Patient safety incident response plan

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Introduction

This patient safety incident response plan sets out how **Alliance Medical Ltd (AML)** intends to respond to patient safety incidents over a period of 12 to 18 months. 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.

We have committed to improve patient safety through the adoption of the Patient Safety Incident Response Framework (PSIRF), supporting a systematic, compassionate and proficient response to patient safety incidents; anchored in the principles of openness, fair accountability, learning and continuous improvement. PSIRF sets out the requirements of healthcare providers and the approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Our services

Alliance Medical Limited is part of the ICON Group and is Europe's leading independent provider of imaging services operating across the continent – in the UK, Germany, Ireland, Italy, The Netherlands, Norway and Spain. Alliance Medical is an independent provider, specialising in Diagnostic Imaging Services. The organisation provides Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography-Computerised Tomography (PET-CT), Plain film X-ray imaging, Ultrasound and DEXA scanning. Outpatient consulting rooms are also provided in some locations.

Services are provided in a variety of models including; Static Units, Mobile Units, Community Diagnostic Centres and Integrated Diagnostic Centres.

In the UK, services are delivered from circa forty-one (41) static (fixed location) sites and fifty (52) mobile/relocatable units forming a nationwide network which means that services can be provided close to the patient's home. Some static locations also utilise a hybrid module incorporating a satellite service by utilising mobile scanners parked for a period of time to support the permanent sites. These satellite units are associated and managed through our static sites.

Imaging services are provided either in fixed, modular or mobile units wholly operated by Alliance Medical or in units hosted by independent healthcare facilities or NHS Trusts.

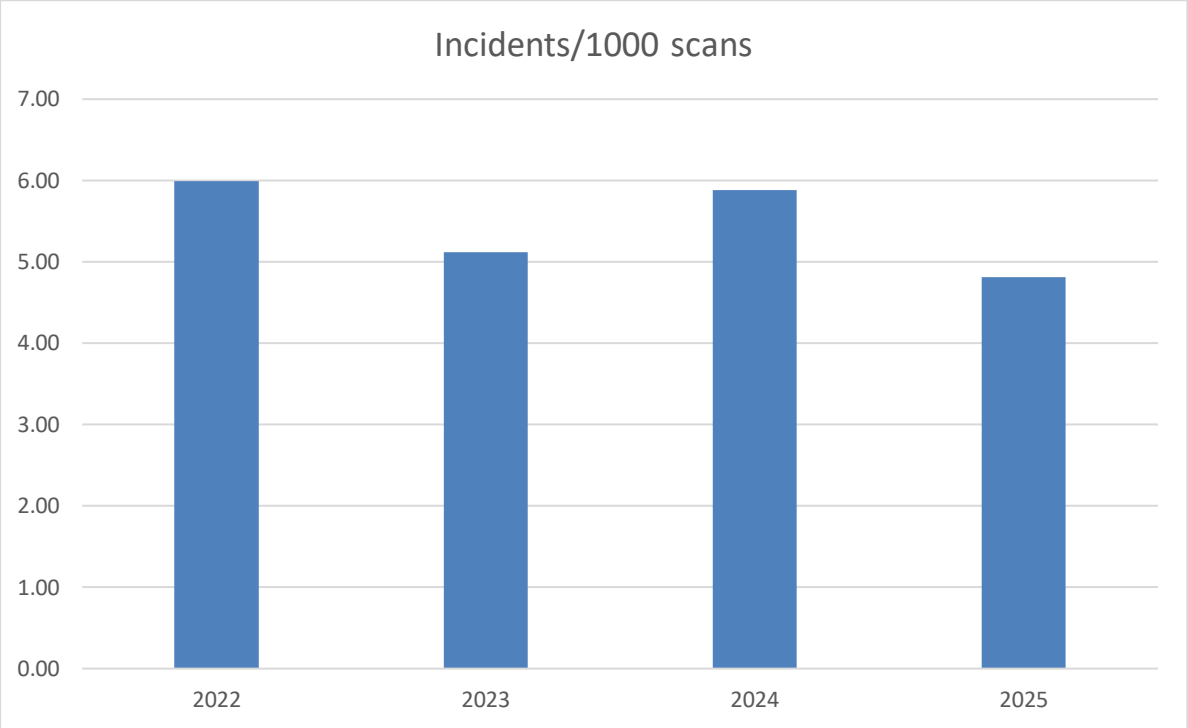
Alliance Medical operates within a robust Integrated Governance framework which through adopting and sharing evidence-based practice aims to provide diagnostic imaging and, where contracted to do so, image reporting, to the highest standards of quality and safety.

Where booking services are provided, Alliance Medical's provision of flexible booking arrangements ensures that examinations can be carried out as soon as possible at a time convenient to the patient.

