Nimbuscare Patient Safety Incident Response Framework Plan 2024–2027

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Nimbuscare Ltd Patient Safety Incident Response Framework (PSIRF) Plan 2024–2027

Contents

The National Patient Safety Strategy (2019) describes PSIRF as *"a foundation for change"* and, as such,it challenges us to think and respond differently when a patient safety incident (PSI) occurs.

We can assure you, PSIRF is *very different* and it is *very exciting*.

Unlike previous frameworks, PSIRF is not a tweak of what came before. PSIRF is a whole system change to how we think and respond when events happen to gain learning and prevent recurrence. The Serious Incident Framework(2015) described when and how to investigate a serious incident, PSIRF focusses on **learning and improvement,** we, as an organisation, are responsible for the entire process including what to investigate and what processes we will use to complete the review. There are no set timescales or external organisations to approve what we do. We will be using several different methodologies selecting the most appropriate and proportionate for the level of investigation to ensure maximum learning from the event and improvement patient and staff experience. The patient and their families remain are very much involved during this process and their thoughts and questions remain considered throughout.

When asked "why do we investigate events?" the common response is "to learn", but what does that mean? Often, we mean learning as understanding what has happened, but it should be much more than that. How much has improved in 20 years using these methods? Have we been learning correctly? Traditional approaches have focused largely on linear cause and effects and haven't considered system issues that have impacted on an incident. The result – action plans that haven't really addressed the factors that caused the event to occur.

Learning is only useful if when you identify areas for improvement you act upon them. Learning often focuses on reducing risk of events rather than improving patient experience and addressing patient and family concerns. Actions plans from current learning are often not tested to see if they make a difference – PSIRF willchange this!

As an organisation we are always looking at how we can improve our approach to patient safety. Our Quality & Governance Committee and supporting subgroups have been fundamental to this.

Key to this also has been fostering a patient safety culture in which people feel safe to identify and report safety events that have occurred. Having conversations relating to a patient safety can be difficult. We will continue to explore how we can equip/support staff to best hear the voices of those involved, helping us achieve our core value of working in collaboration with patients, carers, and staff to improve safety.

It is important to recognise that there are good reasons to carry out an investigation. Sharing findings, speaking with those involved, validating the decisions made in caring for patients and facilitating psychologicalclosure for those involved are all core objectives of an investigation. The challenge for us is to develop an approach that facilitates thematic insights to inform ongoing improvement; it must acknowledge the importanceof an open organisational culture and what it feels like to be involved in a patient safety incident: this is central to our Patient Safety Incident Response Framework Plan (PSIRFP).

Our mission is to develop and foster a restorative just culture in which staff feel psychologically safe and empowered to report incidents. We recognise that changing culture is complex we are passionate about being an organisation that lives and breathes a safety culture in which people feel safe to express their opinion. PSIRF is a core component in continuing this journey. We may not get it all right at the beginning, but we will monitor the impact and effectiveness of PSIRF and adapt when our approach is not achieving our aim.

Jennifer Butcher
Associate Director of Quality Governance and Compliance

Introduction to the Nimbuscare PSIRF Plan

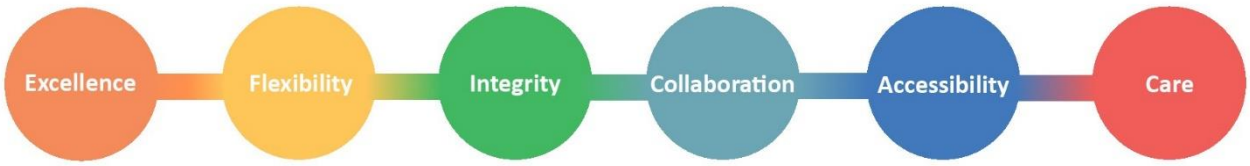
The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF) replaces the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP). Itdescribes our preparations for "go live" with PSIRF, and what comes next.

