

Patient Safety Incident Response Plan (PSIRP)

Patient safety incident response plan

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Author	PSIRF Implementation Team	6/9/2025
Reviewer	BOB ICB	20/9/2023
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Introduction

This patient safety incident response plan sets out how Oxford University Hospitals NHS Foundation Trust (OUH) intends to respond to patient safety incidents in accordance with the [Patient Safety Incident Response Framework \(PSIRF\)](#). The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. The Trust will review patient safety information regularly through governance and safety meetings, providing updates to the workstreams within plan. The whole plan will be reviewed approximately every 18 months to ensure the workstreams fully reflect the patient safety issues with the greatest potential for learning and improvement. This review of the plan will involve re-engagement with stakeholders to discuss and agree changes made in the previous 12 to 18 months and agree proposed updates to the plan. These will be published as a new version of the plan.

Our services

OUH is one of the largest NHS teaching trusts in the UK. It is made up of four hospitals - the John Radcliffe Hospital (which includes the Children's Hospital, West Wing, Eye Hospital, Heart Centre, and Women's Centre), the Churchill Hospital and the Nuffield Orthopaedic Centre, all located in Oxford, and the Horton General Hospital in Banbury, north Oxfordshire.

The Trust provides a wide range of clinical services, specialist services (including cardiac, cancer, musculoskeletal and neurological rehabilitation) medical education, training, and research. Most services are provided in our hospitals, but over six percent are delivered from 44 other locations across the region, and some in patients' homes.

The OUH is governed by a Board of Directors. Day-to-day running of the hospitals and their clinical and non-clinical services is delegated to Executive Directors and senior clinicians and managers. The Board has overall responsibility for the activity, integrity, and strategy of the Trust. Its role is largely supervisory and strategic. The Trust Management Executive is the senior managerial decision-making body for the Trust. It is chaired by the Chief Executive Officer, and consists of the Trust's Executive Directors, and four Divisional Directors. The Council of Governors holds the Trust Board to account. Governors are democratically elected, and roles are unpaid. They represent the interests of Trust members and the public.

The clinical services at the OUH are grouped into Divisions. Each Division is headed by a Divisional Director, a practising clinician who is supported by a Divisional Director of Nursing and General Manager. The four divisions are:

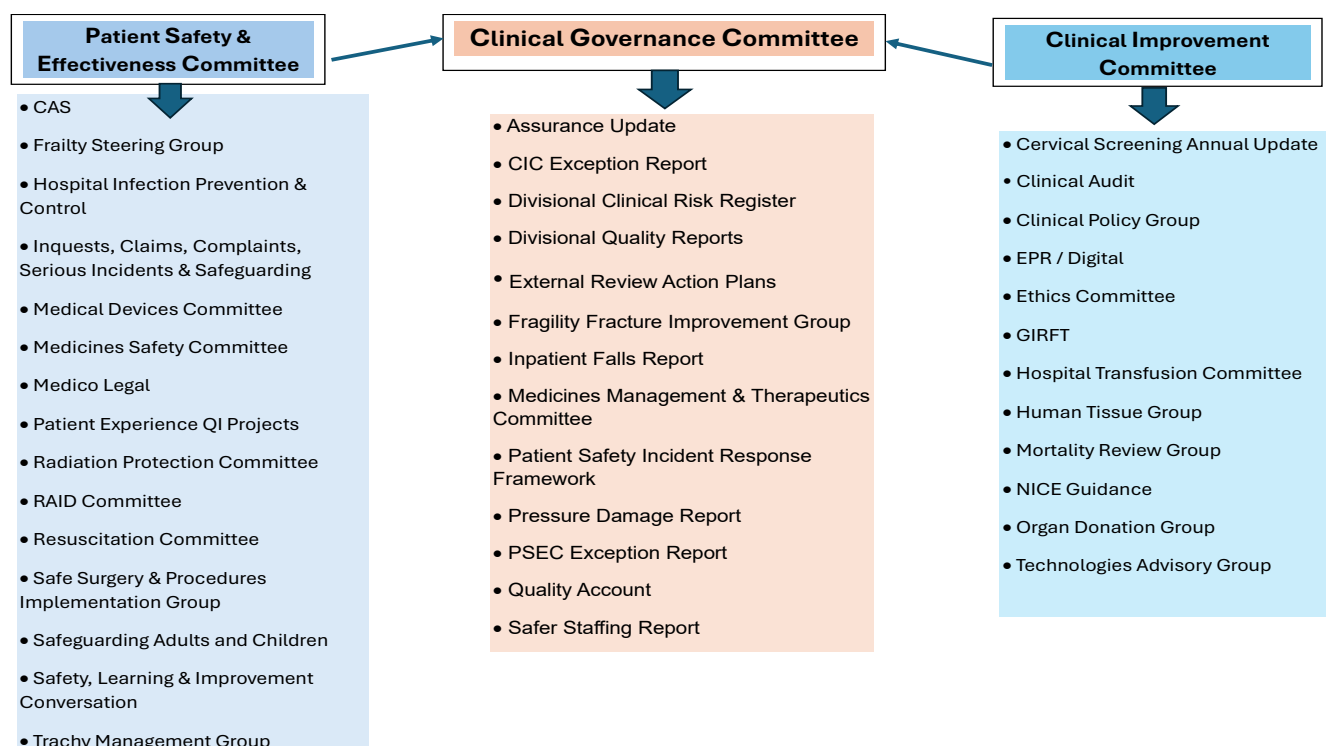
1. Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children's, and Neonates (NOTSSCaN)
2. Medicine, Rehabilitation and Cardiac (MRC)
3. Surgery, Women's, and Oncology (SUWON)
4. Clinical Support Services (CSS)