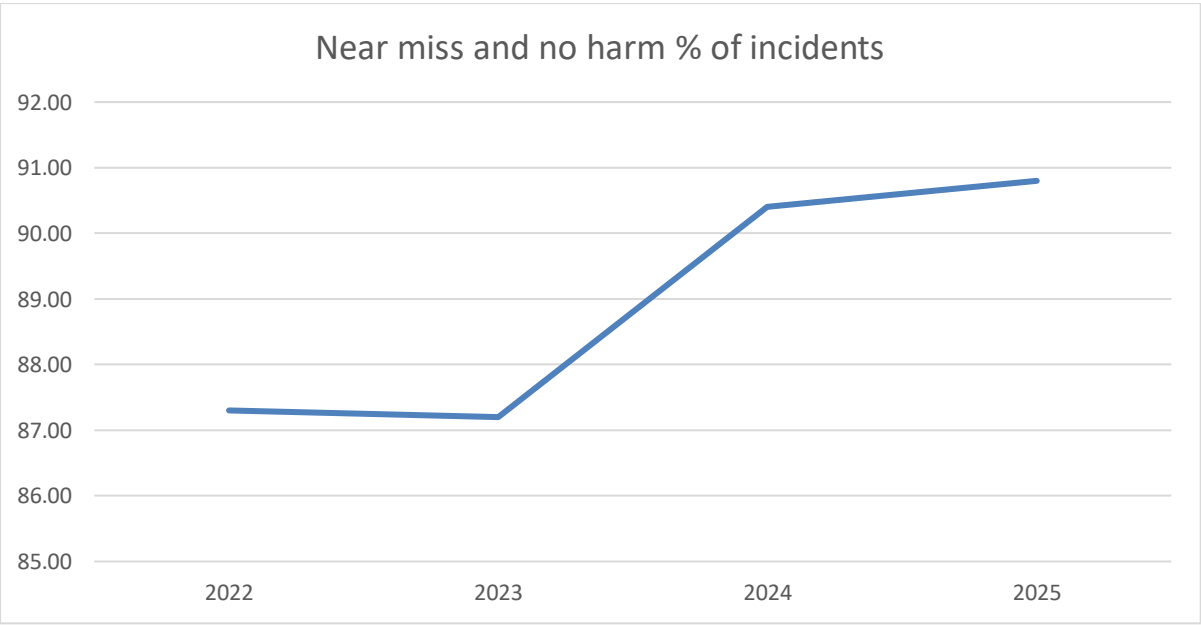
Alliance Medical commits to ensuring that systems are in place for monitoring, maintaining and improving the quality of the service and care provided through a variety of sources, including patient feedback and lessons learned from incidents, patient experience, audit and claims.

Defining our patient safety incident profile

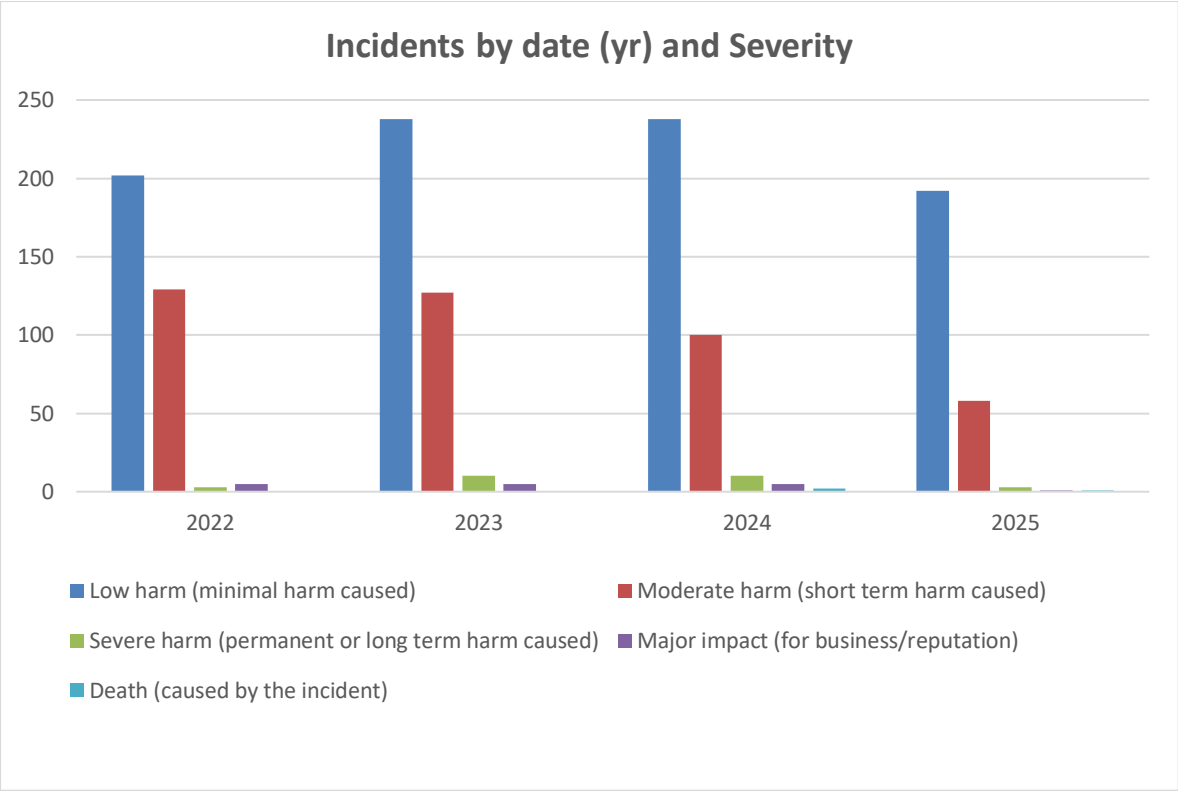
Incident Data was reviewed for the previous three full years and the most recent data for 2025 up to September 2025 relating to the safety profile of the organisation.



