NHS
Oxford Health
NHS Foundation Trust

Patient Safety Incident Response Approach

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1. Purpose

Everyone has a role in patient safety and continually improving the safety of care.

Oxford Health NHS Foundation Trust (OHFT) supports the definition of safety as,

> *Delivering care in a way that minimises things going wrong and maximises things going right, continuously reduces risk, empowers, supports and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights, and ensures improvements are made when problems occur.*

This document is aligned with the requirements of the Patient Safety Incident Response Framework (PSIRF[1]) and sets out OHFTs approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. Central to this is the principle that staff do reasonable things given their goal, knowledge, understanding of the situation and focus at a particular moment. We look at the contextual, system factors to understand what we can learn and change, rather than assigning blame. PSRIF is clear that the review of patient safety incidents "are insulated from remits that seek to determine avoidability/ preventability/ predictability; legal liability; blame; professional conduct/competence/ fitness to practise; criminality; or cause of death." [NHS England, PSRIF standards August 2022, page 11]

We recognise the significant impact patient safety incidents have on patients and their families and carers, and also staff. Getting involvement, engagement and support right with patients and families in how we respond and learn from incidents is essential and an area we will continue to work on, so that we make the changes that matter and improve care. There is a section in this document on how we engage and involve including what patients and families can expect. PSRIF does not change our obligation or commitment to comply with Duty of Candour requirements, further details are in this document.

This document is supported by the following Trust Policies;

- Reporting and learning from incidents and deaths Policy
- Central alerting system Policy (to manage and action national alerts)
- Duty of Candour Policy
- Safeguarding Children and Adults Policy
- A co-produced best practice guide for staff supporting patients/families after a patient safety event. This was developed with Making Families Count and five other NHS Trusts.

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

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

- Compassionate engagement, support and involvement of those affected by patient safety incidents (this includes patients, their families and staff)
- 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 how we learn and apply improvements

This document should be read alongside the **Trust's Patient Safety Incident Response Plan**.

If you have any questions about our approach please contact Jane.Kershaw@oxfordhealth.nhs.uk or the Patient Safety Team on patient.safety@oxfordhealth.nhs.uk.

[1] *See the NHS England webpage for more details about the PSIRF.*

2. Scope

This approach is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all OHFT services as identified in the **Patient Safety Incident Response Plan** and the clinical services listed on the Trust's website, link here.

The Trust takes our role and responsibilities very seriously around learning from deaths overseen by the Chief Medical Officer. All patient deaths across the Trust are initially screened by two clinicians and then the outcome of this alongside the circumstances of the death and any concerns from staff and families will decide what further review is needed based on the potential to identify learning. All unexpected deaths and deaths of those from particularly vulnerable groups such as, people; with a learning disability or diagnosis of autism, aged under 18, or die after we suspected they took their own life by suicide will have a mortality review or similar. The trends and learning from all deaths in the Trust, including patients under our care at the time of their death and those who die within 12 months of their last contact, are routinely reviewed at the Trust's Mortality Review Group. We are also part of two national real time surveillance systems in relation to suspected suicides to support quick identification of deaths and multi-agency learning. Our review and oversight of deaths runs in parallel to the response plan for patient safety incidents and is aligned with the national guidance on learning from deaths. We publish a summary of our learning from deaths annually in the Trust's Quality Account.

Non-patient safety incidents for example information governance, health and safety, or estates and facilities unless also associated with a patient safety incident are outside the scope. Although these will continue to be reported in the same local incident management system for oversight and management.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this approach. Information from a patient safety learning response can be shared with those leading other types of responses, but other processes should not influence the remit or purpose of a patient safety incident response.

3. Our patient safety culture

OHFT attaches a great deal of importance to the culture across the organisation and ensuring that it is one that puts patient care first, is open, just, compassionate and continually looking at ways to learn. Staff and patients are encouraged to raise any concerns about the quality of care, patient safety and poor behaviours and we have developed a range of ways people can do this. We have completed a number of pieces of work over the last two years including work on being restorative and just, kindness into action and civility and respect to support psychological safety and the culture we want in the Trust. Further details about the work carried out to develop the culture, support staff well-being and improve inclusivity can be found in the Trust's annual Quality Account, available here.