The Divisions are responsible for the day-to-day management and delivery of services within their areas in line with Trust strategies, policies, and procedures. The Divisions include Directorates, each of which contain clinical service units covering specific areas of services. Directorates are led by Clinical Directors and supported by Operational Service Managers, Matrons, and other relevant experts. The Directorates include those with services on one or more sites, such as surgery and women's services, and those which are based on a single site, such as cardiac services and neurosciences.

Safety and governance are embedded within the organisations through the corporate and divisional structure. The Chief Executive Officer is supported by the Chief Medical Officer and the Deputy Chief Medical Officer (DCMO) for Patient Safety and Clinical Effectiveness. Within the corporate team, there is also an Assurance team, led by the Director of Regulatory Compliance and Assurance who reports to the Chief Executive Officer, who is responsible for overseeing the management of risks, regulation, and accreditation. The [corporate structure highlighting can be viewed on the OUH Internet site](#). There is a central Patient Safety Team within the Clinical Governance Team and the processes for managing incidents and investigations are described in detail in the PSIRF Policy. Each division has between two to four Clinical Governance Risk Practitioners (CGRPs) who have a dedicated role within their division for improving overseeing and co-ordinating governance-related activities to ensure patient safety. There is one Trust-wide Patient Safety Specialists (with an aim to increase to 2 shortly) who perform this role jointly in addition to their usual role, and a Medicine Safety Officer, a Medical Device Safety Officer, and a Digital Clinical Safety Officer.

The Trust's Clinical Governance Committee has responsibility for monitoring the Trust's Governance (including patient safety) framework. The reporting structure of CGC can be seen in Figure 1.

Figure 1: Clinical Governance Committee Reporting Committees



Updating the OUH Patient Safety Profile – Method

Background

As part of PSIRF, the OUH has developed a Patient Safety Profile (appendix III). This is an overarching view of the key safety issues that are contributing to risk within the organisation. From these issues, four key areas for learning and improving patient safety were selected as PSIRF Thematic Workstreams. These workstreams are long-term explorations of the underlying factors that contribute to the issues involved, and a series of workstreams to address the key issues.

The original OUH safety profile was developed using data gathered from a range of sources and through discussion with stakeholders. The data sources were gathered using a mixture of raw data and annual reports which were reviewed for broad, overarching themes. The time frame used was between 2018 and 2022 to ensure that pre- and post-COVID-19 issues were identified.

Key sources of information:

- Incident reporting and serious incidents
- Freedom to speak up
- Safeguarding
- Complaints
- Compliments
- Quality Improvement teams
- Legal claims
- Mortality reviews
- Risk registers
- Health inequalities
- Population the OUH serves compared with the Patient population
- PFD Reports from coroner letters
- Clinical Negligence Scheme for Trusts (as managed by NHS Resolution)
- CQC reports

The data sources were reviewed themes and assessed according to the frequency of occurrence and how often they were highlighted across the different sources of information. Using this approach, a shortlist of key areas for improvement were identified and shared with stakeholders at a Summit in January 2022 where the participants were able to reflect on whether they agreed with the list of areas, suggest additional areas for improvement and rank the suggestions in order of priority.

Following this event, the four thematic workstreams chosen were:

1. Improving reporting and endorsement of results
2. Improving communication and handover
3. Improving cancer multidisciplinary team processes
4. Improving care for people at risk (Learning disabilities)

The fourth workstream, improving care for people at risk (learning disabilities) reflects feedback from stakeholders at the Summit.

Progress of the four PSII thematic workstreams

The four workstreams have been in progress since October 2022, with Handover and communication beginning slightly earlier. Each workstream has made significant progress, scoping the issues involved, defining the scope of the investigation, agreeing key areas for improvement and change and implementing solutions.