The Serious Incident Framework provided guidance on how to identify, report and investigatean incident resulting in severe harm or death. PSIRF is best considered as a learning and improvement framework with the focus on the system and culture that support continuous improvement in patient safety through how we respond to Patient Safety Incidents (PSI).

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better. Better means taking the time to conduct systems-based investigations by people thathave been trained to do them. This plan and associated policies and guidelines will describehow it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation like ours.

Carrying out investigations for the right reasons can and does identify learning. Removal of the serious incident process does not mean "do nothing", it means respond in the right way depending on the type of event and associated factors. A risk to successfully implementing PSIRF is continuing to investigate events as we did before and simply giving the process a new label. The challenge is to embed a new approach to reviews that forms part of a wider response to PSIs whilst allowing time to learn thematically from other patient safety insights.

PSIRF recognises the need to ensure we have support structures for staff and patients involved in PSIs. Part of which is the fostering of a psychologically safe culture shown in our leaders, and our well-established reporting systems. Our organisational values provide guidance on how we should implement them in PSIRF.



Nimbuscare has developed its understanding and insights of PSIRF through regular discussions and engagement with our Quality & Governance Committee, as well as discussions with the Senior Management Team (SMT) and Directors. Nimbuscare extends thanks to Dr Caroline Johnson, Humber & North Yorkshire Health and Care Partnership for their guidance and support which assisted with Nimbuscare becoming part of the National PSIRF in Primary Care pilot scheme in 2024. This plan provides the headlines and description of how PSIRF will apply in Nimbuscare during the implementation stage.

The Scope of the PSIRF Plan and our Vision

There are many ways to respond to an event. This document covers responses conducted solely for the purpose of systems-based learning and improvement. 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. It is outside scope to review matters to satisfy processes relating to HR, legal claims, and inquests. The 'Just Culture' framework supports a consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents.

This Plan explains the scope for a systems-based approach to learning from patient safety events. We will identify events incidents to review through nationally and internally defined patient safety priorities.

There are four strategic aims of the PSIRF upon which this plan is based. These are aligned with our vision statement.

"We want Nimbuscare to be a well-led, safe and sustainable organisation and be a thriving health and care provider"

The implementation of PSIRF will see both the strategic aims and our vision embodied in our work and link to our values.

Nimbuscare Values	Embedded in PSIRF Strategic Aims
Care	We aim for the highest standards in care. We keep our commitment to patients' wellbeing at heart. We are driven by a desire to make a difference in healthcare access and are dedicated with kindness and compassion to every person's health.
Excellence	We aim for the highest standards in care. We will deliver care with kindness and compassion. We will foster an environment of open-mindedness, support and responsiveness towards our patients, staff, and partners.
Accessibility	We aspire to be helpful, responsive, and motivated. We try to create an environment where every individual feels welcome, understood, and safe.
Collaboration	We seek to be a welcoming community offering a sense of belonging and support.
Flexibility	We openly welcome change as a means of enhancing the healthcare we provide. We are open listeners and welcome feedback from both patients and our workforce.
Integrity	We are honest and transparent. We listen, empathize, and guide patients in their healthcare journey with honesty, transparency, and professionalism.