In addition the Trust has put resources and attention to developing our quality improvement capability and capacity so that this is a golden thread through everything we do and is a key part of our behaviours. The Trust established the Oxford Healthcare Improvement Centre to provide; training and support for quality improvement projects, enable collaboration, sharing of outcomes and horizon scanning for future projects. Our aim is that improvements to patient care are always co-produced with patients and their families. Further details about the Centre can be found here. The Patient Safety Team and Oxford Healthcare Improvement Centre work together sharing learning to inform quality improvements.

The Trust performed reasonably well and above average compared to other NHS Trusts in the patient safety cultural questions in the national 2022 staff survey[2] (completed by 3279 staff) and we have evidence from our local cultural staff survey, feedback from families involved in investigations, feedback from incident learning huddles and feedback from Coroners of the positive impact of the changes we have made so far.

The transition to PSIRF is a significant shift in thinking towards learning from everyday work as well as incidents. Establishing psychologically safe cultures and practices is essential to meaningful learning and applying improvements to enhance patient care. The Trust has been developing our approach in how we respond to patient safety incidents, testing and evolving changes as we go, so that it is more engaging and supportive to learning together. Not only did our patient safety team complete the Healthcare Safety Investigation Branch level 2 systems approach to learning and oversight mindset training but so did a number of our senior clinicians and Executive Directors to role model the changes. We have introduced the national patient safety level 1 training for all staff to complete and are aiming for our Council of Governors to also complete this to develop our culture. We have made progress and this work will continue. We have a positive incident reporting culture in the Trust with high numbers of incidents and near misses reported, the majority of which result in no harm to patients. When an incident is reported this is used as an opportunity to learn through our established safety forums and quality governance arrangements as well as regular data analysis to identify trends and emerging themes. We have an active user group which regularly meets to develop the incident reporting system so that it supports staff to report and learn from incidents and near misses.

We aim to always be curious and work with patients/families to identify and make improvements to the safety of care. An important part of the developments has been to have more people with lived experiences of our services working with us, including as peer support workers delivering care, employed roles to ensure patient/families voices are central to our decision-making such as patient safety partners, and also the involvement of individual patients/service users in particular quality improvement initiatives.

The introduction of the concept of patient safety partners is a national initiative as part of the patient safety strategy. The Trust has taken a novel approach to the roles by employing two patient safety partners with lived experiences of using our services, working within the patient safety team. We decided to employ people on 18 month fixed term contracts to recognise and value the input of their lived experience, to have set regular hours to involve the partners in more substantial pieces of work and to have a rotation of people with new perspectives regularly. The partners have been involved in our change programme as part of preparing and transitioning to PSRIF as well as developing our approach and incident response plan. The partners work alongside clinical staff and patients/families to co-design and implement patient safety initiatives, training, resources, support activities around governance and other opportunities to improve the safety of care. We will be evaluating the roles and hope to expand the number of people directly involved in improving patient safety over time.

[2] *The Trust's 2022 staff survey results in full can found here*

4. Addressing health inequalities

The Trust has a core role to play in reducing inequalities in health by improving access to services and tailoring services around the needs of the local population to be inclusive. As a public authority we are committed to delivering our statutory obligations under the Equality Act (2010) to develop staff knowledge and awareness through training, and to collect and use data to assess for any disproportionate patient safety risks to patients from across the range of protected characteristics. OHFT completes the annual self-assessments against the areas of race, age and disability equality standards with developments overseen by the Trust's Equality, Diversity and Inclusion Steering Group. In relation to understanding inequalities for patient safety incidents we gather and review demographics at incident level and as a result have identified a number of local safety areas in our **Patient Safety Incident Response Plan** this year. An example of this is in relation to people with autism having delays in accessing care.

We also address health inequalities as part of our quality improvement and transformation work, one example of this is in relation to people with a serious mental illness are at a greater risk of poor physical health and have a higher premature mortality than the general population, often dying 15-20 years sooner from conditions like cardiovascular disease or cancers due to poor access to screening and physical health checks. To address this health inequality, we have committed to increase the number of patients open to our community mental health teams that have a full annual physical health check each year and any actions are included in the patients care plan.