Across 2022 to 2025 there have been between 4.81 and 5.99 incidents per 1000 scans. The actual numbers of scans have increased, from around 450,000 in 2022 to close to 650,000 in 2024. The numbers of incident reports have also increased and so have the number of near miss and no harm incidents being reported reflecting an improved incident reporting culture



In relation to incidents identified as causing harm most incidents reported were low harm. When the data was interrogated most of the incidents reported by the teams as 'moderate' harm did not meet the threshold for 'moderate harm'. In 2024 additional guidance was added to Datix to guide staff to make the correct choice when reporting. This is reflected in the reduced number of moderate harm seen as a percentage of all incidents as we progressed through 2024 and into 2025.



Across the period reviewed the total number of incidents in each category is outlined below:

Category	2022	2023	2024	2025 (end Oct'25)	TOTAL
Appointment Issues	0	1	362	278	641
Clinical Audit	70	80	106	44	300
Clinical	764	900	1107	855	3626
Health and Safety	254	238	289	187	968
Information Governance and Security	291	301	319	204	1115
Infection Control	65	64	62	33	224
MRI Safety	81	102	132	91	406
Operational	646	750	532	345	2273
Radiation Protection	462	479	695	552	2188
Radiology Reporting	84	87	215	96	482
Safeguarding	0	0	30	25	55
Total	2717	3002	3849	4735	14303

‘Appointment issues’ was a new category added in 2024 to capture issues relating to booking errors, patient preparation and other elements impacting the appointments not related to clinical or other categories.
Radiation protection incidents increased from 479 in 2023 to 695 in 2024, this correlates with the implementation of instadose badge monitoring enabling us to capture and review more such incidents.

Clinical incidents represent 25% of all incidents.
Considering the category of Clinical, this can be broken down further (as shown in the table below):

Subcategory of clinical incidents	2022	2023	2024	2025	TOTAL
Adverse reaction to contrast	82	66	63	66	277
Adverse reaction to medication (non contrast)	9	3	10	5	27
Adverse reaction to Radioactive Tracer	0	1	1	1	3
Cannulation Issues no extravasation	53	53	68	40	214
Claustrophobia	28	35	157	127	347
Extravasation	176	193	199	175	743
Injected Isotope Quality Failure	5	9	12	7	33
Medication Issues	8	12	5	8	33
Poor Image Quality	17	29	39	27	112
Safeguarding	5	16	3	0	24
Unwell, not requiring medical assistance	54	71	98	77	300
Unwell, requiring medical assistance	106	122	149	106	483
Procedure Failure or Error	143	179	181	133	636
Patient Pregnancy	2	3	6	8	19
Wrong anatomical Side Imaged (R/L)	7	7	7	0	21
Wrong Body Part Imaged	11	16	12	10	49
Wrong Protocol	34	51	50	36	171
Wrong Scan	13	12	15	10	50
Wrong Patient Scanned	10	19	25	16	70
Wrong Radioactive Tracer PET-CT	1	3	7	3	14
Total	764	900	1107	855	3626

NB – review of the subcategories has identified that some incidents may have been better classified under a different main category – work is ongoing in 2025 to provide updated guidance to teams on categorisation – this impacts ‘Wrong radioactive tracer’ which is recorded here under ‘clinical’ but has also been recorded under ‘radiation protection’

The key themes identified from the data are Extravasation, Procedure failure or Error and Unwell, requiring medical attention. These areas, whilst identified as high trends, already have a significant resource and training identified, these areas would be expected to be identified through swarm huddles or other on-site investigation tools with fast learning and further training needs identified.

In relation to Extravasation incidents, staff are encouraged to report these including the no harm incidents where the extravasation is minor and any which are identified at the flushing stage as a near miss. Increases in extravasation incidents within regions will be identified and monitored as part of the incident review reports for clinical governance committee and any areas reporting high incidence of extravasations will receive targeted support.

Procedure failure or error is a wide-ranging category and is being reviewed within some work around the Datix system and reporting categories review running concurrently with the PSIRF plan, this will allow for further detail to be captured for specifics of this category at the next thematic review stage.

'Unwell requiring medical attention' cases are all dealt with on an individual basis and supported by the Emergency Care Assessor to ensure appropriate learning.

