Patient Safety Incident Response Plan

Quality & Governance Policy

Department:	Quality	**Version No:**	3
Responsible Executive	Chief Operating Officer	**Review Due:**	21/07/2026
Owner:	Associate Director of Quality	**Review Date:**	21/07/2025
Intended Audience:	Internal		
Policy Status:	This policy does not give contractual rights to individual members of staff. The company reserves the right to alter any of its terms at any time, although we will notify you of any changes. For the purposes of these documents, the Company name is referred to as HealthHero. This policy is applicable to the following entities: - ☐ Group ☐ Enterprise IE ☐ Enterprise UK ☒ NHS UK – HealthHero Integrated Urgent Care ☐ Doctorlink Document uncontrolled if downloaded or printed		

Amendments Summary

Version	Section	Amendment Details	Date Issued
1	New policy / plan document	New document created by the Medvivo Quality Team as a result of the Patient Safety Incident Response Framework replacing the previous Serious Incident Framework (2015)	31/07/2023
2	Section 7 and Appendix A	A further year's worth of data was reviewed to verify the original priorities established, confirming their validity	11/11/2024
3	Troughout	Policy document also reviewed in July – document updated so both policy and plan will be reviewed in July 2026. Naming updated to ensure reference to Health / HealthHero Integrated Urgent Care. Full review of data to begin in 2026 ready for updated plan & policy no later than July 2026. Full review of Datix (standard Datix, complaints and PSIs to be completed early 2026 (Frb-26) in order to use data to review HealthHero safety and investigation priorities.	21/07/2025

HEALTH HERO

Contents

1. Introduction

1.1. A patient safety incident response plan (PSIRP) is a requirement of each provider delivering NHS-funded care.

1.2. Unlike previous frameworks, the Patient Safety Incident Response Framework (PSIRF) is not a tweak or adaptation of what came before. PSIRF is a whole system change to how we think and respond to incidents in order to prevent reoccurrence. Previous frameworks have described when and how to investigate a serious incident, PSIRF focuses on learning and improvement.

1.3. Essential to PSIRF is fostering and maintaining a culture in which people feel safe to talk. HealthHero Integrated Urgent Care recognises having conversations with people relating to an incident can be difficult and it is vital to support staff, patients, families, and all involved during a patient safety investigation.

1.4. The aim of this approach is to continually improve. HealthHero will monitor the impact and effectiveness of implementing PSIRF. HealthHero will respond and adapt as and when the organisation's approach is not achieving what was set out, and as such this document will be reviewed annually.

1.5. The plan is not a permanent rule that cannot be changed. HealthHero will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

2. Purpose

2.1. This PSIRP sets out how HealthHero will seek to learn and respond to patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care we provide.

3. Scope

3.1. There are many ways to respond to an incident. This plan explains the scope for a system-based approach to learning from patient safety incidents. HealthHero will identify incidents to review through nationally and locally defined patient safety priorities.

3.2. There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

3.3. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, HR matters, legal claims, and inquests. Incidents requiring other types of investigation and decision-making, which lie outside the scope of this work, will be appropriately referred as follows:

- professional conduct/competence – referred to human resource teams
- establishing liability/avoidability – referred to claims or legal teams
- cause of death – referred to the coroner's office
- criminal – referred to the police

4. Strategic Aims and Objectives

4.1. The overall aim and objective of incident management is to improve the safety of the care and support HealthHero provides for patients.

4.2. The aim and objectives of this PSIRP is to improve the efficiency of our patient safety incident investigations (PSIIs) by:

- refocusing investigations towards a systems approach and the identification of interconnected causal factors and systems issues
- focusing on addressing causal factors to help mitigate risks and prevent reoccurrence of patient safety incidents
- develop and implement systems and processes to continually improve the quality and efficiency of care
- transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents
- transferring the emphasis from the quantity of investigations to a higher quality, this will make more effective use of resources, and create more proportionate response to patient safety incidents as a whole
- maintaining and develop a climate that supports a Just Culture[1] and an effective learning response to patient safety incidents
- improving the experience for patients, their families and carers whenever a patient safety incident or the need for a PSII is identified

5. Our Services

5.1. HealthHero is a provider of Integrated Urgent Care (IUC) and related services, with a HQ base located in the South West of England. HealthHero is led by a management team of executive and associate directors with both clinical and non-clinical expertise. They are fully engaged at a strategic and operational level to coordinate safe service delivery for patients, service

[1] Just Culture is about creating a culture of fairness, openness and learning in the NHS. This is to make colleagues feel confident to speak up when things go wrong, rather than fearing blame NHS England » A just culture guide

users and staff with strong clinical and corporate governance.