The Trust is starting to implement the national Patient and Carer Race Equality Framework to improve equality of care and access to services, and we have an action plan against the NHS workforce equality, diversity and inclusion improvement plan. Both these programmes help to identify emerging issues and develop the culture in the Trust to value and respect differences, to improve access to services and to not tolerate abuse or discrimination.

Engagement of patient, families and staff following a patient safety incident is essential to how we can review and learn from patient safety incidents, therefore we ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved and work with us to identify improvements to care.

More information about what we are doing is available on our website here.

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

We recognise the significant impact patient safety incidents have on patients and their families and carers, and also staff. Our approach is to be open, compassionate, to listen and individualise our contacts to recognise the different needs of those we involve and engage to learn from incidents. We are mindful not to cause further distress or harm when identifying learning from an incident. We have made improvements to how we engage, involve and support those affected by an incident over the last year based on feedback. Our focus is always on making the changes that matter to improve care.

The Trust will always attempt to involve and engage patients/families when a serious harm occurs, or an incident that is within the remit of our incident response plan, or has the potential for significant learning.

We will offer patients/families;

- A single point of contact
- Support and signposting to services as required
- A meeting(s) to ask questions, share their experience of the incident and any concerns
- Regular communication on the progress and timescales with completing a learning response
- The opportunity to tell us what concerns and questions they have, which we will make every attempt to respond to and explain where we cannot answer a question
- To share the outcome of our learning response, this could be through a meeting, over the telephone and/ or in writing.

For the cases where we carry out an in-depth investigation we will also involve those affected in the scope/terms of reference and share the draft findings to check for any inaccuracies and as an opportunity to ask any additional questions. We will then offer to share the final report. These commitments are overseen by the central patient safety team and checked routinely through our processes up until the final outcome is signed off by the Executive Team.

If a patient or family member raises concerns or a complaint following an incident we will look into this, offer support and respond to any questions. However as part of being proportionate with resources we may not always carry out a specific learning response if we already understand the underlaying factors/issues to address and these are being taken forward in existing actions or a quality improvement initiative.

The Trust's central and dedicated patient safety team will lead on the completion of the majority of learning responses and oversee all responses by the Trust. Having this unique team means we can maintain a high level of quality and consistency across learning response methods and also engagement with patients, families and staff. The team is made up of specialists who have completed the recommended training and meet the desired competencies detailed by the PSRIF (further details of the training requirements are here). We have information resources we share with those affected, which are regularly reviewed. OHFT were also part of co-producing a best practice guide for staff on how to support patients/families after a patient safety event, this was launched in September 2023 as an aid for staff, developed with Making Families Count and five other NHS Trusts. We routinely ask for feedback after completing the learning response from patients, families and staff to help the continual development of our processes. If you are reading this and have feedback please contact the team at patient.safety@oxfordhealth.nhs.uk.

PSRIF does not change our obligation or commitment to comply with Duty of Candour requirements, regardless of whether the incident is included or not in our incident response plan. For all incidents that result in moderate or greater harm[3] to a patient we will speak to those affected or their next of kin, say sorry, offer support, a single

[3] *The national definitions for harm, NHS England » Policy guidance on recording patient safety events and levels of harm, with moderate harm defined as a patient needing further healthcare beyond a single professional/hospital or clinic visit, and beyond a dressing change or short course of medication. But less than 2 weeks of additional inpatient care or less than 6 months of further community treatment. A patients independence could be affected but would need to be for less than 6 months to be classed as moderate. If there is permanent harm to a patient, reduced life expectancy or a need for immediate life saving interventions as a result of the incident then the incident has resulted in severe harm.*

point of contact in the Trust and detail the next steps and any further reviews planned. The Trust has a policy for staff to follow and also training. We monitor the requirements through the incident reporting system and also as part of our oversight process for all learning responses overseen by the central patient safety team.

The Trust provides a Family Liaison Service independent to clinical teams to support bereaved families including general bereavement support, signposting to external agencies, providing information and practice advice and support to help raise concerns and questions. We have a separate Post Incident Psychological Support Service for staff to access following an incident or death, alongside the occupational health service, employee assistance programme and in 2023 we have started to trial the peer support approach of Trauma Risk Injury Management (TRiM).