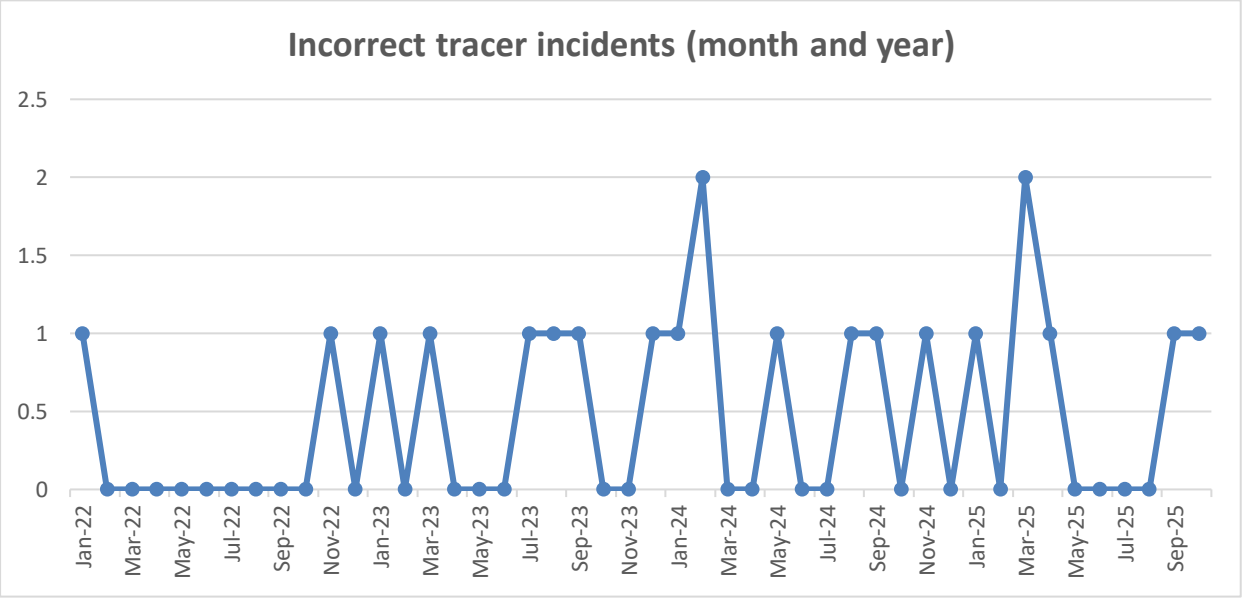
Within the category of Radiation Protection these incidents are already monitored and managed through the Radiation Protection committee and may be externally reportable which requires appropriate learning and associated action plans as required by the CQC.

Engagement with teams across the organisation was completed throughout 2024 and continues in 2025 to ensure a wide range of input across the organisation through Unit Manager meetings, Clinical Lead meetings, Mobile Manager Meetings, Modality Specific meetings (PET-CT and DI) and Quality and Risk (Q&R) team meetings. This sought to ensure that themes were identified where the possibility of maximum system learning could be identified. The outcome of engagement coupled with the data evaluation of incidents across the organisation from January 2022 to December 2024 and subsequent analysis in 2025 has guided the decision-making process around the PSIRF priorities. The following priorities were identified:

- Incorrect Radioactive tracer - including near miss incidents identified at vetting or booking stage
- 'Wrong' patient scanned
- Booking errors AML

Data was reviewed to assess trends and key areas for focus. Additionally, AML have engaged with our external stakeholders in referring Trusts to determine the selection of priorities. Specifically, the first priority has been identified as requiring Trust involvement and engagement relating to the referrals received and the process undertaken to authorise these scans. Joint work on this is proposed with Trusts in the South of the country. Service reviews with Trusts supports identifying priorities and allows AML to share lessons learned from incidents with Trust teams.

Incorrect radioactive tracer - PSMA, FDG and Dotatate - where the wrong tracer has been selected to be administered to the patient



Incidents identified as incorrect tracer in PET-CT appear to be becoming more frequent in line with our increased scanning in this modality. This includes near miss incidents which provide valuable data for how sites are picking up incorrect tracer incidents before the patient is injected.

A PSII investigation would identify system issues across this incident category and facilitate system improvements to prevent recurrence. The PSII can also identify and assess the effectiveness of learning from the previous investigations and actions. External stakeholders for this priority are CQC IRMER as incorrect tracer incidents are externally reportable.

Wrong Patient

Between January 2022 and November 2025, we recorded 78 incidents of 'wrong patient scanned'. These entries cover a variety of situations including where the wrong patient has been referred, through to the wrong patient having been selected from the patient list (right patient details attached to wrong patient record) and, very rarely, the wrong patient booked and scanned. A third of the incidents were recorded as near misses

56/78 (72%) – selection of wrong patient from booked list resulting in scans being attached to incorrect patient records although correct scans completed and error corrected at point of image transfer
8/78 (10%) – Incorrect referrals (pt referred in error to our services)
5/78 – booked incorrectly
6/78 – wrong patient from waiting area

During 2025 AML have actively analysed a number of these incidents using a SEIPS approach and established that a thematic review of incidents where systems failures with AML 'Pause and Check' processes is warranted. Modernising the diagnostic imaging system technology infrastructure will reduce the 'incorrect patient record selection' risk and as this rolls out we anticipate a reduction in these incidents.