Reporting and Endorsement of results

A stakeholder group has supported this workstream. Membership includes digital, clinical, radiology and pathology and patient safety representatives. Key actions include:

- Reviewing and updating the management of results for staff who leave the Trust so that these will be assigned to another staff member to review. [Complete].
- Time results remain in clinician lists increased from 30 to 60 days. [Complete].
- Large numbers of results for review, and therefore the noise to signal ratio leads to increased risk of error when endorsing. Task and finish group to develop and define auto-endorsement parameters. Due for completion in Quarter 2 of the 25/26 financial year, after the South 4 LIMS Go-live.
- Improve accuracy of data. [Ongoing].

This workstream has identified key issues and is implementing changes to change the system to reduce the risk of missed results.

Stage of progress: Embed into business as usual once auto-endorsing and safety netting system for actionable radiology and histopathology results is implemented. Follow up and monitoring to be overseen through quarterly reporting to the Patient Safety and Effectiveness Committee.

Cancer referral and multidisciplinary team (MDT) processes and pathways

The Cancer Management Team and stakeholder group undertook the scoping, action development and oversight of this workstream. Actions included:

- Development of an SOP defining the process, responsibilities and communication requirements for internal Cancer MDT to Cancer MDT referrals. [Complete].
- Develop and launch a policy on a page and communicate with all co-ordinators. [Complete].
- Define Cancer MDT Co-ordinator responsibilities and provide templates to support activities. [Complete].
- Develop process for managing incidental findings and communicate Trust-wide. [Ongoing].

This workstream has identified key issues and is implementing changes to change the system to reduce the risk of missed results.

Stage of progress: Embed into business as usual. Follow up and monitoring through to be overseen through quarterly reporting to the Trust's Cancer Improvement Group.

Handovers including communication and documentation

The task-and-finish group exploring the issues around clinical handovers includes representatives from medical, nursing teams, Divisional governance teams, PSIRF Implementation team, Quality Improvement, Operational team, Divisional digital leads, and Patient Safety partners. Actions included:

- Update the Trust's Transport and Escort policy to improve clarity around roles and responsibilities. Reduce size of policy. Create short summary on a page. [In progress].
- Develop digital documentation process between emergency areas to the rest of the Trust. Creation of a digital handover document for the whole Trust. [Complete].
- Patient Safety Partner to work alongside portering team to understand their role and challenges particularly in relation to transferring patients from one clinical area to another. [In progress].

Stage of progress: Embed clinical handover aspect into business as usual following the introduction of the digital handover form. Follow up and monitoring to be overseen through quarterly reporting to the Patient Safety and Effectiveness Committee.

Scope whether communication on discharge should be new area of focus in 2025. See below for additional information about potential changes to workstreams.

Improving care for patients at risk (people with learning or intellectual disabilities)

A Learning Disability Steering group is in the process of being set up, to be chaired by the CSS Divisional Director of Nursing. ToR have been created and membership considered. The role will be to support the co-ordination of actions to improve the safety and experience of patients with a learning disability across the Trust. Planned actions include:

- Currently there is no provision for showing patients with learning disabilities but technically possible using a list of people known to have a learning disability in EPR. Action to create such a list and then use to identify patients on a waiting list. [In progress] This is a Trust Quality Priority for 2025/6.
- Develop a pathway for people with learning disabilities and/or autism to have bloods and scans carried out with appropriate sedation or anaesthesia. [In progress]. Trust Quality Priority for 2025/6.
- Improve awareness for staff of needs for people with learning disabilities and their ability to meet these additional needs by:
 - Rolling out Oliver McGowan e-learning. [Complete].
 - Increase numbers of patients with electronically held Healthcare Passports [In progress].
 - Implement the use of the Reasonable Adjustment flag on EPR. [In progress] Trust Quality Priority for 2025/6.

Stage of progress: This workstream has identified key areas for improvement have been identified and has led to the development of a Learning Disability steering group. The scoping and investigative stage of this work has been completed, and it is proposed that the steering group take over implementation of actions, overseen by the Patient Safety and Effectiveness Committee (PSEC) and the Health Inequalities Steering Group.

Emerging patient safety areas of concern

As part of PSIRF, the patient safety processes continue to monitor incident reports and other sources of safety information to understand current and emerging issues and risks. At the PSIRF One Year Anniversary event, participants were asked to share ideas for future workstreams. At the weekly Safety Learning and Improvement Conversation, learning and issues identified are shared and areas where there is the potential for safety improvement are highlighted. Conversations and feedback from the Trust's annual Quality Conversation were also considered.

Following a review of the initial data gathering exercise performed in 2022, and the discussions and feedback provided, there are three areas where there is potential for new thematic PSII workstreams.

Escalation of deteriorating patients

1. This theme was suggested following discussion of several learning responses where a patient deterioration was not recognised, and escalation was not performed.
2. There are several issues to be analysed in order to improve safety, including how to recognise deteriorating patients, when and how to escalate, how to encourage a culture of escalating when there is any uncertainty, rather than anticipating an unsympathetic response if a concern is escalated.