5.2. In May 2018, HealthHero was awarded the Integrated Urgent Care contract incorporating other related services across Bath and North East Somerset (BaNES), Swindon and Wiltshire.

5.3. Key services delivered include:

- Clinical Assessment Service (CAS)
- Out of Hours (OOH) Primary Care
- Access to Care (ATC)
- Non-Clinical Response
- High Intensity User (HIU) Service
- Care Coordination

5.4. In addition to providing these core services, by working with system partners such as local acute hospitals and the South Western Ambulance Service, HealthHero continually develops and delivers new services to best support the needs of local patients and the local health and care system as a whole. As and when required, HealthHero enhances its existing workforce and infrastructure to quickly roll out additional services.

5.5. HealthHero has several bases located across BaNES, Swindon and Wiltshire, with the main Headquarters based at Fox Talbot House (FTH) in Chippenham. The call centre is located here along with office-based staff who provide support services such as Rota Management, Human Resources, IT Technical Support and the Quality Team.

6. National Situation

6.1. Many millions of people are treated safely and successfully each year by the health and care services in England, but evidence tells us that in complex healthcare systems things will, and do, go wrong no matter how dedicated and professional the staff.

6.2. When things go wrong, patients are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical and non-clinical teams to which they belong can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatment, and litigation. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

6.3. Historically, the NHS has required organisations to investigate each incident report that meets a certain outcome threshold or 'trigger list'. When this approach was developed it was not clear that:

- luck often determines whether an undesired circumstance translates into a near miss or a severe harm incident[2] – as a result, focusing most patient safety investigation efforts on incidents with the most severe outcome does not necessarily provide the most effective route to organisational learning[3]

- there is no clear need to investigate every incident report to identify the common causes and improvement actions required to reduce the risk of similar incidents occurring – to emphasise this point, it has been highlighted that in-depth analysis of a small number of incidents brings greater dividends than a cursory examination of a large number

6.4. An increased openness to report patient safety issues has also led to an ever-growing number of incidents being referred for investigation. NHS organisations are now struggling to meet the number of requests for investigation into similar types of incident with the level of rigour and quality required. Available resources have become inundated by the investigation process itself – leaving little capacity to carry out the very safety improvement work the NHS originally set out to achieve.[4,5,6,7,8]

6.5. In addition, the remit for PSII has become broad and mixed over time. This originates from an attempt to be more efficient by addressing the many and varied needs of different types of investigation in a single approach. Sadly, the very nature and needs of some types of investigation (e.g. professional conduct or fitness to practice; establishing liability or avoidability; or establishing cause of death) have frustrated the original patient safety aim and blocked the system-learning the NHS set out to achieve.

6.6. The NHS needs to remove the barriers in healthcare that have frustrated the success of learning and improvement following a PSII. The NHS also needs to increase the opportunity for continuous improvement by:

- improving the quality of PSIIs

- conducting PSIIs purely from a patient safety perspective

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[2] Health and Safety Executive (2014) https://www.hse.gov.uk/pubns/books/hsg245.htm
[3] Vincent C, Adams S, Chapman A et al (1999) http://www.patientsafety.ucl.ac.uk/CRU-ALARMprotocol.pdf
[4] Public Administration Select Committee (2015) https://publications.parliament.uk/pa/cm201415/cmselect/cmpubadm/886/886.pdf
[5] Parliamentary and Health Service Ombudsman (2015) http://www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has
[6] C are Quality Commission (2016) https://www.cqc.org.uk/news/stories/care-quality-commission-reviews-how-nhs-acute-trusts-are-learning-serious-incidents
[7] NHS Improvement (2018) https://improvement.nhs.uk/resources/future-of-patient-safety-investigation/
[8] NHS Improvement (2018) https://improvement.nhs.uk/resources/future-of-patient-safety-investigation/

- reducing the number of PSIIs into the same type of incident

- aggregating and confirming the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents

6.7. This approach will allow NHS organisations to consider the themes that are common to similar types of incident and, on the basis of the risk and learning opportunities they present, demonstrate that these are:

- being explored and addressed as a priority in current PSII work

- the subject of current improvement work that can be shown to result in progress or listed for PSII work to be scheduled in the future

7. Local Patient Safety Incident Analysis

7.1. HealthHero and the services the organisation provides are complex with many interrelated components that are crucial to ensuring that everything works effectively. A review of the PSII resource and activity (associated with patient safety incident investigation) for the period July 2020 to July 2023 has been undertaken. A second review was completed for the period July 2023 to July 2024 to verify the established priorities, confirming their validity.