Booking Errors – table showing sub-categories of incidents relating to appointment issues in 2024 and 2025

	Billing issue	Booking error by AML	Booking error by third party	Patient attended late	Patient attended wrong site location	Patient escort	Patient Preparation	Patient Transport	Translation Services	Total
2024	4	150	73	12	7	14	50	20	11	341
2025	4	139	50	7	7	5	40	36	6	294
Totals	8	289	123	19	14	19	90	56	17	635

From discussion with teams at site and review of incident detail, an additional category was added to Datix in February 2024 for 'appointment issues'. We also identified appointment issues in 23 complaints or concerns reported in 2024. Resolving such errors would improve the safety and quality of the service from first point of patient contact although recent initiatives involving staff training have only been partially effective. Using our PSIRF approach to investigate these errors will allow us to identify areas for systemic change where we can eliminate, reduce or replace processes to reduce risk, removing our reliance on the weaker methods of improvement e.g. 'staff training'.

Management of incidents resulting in severe harm

Patient safety incidents which have resulted in severe harm to patients would have previously been considered a serious incident under the Serious Incident Framework. With the introduction of the Patient Safety Incident Response Framework, it is crucial that these incidents are not routinely escalated to PSIIs unless they meet the AML PSIRF plan priorities or a national PSII requirement.

The routine response to an incident that results in severe harm will be to follow the Statutory Duty of Candour requirements. outlined in the Duty of Candour policy which is available on SharePoint. Through the Duty of Candour process, those involved in a safety event will be asked for their questions to be answered through the investigation, this will both provide insights to thematic learning and provide information about the events to share with those involved.

Defining our patient safety improvement profile

The AML PSIRF policy outlines the reporting lines of the organisation and the way incidents are escalated. As a national organisation, challenges may arise with sharing of learning from incidents. Cross system learning responses across multiple organisations or services will be undertaken collaboratively with the host organisation. The AML Quality and Risk team will support Unit Managers (UMs) liaising with external organisations where indicated, and will ensure the necessary expertise can be allocated for cross-system incident investigations. AML will ensure it complies with the ICB's process for alerting the ICB to patient safety investigations and providing copies of PSIIs for review.

Where the learning from an incident may impact services external to AML, unit and mobile managers are responsible for sharing the learning outcomes from investigations with the host trust or referrers. AML are committed to sharing learning both internal and external to our services for example we have recently worked with the Society of Radiographers to establish safe processes for the use of heparin in maintaining patency of PICC lines when radioisotope is administered. Training sessions on learning outcomes will cover cross system responsibilities. The fortnightly quality and incident review calls held regionally provide an opportunity for sharing of investigation outcomes and lessons learnt across modalities within AML.

Alliance Medical promotes safety across all areas of the business and continual development of safety culture across all business operations. A SEIPS guide and template is in place within the organisation and is encouraged to be completed during investigation of incidents to support learning improvements and adoption of a systems-based approach to incident management.

Incident management workshops with incident investigators, including SEIPS investigation training are delivered on a rolling basis to embed the culture and maintain the skills of the incident investigators. A total of 6 SEIPS investigator training sessions were delivered in 2024 with 44 staff completing the training, a further 43 completed the training in 2025 across 3 separate events.

The cascade of PSIRF and the principles of a just safety culture will be via Unit and Mobile managers to staff which will be supported by the AML Heads of Quality and Risk.
Items such as near miss and no-harm reporting rates for incidents are reported and tracked via Clinical Governance Group as measures of the organisations safety culture. Staff are encouraged to identify near misses as well as no/harm incidents and share learning from these at the fortnightly quality calls. The rates of whistle blowing incidents are also recorded and reported as another measure of safety culture.
In the rare circumstances that a learning response raises concerns about an individual's conduct or fitness to practice AML have adopted the NHS Being Fair Tool to support applying a just culture.

Freedom to Speak Up: AML have an organisational whistleblowing policy and Freedom to Speak up Guardian so staff are able to report any concerns centrally for investigation confidentially and openly. In 2024 there were 2 Freedom to Speak up concerns reported and investigated within the organisation. In 2025 there were a further two - In both cases the speak events acted as an early warning call out as opposed to any irreversible issues being created which would impact on patient care or staff wellbeing. Both reports were welcomed and of benefit to the organisations ability to maintain standards of leadership in our clinical services
There is some commonality to the incidents although they are not directly related. Observations and learnings to support our obligations to have Well Led clinical services are as follows.