Communication at discharge (with specific reference to medication)

1. This safety issue has been raised widely during conversations, during the PSIRF one year on Seminar, and at the Trusts Quality Conversation, held in early December 2024.
2. Providing clear information to patients being discharged and to all relevant parties in primary care is important for the safety of people being discharged from hospital and improves the chances of successful discharge. With operational pressures, there is a risk that discharge processes can become less safe (for example, sending people home with their medications to follow by courier). There is a need to ensure robust processes are in place to ensure that safe discharges take place even when the system is under pressure to ensure discharges are safe.

Positive Patient Identification (PPID)

1. There have been several learning responses where the PPID processes have not been undertaken as intended, leading to incorrect treatments.
2. PPID is a known safety risk and relies heavily on people remembering to perform the correct checks.
3. This theme would look at the systems available to support PPID to support those involved to perform it consistently.

Thematic PSIs for 2025:

The current four PSII thematic workstreams have advanced.

The Reporting and endorsement of results and the Cancer referral and MDT processes and pathways have delivered changes to the system that are anticipated to improve safety in these areas. It is proposed that these two workstreams become business as usual, with oversight from PSEC.

The aspect of Clinical Handover has been explored and addressed through the creation of the digital handover form. Ongoing work will be undertaken to ensure this is embedded into practice. It is proposed that the focus of the Communication and Handover workstream be changed to Communication at Discharge, focusing on medication.

The People at Risk - Learning Disability workstream has provided an understanding of what needs to improve within the organisation and the data required to do this. Many issues and improvement activities have been incorporated into the 2025/26 Quality Priorities. This work will be overseen by the LD steering group, which reports to PSEC and the Health Inequalities Steering Group.

Current workstreams which will continue:

1. Communication and handover to continue with a new focus on safe and timely discharge with medicines

Two new workstreams for 2025:

Patient Safety Incident Response Plan (PSIRP)

2. Escalation of deteriorating patients
3. Positive Patient Identification

Links with the Quality Priorities

While there is some crossover with the 2025/26 Quality Priorities, the purposes of a PSIRF workstream are different to those of a Quality Priority. Quality Priorities are for projects that have been scoped and are likely to be achieved within a year. PSIRF thematic workstreams are for those safety issues where there are complex contributing causes that need to be investigated and understood before improvement work can be targeted effectively. The staff members chosen to lead the PSIRF thematic workstreams that have links with Trust Quality Priorities will work closely with the Quality Priority leads to ensure shared learning and resources.

Defining our patient safety improvement profile

The OUH safety improvement profile is developed by identifying the organisational improvement activity already underway. At OUH, there is an abundance of patient safety improvement work in progress. This includes, amongst other programmes:

- Integrated Quality Improvement Programme
 1. Quality Improvement Education and Community building
 2. Urgent and Emergency Care Programme
 3. Cancer Improvement Programme
 4. Harm reduction program
 1. Reducing avoidable unwitnessed inpatient falls
 2. Reducing medication errors
 3. Increasing dementia and delirium assessments
- OUH Quality Priorities (Patient Safety)
 1. System for Electronic Notification and Documentation (SEND)
 2. Medicines Reconciliation
 3. Fragility Fracture pathways – including fractured neck of femur
 4. Standard work
 5. Outreach Services from Oxford Critical Care
 6. Discharges
 7. Maternity Experiences
 8. ReSPECT – Recommended Summary Plan for Emergency Care and Treatment
 9. Supporting vulnerable patients including those with learning difficulties

There are also many locally initiated and led quality improvement projects throughout the Trust. These are registered and approved by the division, and learning is shared at the QI stand up events and through the QI Improvers Hub Community.

Learning Response Methods

PSIRF uses new methods to learn from issues and incidents. These are described in more detail in the PSIRF Policy. In brief, there are four main learning responses:

1. Patient Safety Incident Investigation (PSII) – an in-depth system-based investigation that seeks to identify and understand all the factors and issues that contribute to the incident.
2. Learning MDT Review - a follow-up multidisciplinary meeting to understand the wider organisational issues using a systems-based approach, including subject matter experts and other relevant stakeholders.
3. After Action Review (AAR) - a meeting with those involved in the incident and local area seeking to understand what happened, what had been expected to happen, why was there a difference and is there any local learning from the event, and whether there may be wider issues requiring further learning responses.
4. Hot debrief – a rapid meeting to review the event to answer the same questions as for the AAR review and to provide staff support.
5. Local learning – a brief investigation and response by the local manager where local actions may be identified and implemented.

Our patient safety incident response plan: national requirements

Table 1: Learning response methods with a national response required

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and share learning through the weekly SLIC.
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and share learning through the weekly SLIC.
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	PSII	Create local organisational actions and share learning through the weekly SLIC.

