



Oxford Health
NHS Foundation Trust



Patient Safety Incident Response Framework

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What is patient safety?

Patient safety is about delivering healthcare in a way that minimises things going wrong and maximises things going right. It aims to continuously reduce risk, empower, support and enable people to make safe choices.

Patient safety protects people from harm, neglect, abuse, and breaches of their human rights and ensures improvements are made when problems occur.

Patient Safety is a priority at Oxford Health NHS Foundation Trust (OHFT). Our leaders aim to create a culture of openness and continuous improvement. If significant harm unexpectedly occurs to a patient during care and/or we identify a potential for learning, we refer to this as a Patient Safety Incident.

What happens when a patient safety incident occurs and how has this changed?

The Patient Safety Incident Response Framework (PSIRF) published by NHS England has changed the way that the NHS defines and responds to Patient Safety Incidents. This summary details the plan and approach that OHFT is undertaking when responding to Patient Safety Incidents following PSIRF. This approach will be used across the Trust.

The purpose of PSIRF is to learn from incidents and improve patient safety. Learning why the incident happened and what changes we can put in place to try and prevent anything similar happening again.

While PSIRF sets out nationally agreed types of incidents that need to be investigated it also gives some freedom to set local safety priorities depending on how much learning can be gained and existing improvements being made. The safety areas we are focusing on are put into a plan, this is Trust wide and will next be reviewed in December 2024.

Why do we have a plan?

- i** The plan outlines safety priorities that OHFT is going to focus on, chosen as they offer more learning for the Trust to improve the safety of care, this also includes the national safety areas.
- i** The plan has been agreed with organisations we work with including patients and families.
- i** This plan is a living document that will be reviewed regularly and changed to make sure that OHFT is responding to patient safety trends or as new safety issues become clear.

What are the main points of PSIRF?

- i** Patient Safety Incidents are to be responded to in a compassionate way and will involve giving support to all those affected including the patient, their family and staff involved.
- i** Incidents will be responded to in the best way using a wide range of methods or systems chosen to gain the most learning for the Trust. These may include group discussions with staff, reviewing specific processes or looking at previous learning patterns. There will always be communication with the patient/ family.
- i** All incidents will be looked at when reported and then decisions made about what is the best response, depending on the incident type and severity, not all incidents will be responded to in the same way or involve an investigation.
- i** Each Patient Safety Incident will have a written outcome from our review, identifying any learning to be actioned. The leaders of the Trust will help all staff to learn the lessons from each Incident. The focus will always be on learning, what we can do to improve and change our processes and systems and to ensure there is no blame given to anyone affected. The views of the patient and family will always be of great importance.

What are the key safety areas for Oxford Health in 2024?

Local priority safety areas

- Pressure ulcers developed whilst under our care.
- Unexpected death/ serious near miss for a mental health inpatient.
- Incidents which identified learning around involving communication with families e.g. consent/ confidentiality.
- Delays in accessing care where harm has occurred.
- Suspected suicide or serious self-harm where we identify issues in relation to risk formulation and/or safety planning
- Incidents involving poor joint working between teams
- An issue where significant concerns have affected a patient's journey between different organisations
- Emergent issues with significant learning

National priority safety areas

- Never events (events that are considered preventable).
- Deaths due to concerns in care.
- Certain Mental health related deaths that are unexpected
- Domestic homicides, unexpected deaths that occur within family members or household members.
- Deaths of people that have a Learning disability or Autism.
- Child deaths
- Deaths of people with certain vulnerability issues.
- Blood transfusions that cause serious harm

If you would like to know more

For further detailed information about the approach to PSIRF by Oxford Health can be found following this link or use the QR code,

<https://www.oxfordhealth.nhs.uk/about-us/patient-safety/psirf/>.



If you have any feedback or questions about the Patient Safety Incident process, please contact our Patient Safety Partners. Patient Safety Partners have a lived experience of using healthcare themselves.

Patient Safety Partners are not part of the investigation process but have been employed to ensure that the voice of the patient / family is not lost and is always at the forefront of Patient Safety.

Please contact the Patient Safety Partners on safetypartners@oxfordhealth.nhs.uk.

Do you have a concern about a patient safety incident?

If you are concerned about a Patient Safety Incident or outcome, please contact the Patient Safety Team on 01865 902351, or by email: patient.safety@oxfordhealth.nhs.uk.

Accessibility

Patient information leaflets are available on our website:
www.oxfordhealth.nhs.uk/leaflets

Feedback

You can also contact the Complaints and PALS Team for advice and support including help to resolve any problems, concerns, or complaints you may have.

Phone 0800 328 7971
Email PALS@oxfordhealth.nhs.uk

Get in touch

Address Oxford Health NHS Foundation Trust
Trust Headquarters
Littlemore Mental Health Centre
Sandford Road, Oxford OX4 4XN

Phone 01865 901 000
Email enquiries@oxfordhealth.nhs.uk
Website www.oxfordhealth.nhs.uk

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