- Both were newly appointed managers – a review of the selection criteria with specific focus on the behavioural competencies assessment is required
- The company has a leadership training programme in place, in both cases the appointments to management were recent and the individuals hadn't yet attended the training – the timeliness and prioritisation of this mandatory training needs continued focus

Duty of Candour: A key contact will be assigned to any investigations meeting the Duty of Candour requirements and they will be the main contact for those (patients and/or carers) involved in the safety incident. The identified person must have completed appropriate training as per the framework. Considerations of the requests of those involved regarding communication

preferences, accessibility requirements and reasonable adjustments will be documented at the initial contact with the family. This will be led by the Head of Quality and Risk for the region to ensure appropriate support is provided to those affected by the incident. There has been one formal duty of candour notification in 2023, meeting the threshold where harm was caused by Alliance Medical. There were no incidents triggering formal Duty of Candour in 2024, and there was one formal duty of candour notification in 2025, in this case lung changes were not reported although unclear whether reporting at that point would have influenced the outcome. A review of incidents reported as Moderate, Severe Harm or Death has been undertaken as the numbers would suggest additional statutory DoC activity would be warranted. This has identified that several of these cases were known complications of the care being provided e.g. contrast reactions and in most cases the level of harm was reported overly high – this is being addressed through staff training and Datix guides.

Quality improvement and audit: QI activity threaded through all aspects of the organisation with a robust audit programme in place and an audit calendar in place nationally. This is defined in the Clinical Audit policy. Key priorities identified within the audit plan are Health and Safety audits defined by national health and safety requirements and tailored to static, mobile and relocatable facilities. Radiation Protection audits including IRMER (Ionising Radiation (Medical Exposure) Regulations) to be carried out and discrepancies highlighted within the Radiation Protection Committee meetings. Medicines Management and Infection Prevention and Control Audits are also conducted at each site. Audit history forms part of the PSII review process as part of the evidence linking to the incident.

Throughout the course of 2024 and 2025 improvement projects were in place throughout the organisation:

Improvement Project	Rationale	Status
SEIPS training	Education of investigating staff on SEIPS – improved awareness of systems approach to incident investigation leading to better understanding of modifiable risks and actions to address them – improved patient care	Initial training completed – ongoing for new starters and refresher training provided
Change of Safeguarding training provider and streamline of training needs for safeguarding	Streamlined, individualised training for all staff – Improved knowledge of staff leading to improved patient care	Complete
Planning for new radiology information system (RIS) and Picture Archiving system (PACS)	Across 2024/25 the diagnostic imaging system technology infrastructure will be modernised allowing us to set a new standard in respect of meeting stakeholder expectations. We will achieve this through the replacement of our existing RIS & PACS technology infrastructure, ensuring clinical safety through compliance with DCB0129 & DCB0160 – Improved efficiency of service – reducing procedural risks	Roll out started Aug 2025 and planned programme into 2026 (
Referrer Satisfaction Survey	Expanded referrer satisfaction survey to include all modalities – enhanced information relating to experience of care – identifying areas for improvement	Complete

Bookings Process Improvement	Standardisation of the process, effective use of technology and resource to enhance the patient experience -improved experience of care	Pilot complete
Trialling a ferrous metal detector device	To reduce MR risk and support pts to remove metal items before their scan for their safety – safer care	Trial proved technology is useful but demonstrated need for handheld device – business case in to support use
Introducing radiographer led cardiac stress lists	To improve throughput and efficiency to address backlogs and run lists when trust unable to provide consultant cover – resulted in significant decrease in waiting lists at Wythenshawe site (50+ weeks to 6 weeks) – earlier diagnosis	Rolled out as BAU – to be built on via radiographers competencies extension to introduce radiographer led cardiac CT services e.g. procedures involving beta blockers
Introduction of newer PET-CT technology	Reduces bed times for patients and/or reduces radioisotope activity requirements – overall reducing patient exposure – safer care	Rolling out to new sites and when scanners are replaced, includes Mobile PET-CT units

Recommendations identified through the patient safety incident response framework incident reviews that require monitoring through audit will be highlighted to the compliance manager for review of audit appropriateness and inclusion on the audit calendar if required. Audits identified at individual site level will be reviewed at the Quality Assurance Review visits to sites and shared and documented via staff meeting minutes.

Safety improvements utilising the PSIRF framework fit within the organisational core values, reinforcing the values and allowing demonstration of the values through the incident framework.

Alliance Medical Core Values	Openness	Excellence	Efficiency	Learning	Collaboration
PSIRF Strategic Aims	Involving those impacted by safety incidents from the outset. Listening to questions from patients,	Improving patient care by identifying emerging risks and trends in incidents to appropriately action plan	Utilising resources of those with expertise in patient safety to investigate the incidents with the	Focussed investigations highlighting the learning within the investigation. Proportionate responses to safety events	Improve the working environment for staff by developing a just culture and safe space to discuss safety incidents.

	carers and staff involved to form learning actions		greatest impact in learning		Supporting those involved in safety incidents, both staff and patients/carers.