7.2. Other activities within HealthHero that provide insights into patient safety include end-to-end review, thematic workshops, complaints and patient experience feedback responses.

7.3. This review has been undertaken by the Quality and Patient Safety Team with support and involvement from the Risk, Clinical Effectiveness and Quality Committee memberships.

7.4. See Appendix A for a summary of patient safety activity between July 2020 to July 2023, and July 2023 to July 2024.

7.5. Through HealthHero's analysis of the organisation's patient safety insights, based on both Datix data and thematic analysis, five patient safety priorities have been determined that HealthHero will focus on for the next two years. These patient safety priorities form the foundation for how HealthHero will decide to conduct PSIIs and patient safety reviews.

	Incident Type	Description
1	Delay in care	Occurrences of delayed clinical contact with a patient experiencing a significantly longer than expected wait for a remote and/or face-to-face consultation which could have, or did, lead to patient harm. Includes failures in correct application of the principles and procedures of HealthHero's failure to make contact policy, especially in relation to the timeless and effective application of a risk assessment to safety manage any failed telephone and/or face-to-face patient contact.
2	Clinical diagnosis	Errors in incorrect clinical diagnosis (the process of identifying and detecting the nature of a disorder or illness) resulting in, or with the potential to, contribute towards patient harm or delayed recovery.

3	Case flow management	System or user errors in case flow resulting in the failure to correctly forward cases/patients to the next desired location, resulting in patient delay in care and/or potential or actual patient harm.
4	Medication errors	Errors in the process of prescribing, preparing, dispensing, and administering, monitoring or providing advice on medicines. Includes any errors regarding the administration, storage and movement of medicines as part of HealthHero's medicines management procedures.
5	Case documentation	Incorrect documentation within patient records resulting in a data breach or inaccurate information, leading to ineffective patient care.

7.6. The patient safety priorities were agreed at the Quality Committee and Datix Committee.

7.7. HealthHero has identified that with its current resources it is able to undertake 8 PSIIs across the organisation.

8. Identifying Patient Safety Incidents

8.1. Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Deciding what to investigate through a PSII process will be with a flexible approach, informed by the local and national priorities.

8.2. HealthHero utilise well established structures to support the process of decision making. There is an established Datix Committee meeting attended by the Chief Operating Officer, Medical Director, Associate Director of Quality, Associate Director of Operations, Clinical Leads, Service Leads, and members of the Quality Team, in which potential significant incidents and other emerging patient safety issues are discussed.

8.3. Core to deciding what to investigate was the national and local situational analysis. The analysis identified five HealthHero patient safety priority incident categories that learning will be structured against over the first stage (2 years) of PSIRF.

8.4. National guidance recommends that 3-6 investigations per priority are conducted per year. Attempting to do more than this may impede HealthHero's ability to adopt a systems-based learning approach from thematic analysis and learning from excellence.

8.5. Patient safety incidents that must be investigated under PSIRF include:

- patient safety incident is a Never Event[9]
- deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process[10]
- national priorities for investigations

[9] NHS England » Never events
[10] NHS England » Learning from deaths in the NHS

8.6. See Appendix B for a list of nationally defined and locally defined incidents requiring a PSII.

8.7. Apart from the "must investigate" points above, the decision to carry out a patient safety incident investigation should be based on the following:
- the patient safety incident is linked to one of HealthHero's patient safety priorities that were agreed as part of the situational analysis
- the patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases

8.8. Patient safety incidents that have resulted in severe harm would have automatically been a serious incident under the Serious Incident Framework.[11] It is crucial that these incidents are not routinely investigated using the PSII process, otherwise this would be recreating the Serious Incident Framework. The routine response to an incident that results in severe harm will be to follow the Statutory Duty of Candour requirements. This will both provide insights into thematic learning and provide information about the events to share with those involved.