6. Patient Safety Incident Response Planning

PSIRF supports us to respond to incidents and safety issues in a way that maximises resources to focus on learning and improvement, rather than basing responses on arbitrary or generic types of incidents or definitions of harm. Our learning responses will take a considered and proportionate approach, therefore we will not always respond to a specific incident if we are familiar with the factors that need addressing so that we can focus on spreading the learning and making the changes to improve care. Alongside the NHS England national requirements, we have identified local safety areas in collaboration with key stakeholders where we have the most to learn. For further details see the Trust's **Patient Safety Incident Response Plan**. The plan includes details of how this was developed and who we engaged with.

We are driving forward to make Quality Improvement 'the way we always do things here' at the Trust so that we are continuously learning and improving to develop the care we provide. The Trust established the Oxford Healthcare Improvement Centre to provide; training and support for quality improvement projects, enable collaboration, sharing of outcomes and horizon scanning for future projects. Our aim is that improvements to patient care are always co-produced with patients and their families. Further details about the Centre can be found here.

Where we have safety areas but have significant and relevant quality improvement work happening or planned, our efforts are on testing and making the changes with services therefore the area will not be separately identified as a local safety area in the incident response plan.

Response Capacity

We have a centralised, dedicated and specialist team who lead and support the majority of the learning responses following incidents across the Trust. The team receives enhanced training in line with the PSRIF standards, the other patient safety training undertaken is described under the above section on Trust culture. The patient safety team carry out the following roles; facilitating the incident learning huddles, carrying out incident learning responses, supporting those affected by an incident (including patients, families and staff), as well as spreading the learning identified across teams/services. The central patient safety team provide training to senior clinicians who provide subject expertise to reviews and investigations. We will keep capacity to deliver the plan under review so that responses are considered and proportionate with a focus on building capacity for learning and monitoring the impact of safety actions.

The Trust introduced incident learning huddles in 2022, elsewhere these are often called after action learning reviews, they are a structured and facilitated group discussion soon after an incident with the team(s) involved, and includes engaging with the patient/family affected. We have seen a number of benefits of using huddles, this has included greater engagement of the whole clinical team in reviewing what has happened, identifying learning and actions to be taken, and has had a positive impact on the culture within the Trust. We aim to complete an incident learning huddle within 14 days, this varies so that we can consider and be flexible to those affected by the incident and to manage capacity to deliver our **Patient Safety Incident Response Plan**.

The patient safety team works closely with, the; Oxford Healthcare Improvement Centre, our Patient Safety Partners (employed people with lived experience of using our services), Infection Prevention and Control Team, Resuscitation Team, Safeguarding Team, Medicine Safety Officers and Medical Devices Safety Officer.

Reviewing our incident response plan

Our **Patient Safety Incident Response Plan** is a 'living document' that will be kept under review through our weekly and monthly oversight processes at both clinical directorate and Trust-wide level and amended as we use it to respond to patient safety incidents. We continue to review every patient safety incident to identify any emerging issues and any incidents with the potential for significant learning. In addition we will have regular reviews in year of our plan and approach with our commissioner, the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board. We will formally review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made. Any amendments to the plan will be highlighted and re-published on our website.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example patient safety incidents, learning and themes from reviews/investigations, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

7. Responding to patient safety incidents

Incident reporting arrangements

The Trust has a local incident management system, Ulysses, to enable the reporting and learning from all incidents and near misses. All staff are responsible for reporting any incidents or near misses and to discuss these in their clinical team. Incidents are reviewed by multiple people each day, more details below on how this informs decision-making. There are prompts in the system to help staff to comply with the legal duty of candour requirements. We share all patient related incidents at a national level through the NHS Learn from Patient Safety Events system to help identify new or under-recognised safety issues to support learning outside the organisation. Non-patient safety incidents for example information governance, health and safety, or estates and facilities unless also associated with a patient safety incident are outside the scope of this document. Although these will continue to be reported in the same local incident management system for oversight and management.

