or similar nature".

PSRIF does not change the scope of an inquest, but requires all deaths to be investigated where the death is thought more likely than not to have been due to problems in care. Patient deaths are a very unlikely event in our hospitals, with none occurring since our sites have been open (since 2017). However should these type of event occur we will be liaising directly with our coroners and respond when they ask for information. We anticipate that any requested documents may include PSII reports, learning from other response methods and any other relevant supporting materials.

Medical examiners, supported by medical examiner officers, work to:

- Listen to the bereaved, increasing transparency and offering them the opportunity to raise concerns about care;
- Improve the quality and accuracy of the Medical Certificate of Cause of Death;
- Ensure notification of deaths to the coroner where appropriate.

If our local Medical Examiner identify concerns, they may raise these with our Group Clinical or Medical Director or even the Hospital Director. We will work collaboratively to meet the needs of these key stakeholders. Our approach will be to ensure the death is considered for a response in line with this patient safety incident response plan. Where evidence, however identified, suggests problems in care were more likely than not to have led to the death occurring at the time that it did, a PSII must be undertaken.

ICB

ICBs are required to approve and sign off the incident response policies and plans of the providers in their system. This plan will be reviewed and signed off by Hertfordshire and West Essex ICB on behalf of all our commissioners.

Within our local and wider governance arrangements this Plan will outline the agreed mechanisms for escalation of incidents and risks that may require support or action at ICB level.

Medical staff/Group Medical Director

Our Group Medical Director is a crucial member of our PSIRF Implementation Team and has been actively involved in advising the team from the medical staffing perspective. He plays a fundamental role in advising One Healthcare on all issues relating to Medical Practitioners assurance and will be both personally involved in our learning response activities, but will also be central to supporting the participation of our consultant body in these patient safety reviews and learning responses.

Clinicians/Specialist Advisors

Incident reviewers may need to involve specialist advisors to assist in their review (e.g. Safeguarding, Health and Safety, Pharmacy, Radiation Protection Advisor, Clinicians with experience in a particular medical or surgical technique). Patient safety reviewers/Learning responders are responsible for determining when specialist advice is required and specialist advisors have a duty to provide support and advice as and when required. This may be in the form of attendance at multi-disciplinary investigation meetings, provision of a written report/opinion, and review of recommendations.

Our Board

The One Healthcare Board is responsible and accountable for effective patient safety incident management within our organisation. Through the CEO and Group Clinical Director, they have received updates on our progress towards implementation and following full sign off from our commissioners and roll out of the Framework, they will receive assurance that this plan is being implemented, that lessons are being learnt, and areas of vulnerability are improving via our internal governance reporting processes. Assurance will be provided primarily through our group level Governance Committee. Where concerns are identified relating to the robustness of lessons learned or actions planned the Board will seek assurances that these concerns are being acted upon.

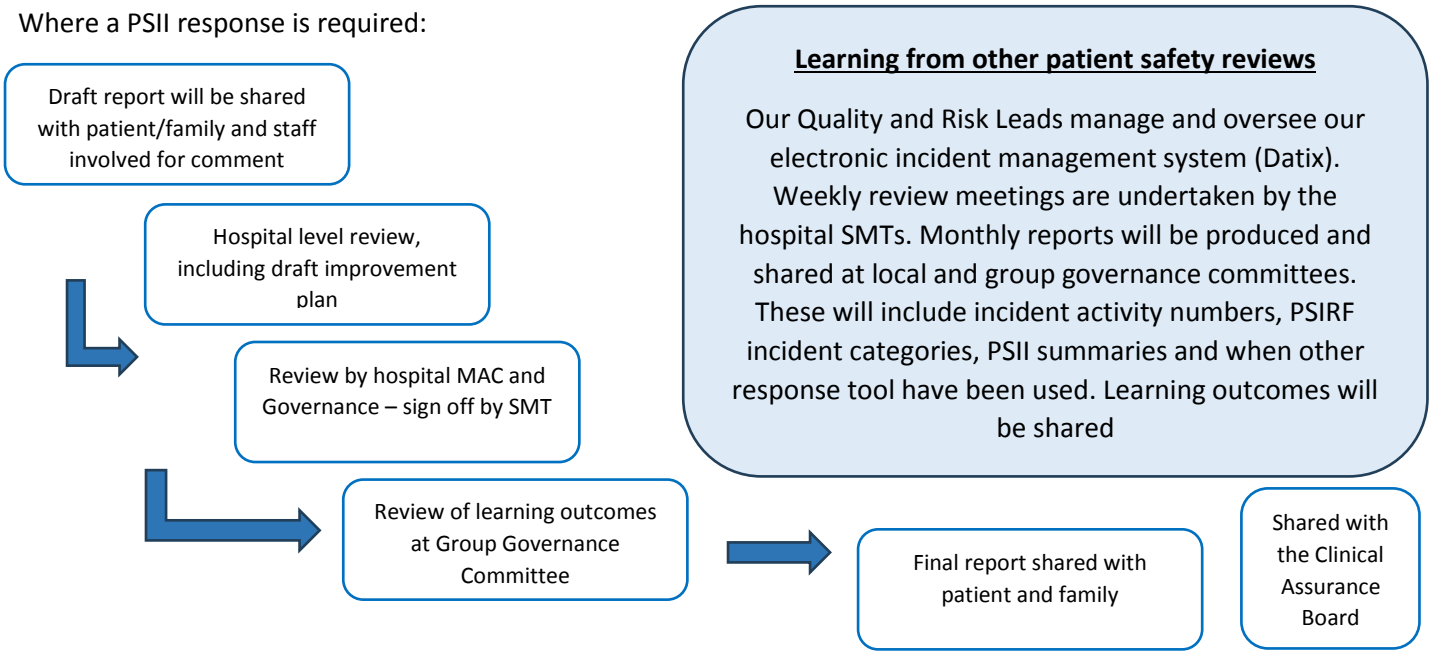
Governance and supporting improvement

Governance and assurance

One Healthcare has robust governance and assurance systems in place at both hospital and corporate level. Our patient safety reviews/ learning response activities will all be reported and monitored through these systems.