System Overview of Nimbuscare

Nimbuscare works within the Humber & North Yorkshire Integrated Care Board

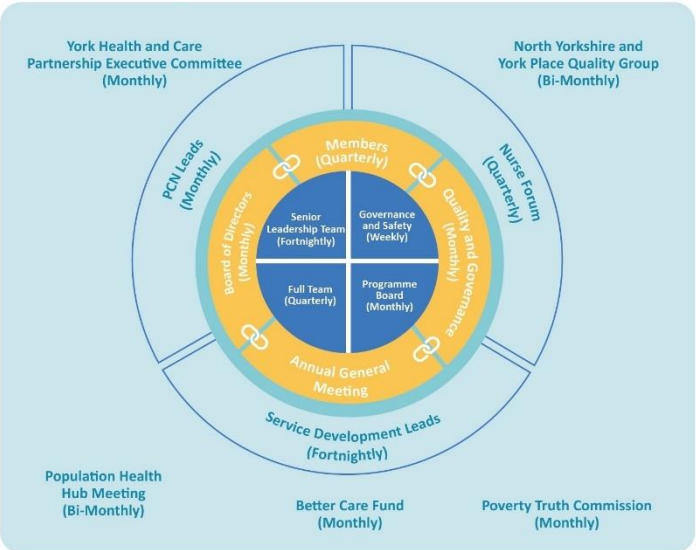
Nimbuscare is a 'not for profit' organisation dedicated to providing collaborative and agile healthcare, prioritising the well-being of both its staff and patients. Based in York and collectively owned by the city's practices, Nimbuscare extends its services beyond the local area. Positioned within the community healthcare spectrum, it operates between GPs and hospitals. In partnership with service users, their carers, other healthcare providers, local authorities, the voluntary sector, and commissioners, Nimbuscare delivers integrated care models.

'We are committed to contributing towards a better NHS based on equity, fairness, innovation, collaboration, and quality'

Prof Mike Holmes, Chair

Our Governance and System Integration

We have adopted a robust governance system. Our Board of Directors, Members Committee, and Quality and Governance Committee provide different layers of checks and assurances for our organisation. This is fundamental to ensure the delivery of the high standard of care we endeavor to deliver. Nimbuscare is well placed in the health and care system with close links to our Member Practices through the Primary Care Network Leads, Nurse Forum and Service Development Leads – there is regular communication and collaboration throughout these forums.



Core patient safety activities undertaken at Nimbuscare and our vision for the future.

These include:

- NHS Patient Safety Strategy – the implementation of safety pledges.
- Education and Training across the Organisation including Human Factors and Patient Safety Culture.
- Development of Quality Improvement Programmes / Audit Cycles.
- Consideration of an Event Reporting System e.g., Datix.
- Learning from Patient Safety Events (LFPSE) with a possible introduction of a Learning Response Panel (to decide on best action for events).
- Safeguarding children and adult reviews
- Learning from CQC, mock assessments and compliance work.

I will use my knowledge, awareness and attitude to make me a safe employee.

I will properly use personal protective equipment, procedures, equipment and materials to ensure my safety.

I will ensure my environment, building and job site are prepared and maintained to ensure my co-workers and I are safe.

Patients will receive a professional standard of care delivered with kindness, dignity and respect

We will ensure you care is based on clinical evidence and best practice and delivered efficiently.

We will be open and honest about our mistakes and work hard to put them right.

Other activities within Nimbuscare that provides insight into patient safety include learning from:

- incidents,
- complaints and concerns,
- patient, carer, and staff feedback,
- claims,
- near misses
- data breaches, and
- speaking up

For clarity we will call all of these ***Events***.

The operational 'work-as-done' for patient safety activities is predominantly owned by our colleagues on the front-line. This is supported by their respective Quality Assurance and Safety colleagues and CQC Ambassadors with oversight from Clinical Directors and Associate Directors. This approach has evolved to fit and respond to the geography and complexity of Nimbuscare and the teams, services, and structures we work in. Our CQC Ambassadors are a new addition to Nimbuscare in 2024. The Ambassadors are made up of the key people from across the Organisation who are integral in facilitating our patient safety system and culture, on our journey implementing PSIRF. They will also form a learning response panel who will decide on 'best action' for events.