Patient safety incident type	Required response	Anticipated improvement route
Maternity and neonatal incidents meeting Maternity & Newborn Safety Investigations (MNSI) criteria or Special Healthcare Authority (SpHA) criteria when in place	Referred to MNSI for independent patient safety incident investigation	Respond to recommendations as required and share learning through the weekly SLIC.
Child deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel.	Create local organisational actions and share learning through the weekly SLIC.
Deaths of persons with learning disabilities or an autistic person (LeDeR)	Refer for Learning Disability Mortality Review (LeDeR). Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	Respond to recommendations as required and share learning through the weekly SLIC. Create local organisational actions and share learning through the weekly SLIC. Issues and learning opportunities shared with the PSIRF improvement workstream.
Safeguarding incidents in which: babies, children, or young people are on a child protection plan; looked after plan or a victim of	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child	Respond to recommendations as required and share learning through the weekly SLIC. Create local organisational actions and share learning through the weekly SLIC.

Patient safety incident type	Required response	Anticipated improvement route
wilful neglect or domestic abuse/violence. - adults (over 18 years old) are in receipt of care and support needs from their local authority. - the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.	safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Issues and learning opportunities shared with the PSIRF improvement workstream.
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes	Respond to recommendations as required and share learning through the weekly SLIC. Create local organisational actions and share learning through the weekly SLIC.
Serious Adverse Events in relation to haemovigilance ¹	PSII	Create local organisational actions and share learning through the weekly SLIC.

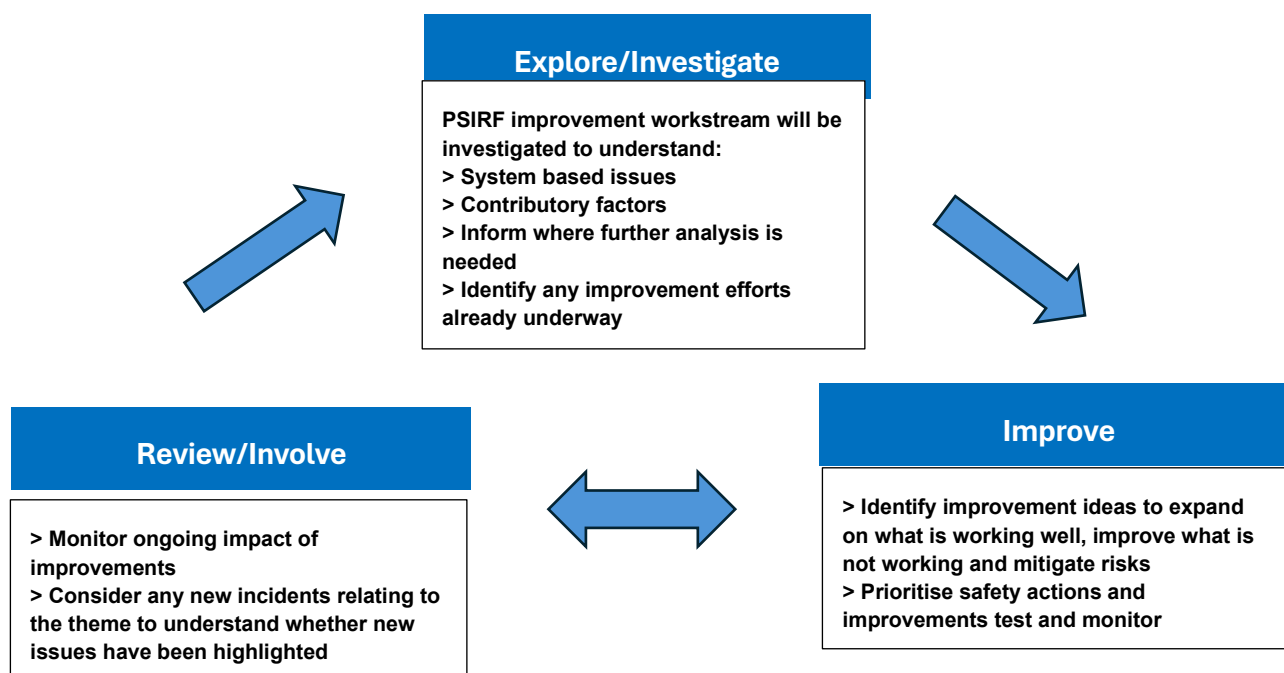
¹ Haemovigilance is the set of surveillance procedures covering the entire blood transfusion chain, from the donation and processing of blood and its components, through to their provision and transfusion to patients, and including their follow-up.

Our patient safety incident response plan: local focus

Incidents relating to the OUH PSIRF Improvement workstreams will be included in the improvement activities being undertaken. Any new incidents or events reported will be included in the workstream for review to understand whether they highlight any new issues that may not have already been identified. By proactively focusing on the three thematic workstreams, resources for investigation are used more efficiently. The learning response methods of After Action Review and Learning Multi-disciplinary Team Review provides a robust learning response with a more effective use of time, allowing a focus on learning and improvement. It is anticipated that in addition to the three thematic PSII workstreams being undertaken, there may be an additional twenty to thirty PSII being undertaken each year depending on risks and issues being identified (not including the MNSI PSII's).