9. Reporting Patient Safety Incidents

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

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

9.3. All information relating to patient safety incidents and the insight generated from all responses must be recorded within Datix and shared with the Learn from Patient Safety Events (LFPSE) Service.

9.4. The process of complying with both internal and external notification requirements for the reporting of patient safety-related incidents can be found within HealthHero's Adverse Incident Reporting, Investigation and Learning Policy.

10. Conducting Patient Safety Incident Investigations

10.1. Patient safety investigations are conducted to identify the circumstances and systemic, interconnected, causal factors that result in patient safety incidents. Investigations analyse the system in which we work by collecting and assessing evidence, to identify systems-based contributory factors. Safety recommendations are created from this evidence-based analysis, to target systems-based improvement.

[11] NHS England » Serious Incident framework

10.2. To improve our ability to deliver against PSII standards HealthHero will:

- assign an appropriately experienced lead investigator with relevant knowledge around the circumstances of the incident
- assign an appropriately experienced member of the Quality Team to oversee delivery of the PSII standards
- assign an appropriate member of the Executive and Associate Director Leadership Team and support the sign off of all PSIIs

10.3. All lead investigators will be supported by the Quality and Patient Safety Team as experienced patient safety matter experts. Further support in terms of administrative support and patient/family/staff liaison will also be provided or arranged by the Quality Team.

10.4. Lead investigators will not be expected to manage any more than two full PSIIs at any one time.

10.5. Each comprehensive PSII will be:

- conducted separately, in full and to a high standard by a lead investigator, who is a member of the Quality and/or Senior Leadership and Management Team.
- undertaken as per the PSIRP and will adhere to the national PSII standards and with national good practice for PSII
- use the national standard template to guide reports and the findings of the PSIIs.[12]
- identify common, interconnected, deep-seated causal factors (not high-level themes or problems)

10.6. For each group of PSIIs dedicated to a similar/narrow focus incident type, HealthHero will:

- design strong/effective improvements to sustainably address common interconnected causal factors
- develop an action plan for implementation of the planned improvements. While some actions may be needed after only one investigation, where possible, we will wait until all investigations for each incident type are completed, and common causal factors identified, so that solutions/action plans can be developed to address them
- monitor implementation of the improvements

[12] Patient safety incident investigation (PSII) report template B1465-PSII-Report-Template-v1.1.docx (live.com)

- monitor effectiveness of the improvements over time

10.7. To monitor the quality of PSII findings and progress against this PSIRP, we will seek answers to the following:
- are actions likely to achieve improvement?
- is there evidence of improvement?

10.8. A valuable and thorough way of accomplishing thematic analysis of PSII findings is to select a number (three to six) of recent and very similar incidents and investigate each individually with skill and rigour, to determine the interconnected, contributory and causal factors. The findings from each individual investigation are then collated, compared, and contrasted to identify common causal factors and any common interconnections or associations upon which effective improvements can be designed. Importantly, investigation of recent incidents allows more accurate information gathering from properly specified, good quality PSIIs, and detailed analysis of the system as it currently stands.

10.9. Not all patient safety incidents require PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers, or staff. Where this is the case, HealthHero will adopt relevant techniques. This will depend on the intended aim and required outcome and might include case note review, timeline, or chronology, learning review meeting or sharing of an anonymised incident report.

11. Timescales for Patient Safety Incident Investigations

11.1. Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified. PSIIs should ordinarily be completed within one to three months of their start date.

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

11.3. No local PSII should take longer than six months. A balance must 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 some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

12. Roles and Responsibilities

12.1. HealthHero describes clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities

and upholding national standards relating to patient safety incidents.