Considering our safety profile above, the following areas will be the AML key priority areas for 2025. For some the work will start with PSIIs to identify system factors impacting on the incidents and identify areas for system improvement. For others the intention is for AML staff to continue reporting and using SEIPS for their reviews and the Quality and Risk team will undertake detailed thematic analysis to identify and make system improvements:

1. **Incorrect Radioactive tracer PSMA and FDG- including near miss incidents identified at vetting or booking stage**

There is potential for delayed diagnosis or additional radiation dose for patients who require repeated scans due to incorrect tracer. This can be potentially identified at vetting or pre appointment stage for incorrectly vetted or booked referrals or at injection stage for those injected with the incorrect tracer against the correct vetted tracer.

Individual cases have been addressed at an individual unit level, but, as PET-CT scan numbers increase, the potential for this type of incident increases. The processes at each unit are slightly different depending on IT configuration. We would like to understand in more detail what configuration and process means that some units have repeat issues with incorrect tracer. We believe that system improvements could assist the staff to prevent these issues, therefore supporting the patient pathways.

2. **Wrong Patient incidents**

Whilst the number of ‘wrong patient’ incidents appears high our analysis of the incidents demonstrates a large number may be incorrectly categorised and work is being undertaken to support staff in correct categorisation.

We anticipate use a grouped thematic analysis approach to explore where the ‘wrong patient’ event occurs and identify potential task, tool or technology factors that influence their occurrence.

Being able to isolate the specific tasks or tools contributing to the events we will be better placed to develop and implement an effective action plan and monitor outcomes.

3. **Booking errors AML**

When comparing triangulated data between feedback and incident themes it is apparent that a key theme is booking errors by AML. Booking errors can delay the patient pathway, cause unnecessary travel or preparation for patients and reputational damage to the organisation. By investigating these we can establish any system factors impacting on their occurrence – specifically looking at the factors we may remove or replace to reduce risk of errors occurring. It is particularly important to take this review of a variety of occurrences since the processes in place for booking patients varies across AML service depending on the referring Trust/service.

Our patient safety incident response plan: national requirements

The organisation reports a wide variety of incident types across all of the services, proportionate responses must be considered for these in line with PSIRF. 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 Alliance Medical’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

Patient safety incident type	**Required response**	**Anticipated improvement route**
Incidents meeting the Never Events criteria	PSII	Create national and/or local organisational actions and feed these into the quality improvement strategy
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 national and/or local organisational actions and feed these into the quality improvement strategy
Externally reportable incidents	PSII escalation if required, Initially Swarm huddle or After Action review with discussion regarding escalation upon the learning identified at initial review	Create local organisational actions and feed these into the quality improvement strategy
IRMER Externally Reportable Incidents	Level 1 Incident Report with Learning Action plan.	Create local organisational actions and feed these into the quality improvement strategy

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Wrong tracer incidents	PSII	Identification of system factors influencing selection of incorrect tracer. Creation of national and/or local action plan and feed into Quality strategy
Wrong patient incidents where the AML 'pause and check' process has been identified through a SEIPS review as contributing to the incident	Grouped Thematic Analysis	Identification of strategies to support effective 'Pause and Check' – leading to shared learning and tools across AML.
Booking errors by AML	PSII – investigations of a discreet number of booking errors to allow theming of factors	Identification of system factors at the top of the Hierarchy of effective interventions that can be addressed (removing or replacing activities) that will improve risk.
Incidents identified over 48 hours after incident occurring	After action review	Documented local action plan, learning fed into Patient Safety meeting for sharing across organisation. Review findings shared at monthly team meetings with all staff.

PATIENT AND STAFF INVOLVEMENT IN SAFETY EVENTS

AML supports the principles reflected in the 2022 PSIRF supporting guidance, Engaging and involving patients, families and staff following a patient safety incident.

Our core values of openness and collaboration (as above) describe how we ensure patients, families and staff are able to report and input to safety investigations or other responses. At the point of contacting a patient/family/carer regarding an incident we cannot change the fact it has occurred but it within our gift to engage compassionately in a way acceptable to them, offering a meaningful apology, listening and ensuring our approach addresses their questions. We have a formal feedback process encouraging patients or their carers to ask questions about their care. Patient feedback is sought after every episode of care and unit managers reach out to patients or their representatives individually if any concern is raised. The patient/family or carer holds critical information relating the circumstances surrounding an episode of care. Without including them the investigation of some incidents may well not identify the various factors impacting on the incident, reducing the chance of changes being made to prevent recurrence. Staff support following incidents is offered at local site level and nationally dependent on the situation and AML have a staff wellbeing service which unit managers can signpost staff to but is also readily accessible from the AML SharePoint pages.

Where relevant, patients and families are asked for their questions to be included in safety investigations to ensure the approach used addresses their concerns. This activity is led by the incident reviewer to ensure consistency and establish rapport with patients and families.

Learning from positive patient feedback and examples of good practice are identified through the compliment system via the Patient Experience and Engagement Manager and Unit/Mobile managers.

AML does not yet have patient safety partners, addressing this gap is in our development plan for 2026.

The regular Unit Managers fortnightly meetings with the Heads of Quality and Risk alongside the Clinical Leads meetings with our specialist advisors allows for staff to raise concerns and share issues in supportive, learning, environments.