Quality improvement methods will be undertaken to explore/investigate the issues in detail, identify the factors contributing to the risks, areas for improvement and recommendations to address these, see Figure 2. As these are live projects, the detail of the progress and planned responses will be maintained in a project plan that will be monitored and shared with the weekly SLIC, as described in the PSIRF Policy.

Figure 2: PSIRF workstream learning process.



Our patient safety incident response plan: Established processes

There are already many committees within OUH who have a role in monitoring and learning from incidents. When incidents occur, the subject matter experts will be involved in determining whether there is any potential for learning, and the need for a learning response. The PSIRF Policy describes how we manage and investigate incidents.

Ongoing safety management and improvement work is overseen by many groups with a focus on ensuring good safety practice is in place, maintained and improved where required. See Appendix II for a list of these pathways. Those safety issues with improvement plans in place are listed below.

Table 2: Safety issues addressed by current OUH Safety Programmes

Patient safety issue	Planned response	Anticipated improvement route
Quality Improvement Harm Reduction Programme - Reducing inpatient avoidable unwitnessed falls - Reducing medication errors - Increasing dementia and delirium assessments	Where incidents occur, they will be reviewed individually using updated processes to include systems-based learning	Learning and improvement activity identified, developed, and shared as part of the Harm reduction quality improvement programme and through the relevant committees such as the Harm Free Assurance group and the Medicines Safety Group.
Quality priorities 2025/26: - System for Electronic Notification and Documentation (SEND) - Medicines Reconciliation - Fragility Fracture pathways – including fractured neck of femur - Standard work - Outreach Services	Where incidents occur that relate to any of the Quality Priorities, the level of investigation will be decided according to potential for learning (either PSII or After-Action Review)	Learning and improvement activity identified, developed, and shared through the Trust's Quality Priority processes.

Patient safety issue	Planned response	Anticipated improvement route
from Oxford Critical Care • Discharges • Maternity Experiences • ReSPECT – Recommended Summary Plan for Emergency Care and Treatment • Supporting vulnerable patients including those with learning difficulties		

Appendix I: Communication Strategy completed for involving stakeholders

Group	Frequency	Type of communication	Role
PSIRF Implementation Team	Weekly	Face to face/teams meeting	Implementation
Chief Medical Officer, Chief Nursing Officer	Ad Hoc for important decisions	Email/teams meeting/phone call as needed Invite to PSIRF Summit to contribute to Safety profile development	Supervision and organisational responsibility
Clinical Governance Committee (CGC)	Monthly until launch Bimonthly post launch	Report Representative invited to PSIRF Summit	Oversight
Integrated Assurance Committee (IAC)	Up to every 2 months as required	Report Representative invited to PSIRF Summit	Oversight
Trust Management Executive (TME)	Via GGC monthly report	Report Representative invited to PSIRF Summit	Oversight
PSIRF Steering Group	Monthly until launch	Meetings, minutes, briefing documents (A4 newsletter format) Invitation to PSIRF Summit	Communication - both disseminating information to local areas and raising issues and contributing to development of PSIRF
PSIRF Improvement Group	Monthly/bimonthly		
Divisional teams	Monthly	Via PSIRF Steering Group meeting feedback from Divisional Representative Briefing Document/newsletter Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Patient Safety Team	Monthly	Via briefing document/newsletter from PSIRF steering group meetings Invitation to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes

Patient Safety and Effectiveness Committee (PSEC)	Ad hoc	Verbal update on request	Potential Subject Matter Experts for key themes/risks Keep up to date with progress and aware of potential implications of future changes
Group	Frequency	Type of communication	Role
Quality Improvement Team	Monthly	Via representation on Steering Group Representative invited to PSIRF Summit	
Assurance Team	Monthly	Via CGC Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Divisional Education Teams	Ad hoc	Bespoke as required	Make aware of new training required, what it is, who it is for, and the resource required to complete it.
Digital teams	Monthly	Via representation on steering group Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Freedom to Speak Up Team	Monthly	Newsletter/briefing document from PSIRF steering group meetings Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Safeguarding Team	Monthly	Newsletter/briefing document from PSIRF steering group meetings Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Legal team	Monthly	Newsletter/briefing document from PSIRF steering group meetings Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
Patient Experience team	Monthly	Newsletter/briefing document from PSIRF steering group meetings Representative invited to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes
LMNS	Monthly	OUH Link person is a member of the PSIRF steering group Invitation to PSIRF Summit	