There are certain types of incidents for example infection incidents which we apply specialised multi-disciplinary reviews to inform wider improvement work and national reporting when required. All nationally reportable infections and outbreaks are reported on our local incident system for individual review to identify learning, these are overseen by the Infection, Prevention and Control (IPC) Team and reported into the IPC Committee. We also have systems in place so the Trust's Medicine Safety Officers review every medicine incident, Safeguarding Team review every incident with child or adult safeguarding concerns flagged and the Medical Device Safety Officer reviews all medical device incidents, regardless of level of harm to the patient to identify and share learning.

Our internal processes are described in the Trust's Reporting and learning from incidents and deaths Policy, this will be fully updated to be in line with our PSRIF plan and approach.

Incident response decision-making

Every incident is reviewed by the team/ward manager and also shared with senior clinicians and managers on the day reported. There are additional reviews on a weekly basis at a clinical directorate level and Trust-wide to identify support needed, immediate good practice and any learning to take forward. The patient safety team is involved in the Trust-wide oversight of all incidents with greater harm or potential for significant learning. A weekly Trust-wide forum focuses on patient and staff safety, bringing together a range of data and softer intelligence including incidents, incident learning huddle outcomes, complaints, claims and inquest findings, to identify themes and immediate actions. This forum reports into the Executive Team. We will review the themes and learning from completed learning response methods on a monthly basis through the Trust's Quality and Clinical Governance Sub-Committee as well as continuing to look for trends across all incidents on a quarterly basis to help identify emerging themes.

Incidents that are within the scope of our **Patient Safety Incident Response Plan** will be reviewed weekly and reported onto the national system provided by NHS England. We use incident learning huddles to understand more about incidents, to ensure support is in place for those affected, to identify immediate learning and to clarify if incidents require a further exploration/ learning response as detailed in the incident response plan. A learning response will be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning but fall outside the incident response plan. We have identified capacity in the plan to look into emerging issues but will keep capacity to deliver the plan under review so that responses are considered and proportionate with appropriate energy and time on learning to inform improvements.

Learning responses

Our **Patient Safety Incident Response Plan** details the patient safety areas/incidents we have identified with our key stakeholders to focus on and to respond to in the next 12 months and what learning responses we expect to use.

Our learning responses take a systemic perspective to better understand how the different factors and their interactions were involved in an incident, directly or indirectly, to help identify learning that will inform improvements. We are using the methodology of Systems Engineering Initiative for Patient Safety (SEIPS) within our learning responses, further details can be found in this brief guide. SEIPs recognises the importance of exploring everyday work (how work is done in reality) and how people are routinely adjusting to match the ever changing conditions and demands of work.

We have identified a range of learning responses in the incident response plan to recognise there is no 'one size fits all' and the application of suitable learning methods needs to be based on the situation, incident type and what is already known about the safety area. Below are details about the learning responses we intend to use;

Learning Response	Description
Incident Learning Huddle (nationally called after action learning review)	Huddles are a structured and facilitated group discussion soon after an incident or event with the individuals involved. The facilitator is independent to the clinical team and engages with the patient/family before and after the event. The huddle is multi-disciplinary involving all professions and staff involved. The purpose is to take a team approach to learning which is engaging and compassionate to understand why the outcome differed from that expected and what learning can be identified to assist improvement. There is a written outcome from huddles to summarise learning, actions and next steps.
Extended Learning Huddle	This is an extension of the incident learning huddle, sometimes there is benefit identified to complete a second or extended group discussion to identify further learning and safety actions together. There is a written outcome from huddles to summarise learning, actions and next steps.
Mortality Review	A mortality review involves a senior practitioner usually within the clinical team reviewing the care provided to a patient before they died, this usually involves reviewing the patient's record, speaking to their family/next of kin, possibly contacting the GP and speaking to staff members who provided recent care. A report called a mortality review or initial review report is produced.
Case Record Review	Similar to a mortality review, this involves a senior practitioner within the clinical team reviewing the care provided leading up to an incident/death. A report called an initial review report is produced.
Thematic review	A thematic review will be facilitated by someone outside the clinical team(s) involved. The review will look at a particular safety area at a more aggregated level than a singular incident and will use a range of data sources and techniques for learning such as focus groups. Usually the review will be led by multiple people. There is a written outcome from each thematic review with a focus on informing improvements.