12.2. **Chief Executive**

- the Chief Executive has overall responsibility for the effective management of all patient safety incidents, including contribution to cross-system/multi-agency reviews and/or investigations where required
- with the executive and non-executive team, support the development of patient safety reporting, learning and improvement systems
- ensure that systems and processes are adequately resourced, including funding, management time, equipment and training

12.3. The **Chief Operating Officer**, supported by the **Associate Director of Quality**, is the executive lead responsible for supporting and overseeing implementation of the PSIRF which includes:

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

- oversee development and review of the PSIRP

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

- ensures HealthHero complies with the national patient safety investigation standards[13]

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

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

12.4. **The Quality Team**

- ensures that patient safety investigations are undertaken for all incidents that require this level of response

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

- ensures HealthHero has procedures that support the management of patient safety incidents in line with the PSIRP (including convening review

[13] B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)

and investigation teams as required and appointing named contacts to support those affected)

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

- works with executive lead to address identified weaknesses/areas for improvement in HealthHero's response to patient safety incidents including gaps in resource such as skills and training

- supports and advises staff involved in the patient safety incident response

- ensures that investigations are undertaken in line with the patient safety investigation standards

12.5. **Lead Investigators**

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

- undertake investigations in line with the patient safety investigation standards

- be the main point of contact for the patient, families and carers to ensure they are fully supported and informed of the investigation and its progress

- identify those patients, families and carers affected by patient safety incidents and provide them with timely and accessible information and advice

- act as liaison between patients, families, carers and investigation teams to help manage expectations

12.6. **Named contacts for staff**

- provide advice and support throughout the investigation process to staff affected by a patient safety incident

- facilitate their access to additional support services as required

- act as liaison between these staff and investigation team as required

12.7. **Service/Department Leads**

- encourage reporting of all patient safety incidents, including near misses, and ensure all staff in their area are competent in using the Datix reporting system and are provided sufficient time to record incidents and

share information

- provide protected time for training in patient safety disciplines to support skill-development across the wider staff group

- provide protected time for participation in investigations as required

- liaise with the Quality Team and others to ensure those affected by patient safety incidents have access to the support they need

- support development and delivery of actions in response to patient safety investigations that relate to their area of responsibility (including taking corrective action to achieve the desired outcome)

12.8. **All staff**

- understand their responsibilities in relation to the organisation's PSIRP

- know how to access help and support in relation to patient safety incident response process

13. Procedures to Support Patients, Families and Carers

13.1. HealthHero is open with patients and relatives when errors are made and ensures that the principles of Being Open and Duty of Candour are applied and adhered to.

13.2. This is integral to the response to incidents, complaints, legal and safeguarding processes. Being open is part of a Just Culture required of all healthcare providers and is fundamental to being a learning organisation.

13.3. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20[14] says we must:

- tell the person/people involved (including family where appropriate) that the safety incident has taken place
- apologise

- 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

13.4. Arrangements for supporting patients, families and carers are detailed within

[14] Regulation 20: Duty of candour - Care Quality Commission (cqc.org.uk)

the Trust's Being Open and Duty of Candour Policy and associated documents.

14. Procedures to Support Staff

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

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

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

14.4. Key components that may be included in the initial acknowledgement to staff include:

- emphasising the importance of identifying organisational learning
- stressing that their input/questions and contribution is pivotal to any investigation
- shared understanding of the potential stress associated (staff should be provided with the support options available)
- clear time frames explained (avoid the possible concern that periods of 'no news is bad news')
- emphasising that transparency is key
- confirming regular 'touch base' periods are built in to any investigation
- advising draft reports are to be shared with staff to encourage feedback and promote the ethos of transparency
- advising final report to be shared and debrief arranged as required

14.5. General arrangements for supporting staff health and wellbeing are detailed

on HealthHero's intranet and include a health plan and employee assistance programme.

15. Evaluating and Monitoring Outcomes of Patient Safety Incidents

15.1. PSII trends and emerging themes are shared throughout the organisation via monthly executive and Integrated Care Board reporting. All incident themes and learning are discussed at both HealthHero's Datix and Quality committees. Reports will include aggregated data on:

- patient safety incident reporting
- findings from PSIIs
- results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- feedback from staff on their experiences of the organisation's response to patient safety incidents

15.2. Results from PSIIs and reviews provide key insights and learning opportunities, but findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

15.3. The Quality Team work in close collaboration and share all findings with HealthHero's Associate Director of Service Improvement to develop and support improvements following PSIIs.

16. Complaints and Appeals Process

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

16.2. Complaint trends and emerging themes are shared throughout the organisation via monthly executive and Integrated Care Board reporting. Complaint themes and learning are discussed at both HealthHero's Datix and Quality committees.

16.3. Complaints processes relating to HealthHero's responses to patient safety incidents, are detailed within the Complaints Management Policy.