As part of these arrangements we already work closely with our commissioners, with our senior hospital teams having regular engagement meetings. As part of the ongoing monitoring of the effectiveness of our new patient safety arrangements we have agreed with our commissioners that we will be sharing certain Learning Response outputs with them. These will include all PSII reports once they have been assured through our local governance arrangements, together with the output of any thematic reviews we undertake. This will include updates on any Quality Improvement activity that results from the learning identified during these events.

Where a PSII response is required:



Learning from other patient safety reviews

Our Quality and Risk Leads manage and oversee our electronic incident management system (Datix). Weekly review meetings are undertaken by the hospital SMTs. Monthly reports will be produced and shared at local and group governance committees. These will include incident activity numbers, PSIRF incident categories, PSII summaries and when other response tool have been used. Learning outcomes will be shared

Findings from PSIIs and PSRs provide key insights and learning opportunities, but they are not the end of the story. These then need to be shared so that practice can be improved.

Our Hospital and Group level Governance Committees have the oversight and monitoring functions for all our patient safety activities and learning outcomes. These committees are held monthly/bi-monthly and promote a positive culture of continuous learning and improvement.

Regular update reports will be created for Committee and Board review and assurance. Contents may vary, but will likely include aggregated data on:

- Patient safety incident reporting
- Findings from PSIIs reports
- Findings from Patient Safety Reviews - what tools were used
- Learning to be shared
- Progress against the PSIRP
- Progress on local and Corporate System Improvement Plans
- Improvement projects and activities

We also hope to be able to share:

- Results of surveys and/or feedback from patients/families/carers on their experiences of our response to patient safety incidents
- Results of surveys and/or feedback from staff on their experiences of our response to patient safety incidents.

Concerns and appeals

Any concerns or complaints raised about our response to patient safety incidents from either patients and their families or our own staff will be taken seriously and managed in a way that upholds the principles of a 'Just Culture' and restorative healing.

Our intention is to involve patients, and the relevant staff, in the process of reviews and investigations, commencing at the earliest stage possible. This is to ensure that their voices are heard, any concerns can be raised, and they are able to make a significant contribution to identifying any systems gaps and subsequent solutions, supporting our organisational learning.

Our patients have access to our formal three-stage complaints process should they want to formalise their concerns. Our staff have access to our Freedom to Speak Up Guardian and Whistleblowing processes, but hope that high levels of staff engagement through the entire review/investigation process will resolve any concerns at the time.

Review

PSIRF is an iterative process. We are all on a journey of learning and this plan will remain live and flexible as we travel this journey together with our key stakeholders and learn from our implementation of the Framework over the next year. We hope that we have reached a balance between proportional response and quality improvement.

Appendix A: National priorities

National priorities requiring a response

National priorities are set by the PSIRF and other national initiatives. These priorities require a PSII to be conducted by the organisation.

There are three categories of national priorities requiring local PSII:

- Incidents that meet the criteria set in the Never Events list (2018);
- Incidents that meet Learning from Death criteria;
- And Death or long-term severe injury of a person in state care or detained under the Mental Health Act.

Further detail is provided below.

Incidents that meet the criteria set in the Never Events list 2018

Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Incidents that meet the 'Learning from Deaths' criteria;

Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

Examples include:

- Deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's mortality review tool and which have been determined by case record review to be more likely than not due to problems in care
- Deaths of persons with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review
- Deaths of patients in custody, in prison or on probation where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS

Death or long-term severe injury of a person in state care or detained under the Mental Health Act.

Examples include suicide, self-harm or assault resulting in the death or long term severe injury of a person in state care or detained under the Mental Health Act.

National priorities to be referred to another team

The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) are as follows, further details are provided below:

- Maternity and neonatal incidents
- Mental health related homicides by persons in receipt of mental health services or within six months of their discharge
- Child deaths
- Deaths of persons with learning disabilities
- Safeguarding incidents
- Incidents in screening programmes

Maternity and neonatal incidents:

- Incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation (https://www.hsib.org.uk/maternity/)
- All cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme
- All perinatal and maternal deaths must be referred to MBRRACE

Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge

These must be discussed with the relevant NHS England and NHS Improvement regional independent Investigation team (RIIT)

Child deaths

For further information, see: Child death review statutory and operational guidance

Incidents must be referred to child death panels for investigation

Deaths of persons with learning disabilities

Incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

Safeguarding incidents:

Incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multi-professional investigation

Incidents in screening programmes

For further information see: incidents in screening programmes

Incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

Deaths of patients in custody, in prison or on probation

Where healthcare is/was NHS funded and delivered through an NHS contract, incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

Appendix B: Key Stakeholders – Contacts

Stakeholder	Contact
Kent and Medway Coroners service	Patricia Harding, Senior Coroner for South East Kent. KentandMedwayCoroners@kent.gov.uk
Kent and Medway – Medical Examiner	Stacey Brown stacey.brown21@nhs.net
Kent and Medway ICB PSIRF Lead	Jessica Campbell Jessica.campbell5@nhs.net
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