MONITORING OF ACTIONS FROM INVESTIGATIONS

As identified within the policy, learning and actions identified within the learning responses must be fed back nationally within fortnightly quality and incident review meetings as well as the Clinical Leads meetings. Other opportunities include the quarterly ‘Risky Business’ company-wide safety newsletter and weekly operational calls accessible to all staff. Any actions put in place must be tracked and barriers to completion of actions and learning can be shared.

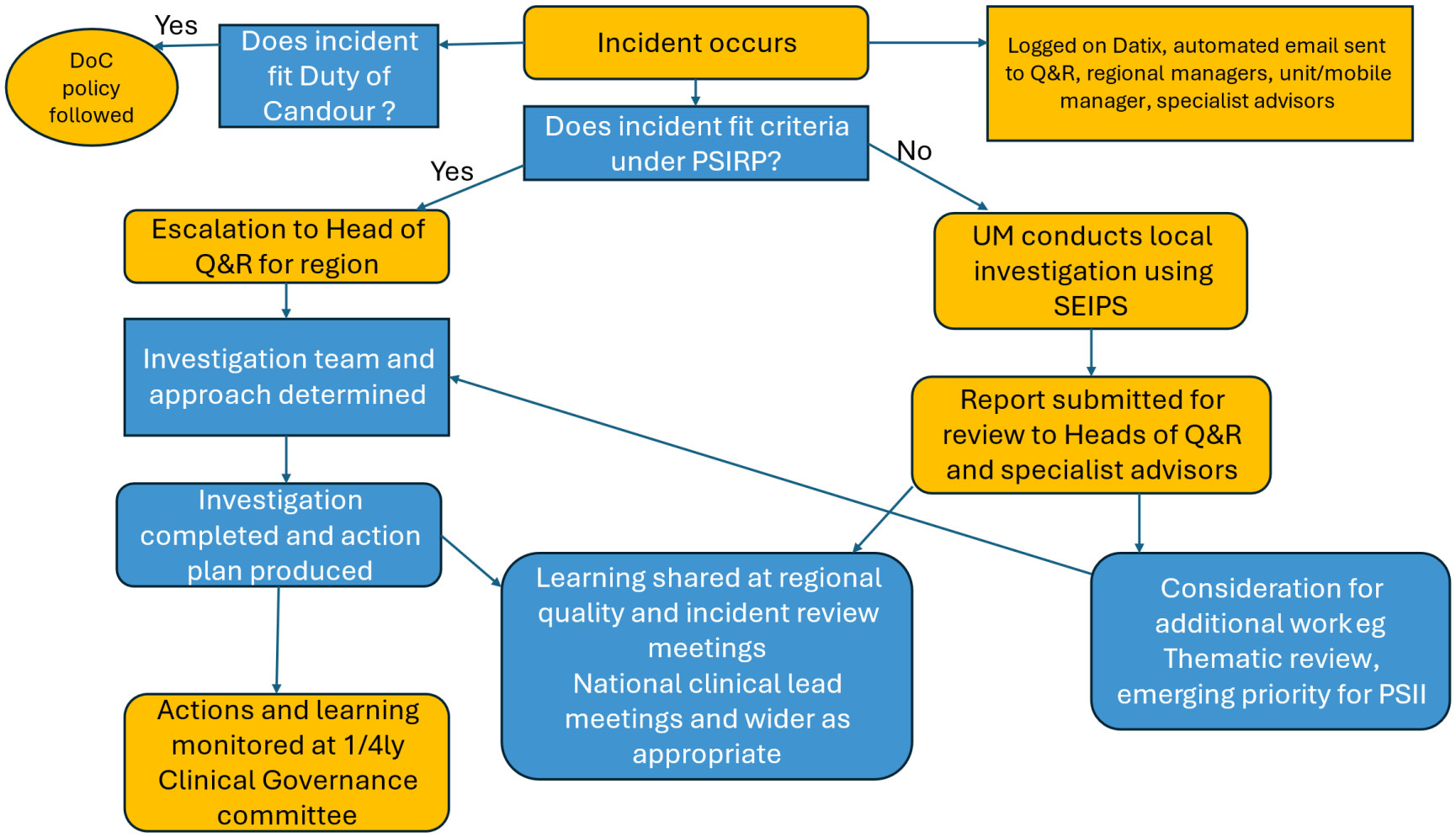
Within the quality and incident review meetings trends will be identified. Types of incidents that have previous had learning outcomes identified will be reviewed to

assess the impact of the actions on the incident trend and potentially develop audit outcomes linked to the actions

Good practice may also be identified through quality and risk reviews and through PSII investigation. This is shared with the unit managers through the fortnightly quality and incident review meetings with the Heads of Quality and Risk.

Actions from PSIIs and notifiable incidents are monitored through the Clinical Governance Committee for assurance of safety.

Decision Making flow for incidents:



UM – Unit Manager or Mobile Manager **Q&R – Quality and Risk**