Situational Analysis of Patient Safety Activity

Between April 23 - 24, 126 events have been reported within the Organisation

Event	Number	Themes, Top 2
Complaints	32	Consultation Skills Administration Error
Incidents (Non-Clinical)	59	Administration Error Facilities
Incidents (Clinical)	29	Administration Error Incorrect disposal of Medications / Sharps / Clinical Products
Near Misses	3	Security
Speak Up	0	NA
Data Breaches	3	Consent Pt letter sent to incorrect Member Practice

A key part of developing the new national approach is to understand the amount of patient safety activity Nimbuscare has undertaken over the last year. This enables us to plan appropriately and ensure that we have the people, systems, and processes in place to support the new approach. For Nimbuscare this can be broken down as follows:

Thematic analysis and our ongoing patient safety risks

We used a thematic analysis approach to determine which areas of patient safety activity were emerging to help identify our patient safety priorities. We reviewed all events between 1st April 2023 to 31st March 2024.This helped to identify key areas to be our focus for Year 1, with reviews in future years to revise these, addressing any emergent themes. CQC Ambassadors will meet each quarter to review data, triangulate this and identify any new or merging themes which require improvement. From this, future PSIRF priorities will be identified and shared annually with the Board of Directors, with our Member Practices and with Patients via our annual report. Revised PSIRF priorities will go to the Quality & Governance Committee for consideration and sign off. Delivery of improvement work will be led by the Quality Assurance & Safety Group who in turn will report to the Quality & Governance Committee.

Our Patient Safety Priorities

Through our analysis of our patient safety insights, based on the thematic analysis, we have determined three PSIRF priorities we will focus on for the next year. These were proposed and agreed at the Quality & Governance Committee.

These patient safety priorities form the foundation for how we will decide to conduct Patient Safety IncidentInvestigations (PSII), patient safety reviews and may include thematic reviews. The circumstances of the incident will determine whether a PSII or other proportionate response is commissioned.

Priority		Concerns	Action
1	Consultation Skills	Complaints regarding HCPs consultation technique in relation to their attitude with patients expressing that they didn't feel cared for, listened to, and rushed. N.B All complaints managed in house with no onward referrals to the Ombudsmen	Recognition that HCPs require support during the investigation process. Full patient / carer involvement. Exploration of workforce pressures, external factors, awareness, and communication of support available. Additional consideration of locums, new starters and how they are supported within the Organisation.

2	Administration Errors	A theme across several events. No theme identified of repeated errors.	Recognition that all staff require support during the investigation process. Full patient / carer involvement. Dury of candour. Workforce considerations – Sufficient staff? Adequately trained staff? Are there advances in technology which could reduce human errors?
3	Incorrect disposal of sharps / clinical products	Failure to dispose of sharps correctly and other contaminated products resulting in possible harm to staff / patients.	Recognition that all staff require support during the investigation process. Consider how SOPs/Policies are communicated and how accessible they are. Is wider training required?

How we will Respond to Patient Safety Incidents (PSI)

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process will be a flexible approach, informed by internal and national priorities. We will bring together key staff to make decisions regarding:

- Deciding if a review is needed in line with internal or national priorities.
- Selecting the type of review.
- Selecting the relevant investigator or reviewer.
- Agreeing if other experts are needed, e.g., Safeguarding Lead, Caldicott Guardian.

We will use existing structures to support the process of decision making with PSII and to support PSIRF these will be renamed:

Name change	Function change
Governance & Safety Group to become Quality Assurance & Safety Group.	We will broaden the topics to include complaints, concerns, data breaches, feedback, and freedom to speak up. We will invite a mixture of HCPs and non-clinicians to ensure a rich representation of staff from within the Organisation.

The process will be described in detail in the PSIRF policy and associated policies which will describe PSI Investigations, PSI Responses and involving patients in discussions about events, learning and improvement. Over time we expect there will be less PSII and our internal priorities, with a reduction in the repetition of themes. We will adopt a systems-based learning approach from thematic analysis and learning from excellence.

Deciding what to investigate through a Patient Safety Incident Investigation (PSII) process will be a flexible approach, informed by internal and national priorities. The decision to carry out a PSII will be based on whether:

- the PSI is linked to a National or one of Nimbuscare's agreed PSIRF Priorities
- the PSI is an emergent area of risk. For example, a cluster of PSIs of a similar type or theme may indicate a new priority emerging and learning needing to be shared. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.
- The PSI may be so serious that the Organisaton chooses to investigate.