BOB ICB	Monthly	Via Patient Safety Specialist meetings Reports likely to be required Will need to approve draft policy etc Via regular workshops based around different PSIRF phases Invitation to PSIRF Summit	Keep up to date with progress and aware of potential implications of future changes Will need to approve Trust Process and provide oversight
Group	Frequency	Type of communication	Role
Patients	Monthly	Involve in Summit for planning Publicity once plan and policy are developed and approved Invite a PSP or representative to join the Steering group Representatives invited to PSIRF Summit	Patient Safety Partner involvement
All staff	Regularly: - Initial communication to highlight that PSIRF is coming, and new e-learning is now required (Level 1 and Level 2) - Update when plan and framework agreed	Staff Briefing - presentation Email bulletins - brief description and link to intranet site Corporate e-mail - longer description, link to intranet site and new policies, flowchart, at a glance documents, video etc Staff Text - direct to internet site with news item e-Learning - highlight some of the changes, introduce system thinking Intranet site with information - PSIRF plan and policy, at a glance document, flowcharts, guidance, FAQs, video from national site, contact details for further information Cascade via governance pathways Listening events and focus groups	Make aware of changes Highlight systems-based approach to incident review Share information and updates around involving staff and patients after a patient safety event
NSHE	Via regular ICS workshops arranged by BOB ICS or through ICS team	Face to face or email Representative invited to PSIRF Summit	Escalate any issues that may be relevant to other Trusts, e.g. so far highlighted different processes required for maternity who may need two systems due to other regulatory requirements. Also IPC reporting requirements to be discussed with NHSE to make sure systems are aligned. Duty of Candour wording in PSIRF being reviewed.

Coroner	Bespoke conversations Collaborative conversations with ICS involvement	Teams calls or in person conversations	Make aware of changes Highlight systems-based approach to incident review
Group	Frequency	Type of communication	Role
			Explain likely changes in reports that will be available once transition to PSIRF is completed.

Appendix II: Established processes

Incidents relating to the specialist areas below will be monitored and reviewed by the relevant subject matter experts. The specialist teams will be involved in relevant learning responses and have oversight of these. They may steer the appropriate learning response for specific incidents depending on the level of issues identified. Improvement activity will be overseen by the relevant Trust group as listed in the table below.

Patient safety issue	Overseeing Group managing improvement
Harm Free Assurance (Hospital Acquired Pressure Ulcers, Inpatient Falls, Nutrition and hydration)	Harms Free Assurance group
Hospital Acquired thrombosis	Thrombosis Working Group
Hospital acquired infections	Hospital Infection Prevention and Control Committee
IRMER	Radiation Protection Committee - Learning and improvement activity reported to CQC.
Positive Patient Identification, WHO checklists, Never Event assurance related to surgery	Safe Surgery and Procedures Implementation Group

Appendix III: Defining our patient safety incident profile

Defining our patient safety incident profile

A key part of developing the PSIRF Plan is understanding the key issues that lead to risks for patient safety within the OUH, known as the Patient Safety Profile. To understand the patient safety incident profile, a wide source of information about risks to patients are reviewed and evaluated. The process of developing the patient safety incident profile is described below.

Stakeholder engagement

The OUH patient safety incident profile which has informed the PSIRF plan has been developed in collaboration with stakeholders from across the organisation, with patient representatives and with relevant external organisations. Key stakeholders were identified and invited to form the membership of the PSIRF steering group. These include:

- Deputy Chief Medical Officer (DCMO) Patient Safety
- DCMO, Clinical Improvement
- Head of Clinical Governance
- PSIRF Implementation Project Leads
- Patient Safety Specialists
- Patient safety Champions
- Divisional Leads for each Division
- Patient Experience & Engagement Lead
- Portfolio & Quality Improvement Team Lead
- Deputy Chief Nursing Officer (CNO)
- Representative from Legal Services
- Quality Assurance Manager
- Culture & Leadership Lead
- Communication team link person
- Chief Clinical Information Officer (CCIO)
- A member of the Clinical Governance team (minute taker)
- A patient representative/Patient Safety Partner