Learning Response	Description
Horizon scanning tool	This tool will usually involve a facilitated workshop with teams to explore a safety theme/issue or emerging safety risks by mapping work as done, current risks and looking forward to understand how risks/issues may be impacted by future changes. A summary of the learning and what changes should be made.
Appreciate Inquiry Approach	Appreciative Inquiry is a strengths-based method to build on what is working well to make improvements. We will use this in facilitated sessions with individual teams for specific situations. The method reinforces relationships and culture, creates common direction and promotes learning and collective action.
Audit against the national Carers Trust, Triangle of Care standards	The Trust uses the national Triangle of Care standards to assess, audit and improve practice of how we work with, involve and support families/carers in their loved ones care. The audit involves gathering information about processes, speaking to team members and family members/carers. Information about the Triangle of Care standards and tool is available here.
Patient Safety Incident Investigation (PSII)	An investigation is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. The process involves identifying two authors independent from the clinical team involved to undertake an in-depth investigation including case discussions with all those involved. A report is produced, following the national template. We expect to use this learning response less often than the other methods.

Responding to cross-organisational incidents

We will identify incidents that require a cross-organisational learning response when we first start looking into an incident and understand the care provided to a patient. We then actively engage relevant partners organisations to identify an appropriate learning response, coordinate a single learning response outcome and a single point of contact for patients/families. The Patient Safety Team will act as the liaison point to support and/or lead on cross-organisational reviews. We expect to be supported as needed by our commissioner, the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board, to facilitate cross-organisational reviews. The Trust recognises the significant learning and also the effort it takes to carry out a cross-organisational review so have identified resource to undertake these in our **Patient Safety Incident Response Plan**.

We have been part of developing principles and a process for all healthcare providers within Buckinghamshire, Oxfordshire and Berkshire West to follow in relation to identifying and managing cross-organisational learning responses.

Timeframes for learning responses

We aim for learning responses to start as soon as possible after the incident is identified and expect most responses to be completed within 3 months although this will be flexible and we will work at the pace of those affected, particularly patients, families and staff. If a response requires the involvement of a number of partner organisations or we are carrying out a full in-depth patient safety incident investigation this may also take longer but we will still aim to complete this within 6 months.

During any of the learning responses detailed in our incident response plan we recognise communication with those affected is essential so we will provide routine updates on progress and any changes to the timescale. The timeliness of learning responses will be monitored to support the implementation of the incident response plan.

Safety actions and improvement plans

The key findings and areas for improvement for each learning responses are shared with those affected by the incident to check factual accuracy, scrutinised by senior clinicians from the relevant clinical directorate, and then finally signed off by the Trust involving the Executive Directors, Chief Nurse and Chief Medical Officer or deputies as agreed. Any areas of good practice and areas identified for improvement are widely shared in multiple formats across the Trust to promote learning. We develop safety actions with clinical services taking a system-

based approach to inform improvements. The completion of individual safety actions is managed through a centralised electronic system with automated reminders to action leads, regular reporting on status with actions and escalation routes through the Trust's quality governance framework as needed.

From the key areas for improvement we will use a Trust-wide patient safety improvement plan to support the development and implementation of more complex actions and where there are reoccurring themes, as well as to monitor the impact of the actions we are taking. Some parts of the plan may focus on specific pathways and other elements on broader actions impacting on a number of services. The improvement plan will have organisational oversight in the Trust Quality Improvement and Learning Group with alignment to existing quality improvement projects, CQUIN goals and also the Trust's annual quality objectives (within the Quality Account).

We have some alignment between our patient safety and quality improvement approaches and have examples of where incident learning has led to specific quality improvement programmes however we aim to strengthen this over the next year to improve the quality of safety actions and their impact on improving the safety of care.