The Organisation is obliged to report data breaches to the ICO and NHSE. Under Regulation 18 (2) the Organisation is also obliged to contact CQC

If the PSI does not meet these criteria, it still may meet the threshold for Statutory Duty of Candour. The routine response to an event that results in moderate harm and above still requires Nimbuscare to follow the Statutory Duty of Candour. Events will be reviewed proportionally using one of the PSIRF tools and the outcome of these reviews will be shared with patients and/or their family/carers, who will have been compassionately engaged throughout the review process.

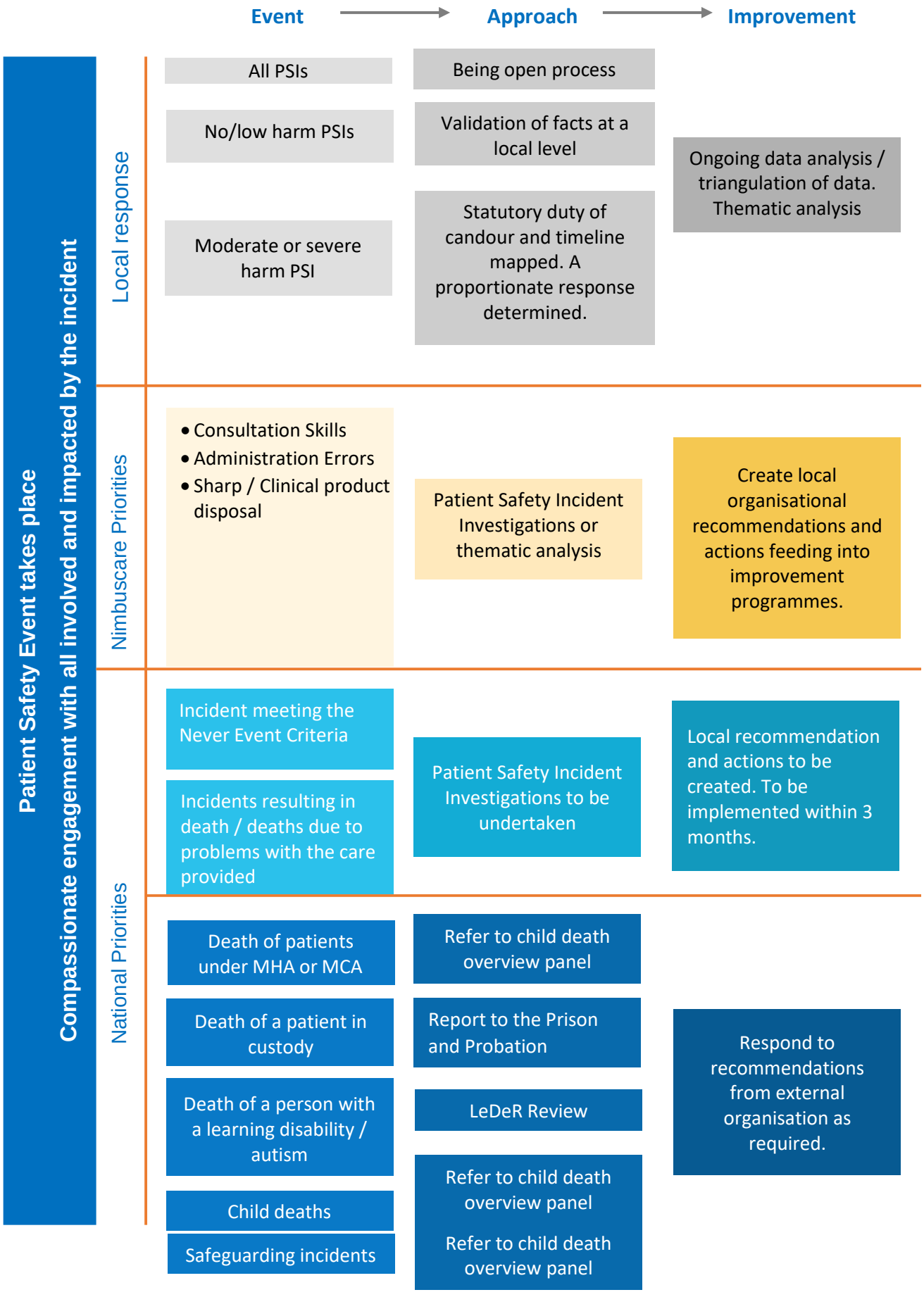
Incidents that meet the Statutory Duty of Candour thresholds:

There is no legal duty to investigate a patient safety incident. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20, says we must:

1. Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
2. Apologise. For example, “we are very sorry that this happened”
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
6. Keep a secure written record of all meetings and communications.

Whilst the Statutory Duty of Candour only applies to a defined group of PSI, PSIRF will support the organisation and our staff to apply the principles of involvement, apology andfeedback, where this is needed.

Responding to Patient Safety Incidents



Training to Support PSIRF

PSIIs are conducted to identify systemic, interconnected causal factors.PSII allow us to analyse the system in which we work by collecting and analysing evidence, to identify systems-based contributory factors and learning. Safety recommendations are created from this evidence-based analysis, to target systems-based improvement.

Human Factors

Nimbuscare has moved towards a greater understanding of Human Factors regarding causal factors. We have moved away from using Root Cause Analysis as the recognised tool to for **all** investigations and are testing out After Action Reviews and Swarm Huddles – two of our new methodologies. Investigations into some PSIs within our services have followed the Human Factors model. The initial feeling is that this model is smarter and more collaborative supporting us in looking at the system and not at the individuals who work within it.

The National Patient Safety Syllabus may be met by e-learning safety training, available for all staff. Nimbuscare's preferred e-learning platform is 'Bluestream' where a new Patient Safety Syllabus can be found with various modules available and relevant to your role. Advice can be sought from your line manager. Those in clinical or support roles can access more detailed nationally provided courses.

Other tools to support reviews of care:

PSI investigation is not the only tool we use to respond to incidents. Our PSIRF policy will describe other ways staff can respond to incidents. This will detail both how to respond to incidents thematically, but also how to respond to individual incidents. There are several tools that we can use to respond to individual incidents. In Year 1 we plan to embed:

- **Safety huddle**: A proactive team gathering to regroup, seek advice, talk about safety.
- **Initial Learning Review**: Post incident report that captures what happened and initial learning.
- **Swarm Huddle**: Immediately post PSI, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk (a "hot" debrief).
- **After action review**: A structured facilitated debrief.
- **PSII:** PSI investigation

Further tools will be tested and embedded in Years 2 and 3 as we look at a stepped approach to PSIRF implementation.

Involvement and Support for Patients, Families and Carers following PSIIs

To provide detailed guidance we will be formalising our PSIRF Policy in 2024 through our Quality Assurance & Safety Group, NHS Humber & North Yorkshire ICB and Member Practice engagement to support the creation and development. Our involvement in the Primary Care pilot should also prove beneficial.
We recognise the significant impact PSIIs can have on patients, their families, and carers. Getting involvement right with patients and families in how we respond to incidents is crucial,particularly to support the improvement of the services we provide.

'Patients are at the heart of everything we do.'

The patient voice is an integral part of our work at Nimbuscare; the Patient Liaison Team (PLT) will share insights from PSIRF with member Practice Patient Participation Groups (PPGs).