17. Related Policies and Procedures

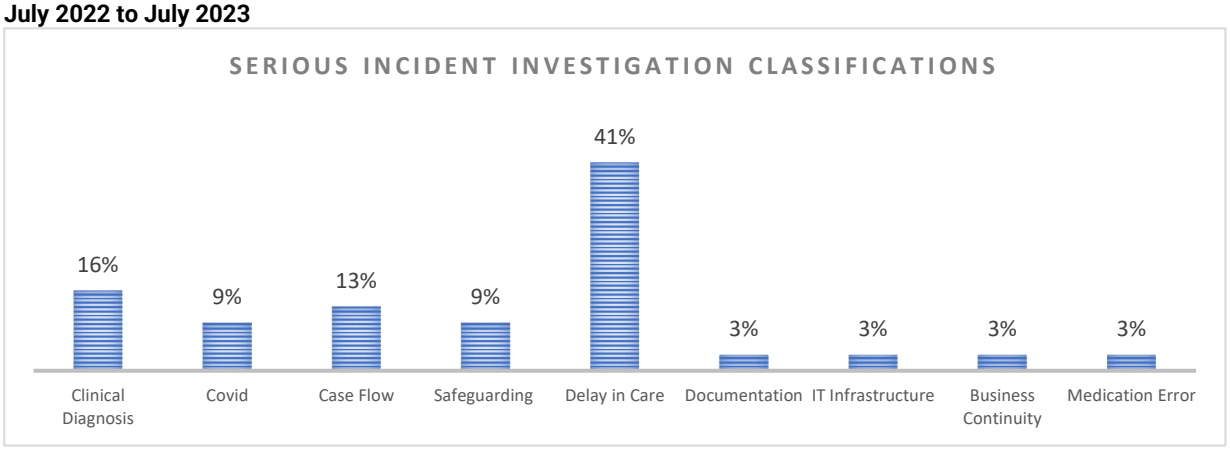
-Patient Safety Incident Response Policy
-Adverse Incident Reporting, Investigation and Learning Policy
-Complaints Management Policy
-Being Open and Duty of Candour Policy
-Advocacy Policy
-Disciplinary Policy

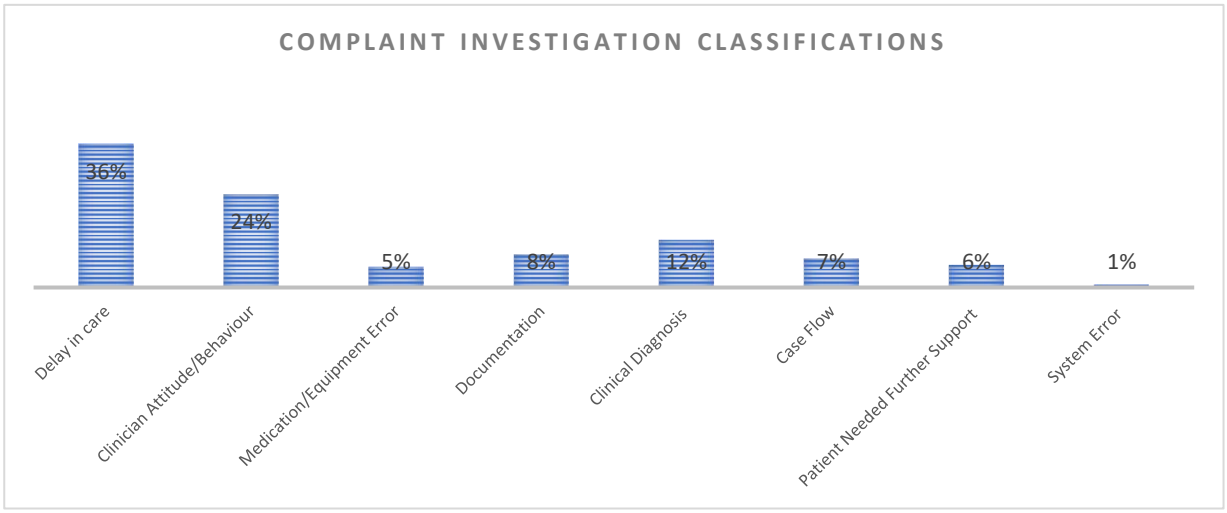
Appendix A

Patient Safety Activity Overview:

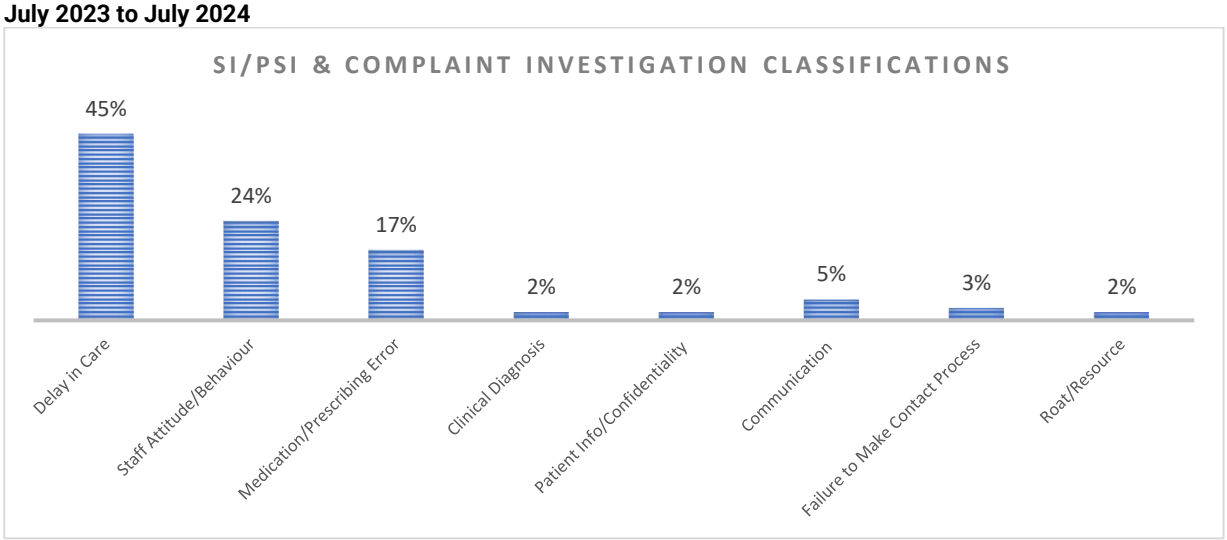
	2020/21	2021/22	2022/23	2023/24	Average
Serious Incident (SI) Investigations	10	7	4	5	6.5
Complaint Investigations	87	112	54	40	73.25

July 2022 to July 2023





July 2023 to July 2024



Appendix B

Nationally defined and locally defined incidents requiring a Patient Safety Incident Investigation (PSII)

	Indications
Nationally defined priorities to be referred for PSII or review by another body or team. Full details are also listed in the https://improvement.nhs.uk/resources/patient-safety-investigation/	**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. 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. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/ All perinatal and maternal deaths must be referred to MBRRACE. https://www.npeu.ox.ac.uk/mbrrace-uk/faqs
	Mental health related homicides by persons in receipt of mental health services or within six months of their discharge Must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT).
	Child deaths Incidents must be referred to child death panels for investigation. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777955/Child_death_review_statutory_and_operational_guidance_England.pdf
	Deaths of persons with learning disabilities Incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme. http://www.bristol.ac.uk/sps/leder/notify-a-death/
	Safeguarding incidents Incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multiprofessional investigation.
	Incident in screening programmes Incident 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). http://www.screening.nhs.uk/incidents
	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.
Nationally defined incidents requiring local PSII	**Incidents meeting the Never Events criteria 2018**. https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf
	Incidents meeting the 'Learning from Deaths' criteria' That is, deaths clinically assessed as more likely than not due to problems in care. https://improvement.nhs.uk/resources/learning-deaths-nhs/

Locally defined incidents requiring local PSII	**Locally defined emergent patient safety incidents requiring PSII** An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.
	Locally predefined patient safety incidents requiring investigation Key patient safety incidents for PSII have been identified through analysis of local data and intelligence from past years, and agreed with the commissioning organisations as a local priority in line with the following guidance: Criteria for selection of incidents for PSII: a. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc.) b. likelihood of recurrence (including scale, scope and spread) c. potential for learning in terms of: – enhanced knowledge and understanding – improved efficiency and effectiveness (control potential) – opportunity for influence on wider systems improvement.