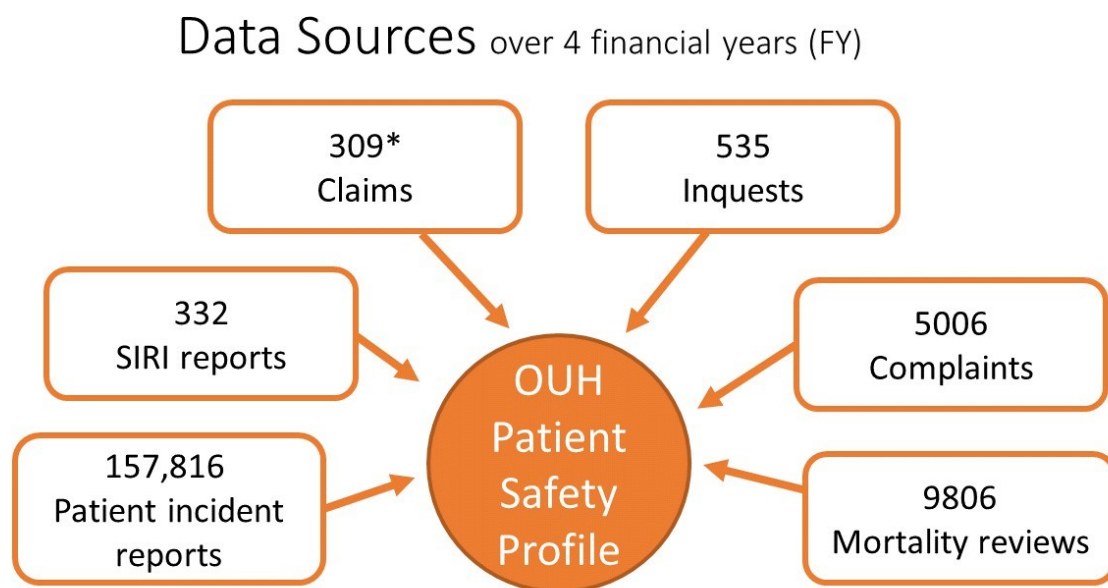
Additionally, the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB), jointly with the OUH during our Serious Incident Closure Meetings, have identified potential themes which have helped to shape our Patient Safety Profile.

Other stakeholders were kept informed using a comprehensive communication strategy (see **Appendix I: Communication Strategy**).

Data Sources

The PSIRF implementation team used multiple sources of information and data to identify the overarching and key patient safety issues that are contributing to risk at the OUH (Figure 3). Additionally, conversations were held with representatives from each division to identify the key issues affecting patient safety within their division. Open sessions were held over Microsoft Teams where any staff member was able to hear about PSIRF and share safety concerns. The data sources were collated and mapped according to frequency of occurrences (where information is available), and by the breadth of impact across different sources of information. Where available, data was collected from the previous four financial years, dating from 2020/21 through to the present 2022/23.

Figure 3: Data sources used to develop the OUH Safety Profile



* 2 FY data

Plus, key themes and issues identified from QI projects, risk registers and the Freedom to Speak Up and Safeguarding teams

Figure 3: Data sources used to develop the OUH Safety Profile

The top ten patient safety issues, identified by the above process, were shared, and discussed at a PSIRF Summit with 72 key stakeholders (which included the BOB ICB, Oxford Academic Health Science Network (AHSN) regional representatives from NHSE, Maternity Patient Voices Partnership, and our new Patient Safety Partner) who provided feedback on these and issues they felt were not represented. Following compilation of the data and feedback, the following four topics were chosen as the first PSIRF improvement workstreams:

1. Handovers including communication and documentation.
2. Referral and MDT processes and pathways.
2. Reporting and pathology/imaging endorsement.
4. Patients at risk (People with learning or intellectual disabilities, safeguarding and mental health issues).

The impact of estates and facilities, staffing and workforce and IT issues were also considered to be significant issues contributing to patient safety risks. It was felt that there are other Trust-wide strategies responsible for delivering improvements in these areas that will address these issues ([Our Strategy](#), [Our People Plan](#), [Our Digital Strategy](#), [Our Clinical Strategy](#)). Therefore, they

have not been proposed as PSIRF workstreams for 2023-24. Each patient safety incident investigation will be asked to consider each of these factors as part of the learning response to feedback into the Strategies above.

In April 2023, a report was published ["Prevention of future death reports in inquests – what are the recurring themes?"](#) This summarised a review of all the Prevention of Future Death (PFD) reports issued by Coroners in 2022. Many of the key themes align with the proposed PSIRF workstreams, including communication between and within teams, handovers, record keeping (for example electronic systems and flagging of abnormal results) and imaging results not being detected or acted on.

The OUH patient safety culture analysis is described in the PSIRF Policy and were considered during the development of the PSIRF themes. This analysis showed that the OUH have a good reporting culture, and the high rates of incidents reported relating to medication safety and pressure damage show good rates of reporting. As there are already processes and structures in place to oversee these risks and issues, they were not selected as PSIRF improvement themes.

PSIRF Improvement workstreams will follow a Quality Improvement process to understand these areas of risk in detail and at a deeper level. Once this analysis has been performed, areas where improvements could be made to reduce risk and potential for harm are identified. Actions to reduce risk (i.e., safety actions) are then generated in relation to each defined area for improvement. Following this, measures to monitor safety actions and the review steps are defined. This will be an iterative process and will continue over 12 to 18 months. As the workstreams are very broad, resources may be focused on one aspect of the issue at a time. The PSIRF improvement workstreams will share and be monitored by the weekly Safety, Learning and Improvement Conversation (SLIC) (described in the PSIRF Policy).

Where other issues or risks to patient safety are identified that span different locations and many different incidents that share likely contributory factors and would benefit from a co-ordinated response, these may be added as additional PSIRF Improvement workstreams. Issues will be escalated, monitored, proposed, and accepted as PSIRF workstreams through the weekly SLIC meeting.