8. Oversight roles and responsibilities

We have clear roles and responsibilities for staff in relation to implementing and overseeing this approach and our incident response plan. The Chief Medical Officer and Chief Nurse are the Executive Director leads responsible for effective patient safety incident management and they are supported by their deputies who have a focus on patient safety. The other staff with responsibilities around how we respond and learn from incidents are the Head of Patient Safety, the Associate Director of Quality Improvement and Clinical Effectiveness, the Patient Safety Team, and the five clinical directorates each with senior quality leads (Associate Director of Nursing and Clinical Directors). We are all responsible for guiding how we learn from patient safety incidents and using this information to make improvements.

The above roles are supported by a quality governance framework with weekly, monthly and quarterly forums held at clinical directorate and Trust-wide level to review incidents, bring this together with other safety information, and to identify, share and oversee improvements. The PSRIF has informed and is central to our governance arrangements and the new incident response plan will be embedded into our governance processes.

The key internal quality forums include, the;

- Directorate weekly safety meetings
- Trust-wide weekly safety meeting called the weekly review meeting
- Directorate panels for reviewing learning responses
- Trust-wide panel for sharing learning, reviewing safety actions and signing off learning responses
- Directorate monthly Quality oversight forums
- Directorate monthly/bi-monthly Quality Improvement Hubs
- Trust-wide monthly Quality and Clinical Governance Sub-Committee
- Trust-wide quarterly Mortality Review Group and quarterly Suicide Prevention Strategy Group
- Trust-wide quarterly Positive and Safe Committee (focused on reducing the use of restrictive interventions in our mental health inpatient wards)
- Trust-wide quarterly Quality Improvement and Learning Group
- Trust-wide quarterly Quality Committee
- Trust-wide bi-monthly Board of Directors meeting

The Integrated Care Board is invited as a member to a number of the above internal quality forums to share wider learning from outside the Trust. The Trust is also a member of system-wide safety forums covering Buckinghamshire, Oxfordshire and Berkshire West, including the Medicines Safety Group, Learning from Deaths Group, Suicide Prevention Groups in each County and the Patient Safety and Improvement Forum.

Those in an oversight role, including our identified Executive Directors, have completed the suggested training detailed in the PSRIF standards. Further training will be completed as part of continual professional development.

Our oversight processes are underpinned by the following mindset principles;

- Improvement is our focus
- Blame restricts insight
- Learning from patient safety incidents is a proactive step towards improvement
- Collaboration is key
- Psychological safety[4] allows learning to occur
- Curiosity is powerful for learning

The experiences and views of patients, families and staff affected by patient safety incidents provide some of the best and most pertinent learning. It is a fundamental part of how we learn to speak to those affected and to ask for their support to understand how we can improve. This is covered in more detail in the above section on engaging and involving patients, families and staff. We also involve our patient safety partners in our oversight processes.

The Trust uses a range of quality and safety metrics to help monitor the care we provide and to identify areas for improvement. This information is regularly brought together on at least a weekly basis with learning from patient safety incidents. We have adopted the Institute for Healthcare Improvement's methodology for quality improvement which has a strong focus on using measures to understand if a change is an improvement.

We have been part of developing an oversight system with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and partner organisations with a focus on sharing insights and learning across organisations and supporting the achievement of improvements, in line with the PSRIF. We are still to develop a system of external peer reviews for a sample of completed learning response reports with other partner organisations.

As part of our oversight processes updates to this document and the incident response plan will be made as required.

9. Complaints and appeals

We hope that your contact with our staff and services is positive, however, we know that occasionally things might not be to the standard we expect so if that does happen we want to know so that we can make changes.

If you are unhappy about how the organisation has responded to a patient safety incident please contact our Patient Advice and Liaison Service on 0800 328 7971 or at PALS@oxfordhealth.nhs.uk. The service is open Monday to Friday from 9:30am to 4:30pm. More details about the Patient Advice and Liaison Service are available here and the Trust's Concerns, Complaints and Compliments Policy is available on our website at the following location.

Sometimes a complaint can be raised that brings to light a patient safety incident. All new complaints are reviewed at the weekly Trust-wide forum which focuses on patient and staff safety to consider the best approach to responding to these to maximum our learning.

[4] *Psychological safety is a shared belief held by members of a team that it's ok to take risks, to express their ideas and concerns, to speak up with questions, and to admit mistakes — all without fear of negative consequences.*