> *"Listening and understanding a patient's complaint is crucial because it fosters trust and enhances the effectiveness of future care for themselves and others. An empathetic approach not only validates the patient's experience but also encourages them to share more openly, leading to improved learning. The Patient Safety Incident Response Framework represents an excellent opportunity to do this and it is a very welcome development for people using our services."*

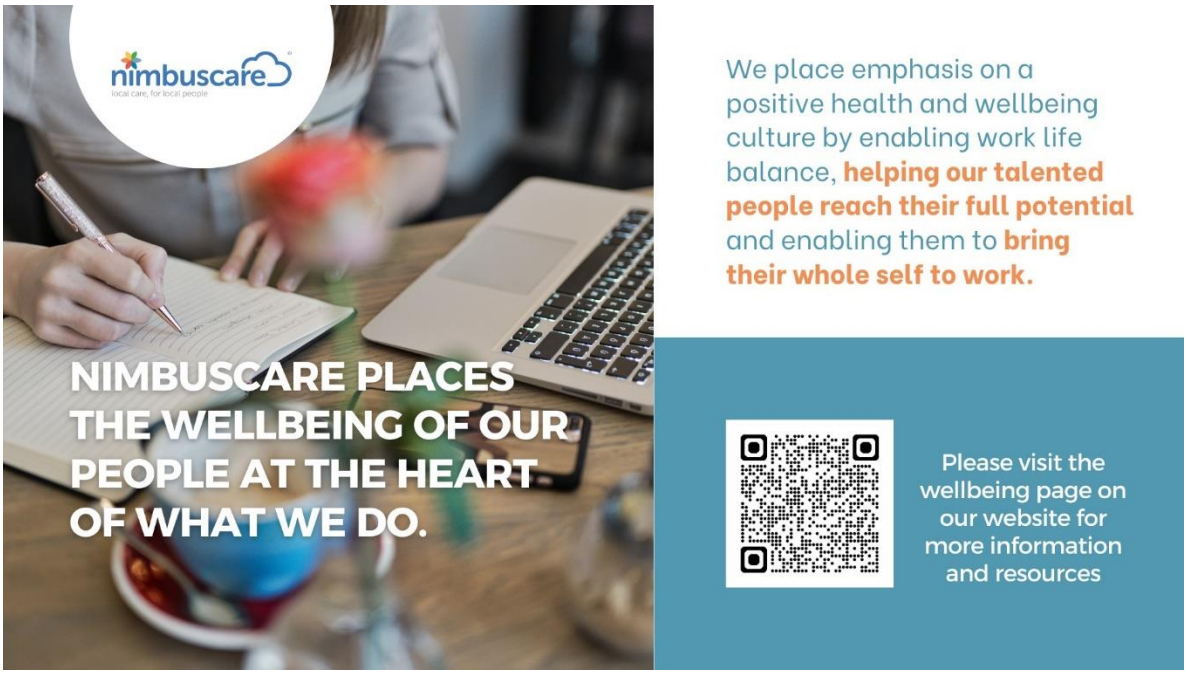
Ellie Holmes
Head of Corporate Affairs

Involvement and Support for Staff following PSIIs

We are on an ambitious journey at Nimbuscare to ensure it is a safe and fair place, where everyone's voice is encouraged, valued, and listened to, helping us to continually learn, inspire change and improve.

When a colleague reports an event or is providing their insights into the care of a patientfor an investigation, we will actively encourage a safe space to discuss and explore the system in which they work, listening openly without judgement. The new PSIRF policy, procedures and guidance will support this in practice.

We recognise that many staff will be involved with a PSI at some point in their careers andthis can be a traumatic experience. We have wellbeing support in place for all staff.



Oversight and Monitoring

We have specific governance structures that represent our organisation wide approach to bringing Nimbuscare together as a comprehensive patient safety system, which will support the implementation and progression of PSIRF.

Quality Assurance & Safety Group will be actively involved in safety huddles, initial learning reviews, swarm huddles and after-action reviews.

The **Learning Response Panel,** chaired by the AD of Governance and created from the CQC Ambassadors, will oversee the implementation of PSIRF, the ongoing thematic analysis and triangulation of data to ensure that the priority improvement programmes remain current and responsive to any new or emerging themes and trends. They will monitor the Plan (this document), the PSIRF Policy, training and links to learning from Patient Safety Events - (LFPSE) System. They will provide quarterly high-level reports to the Quality & Governance Committee.

The **Quality & Governance Committee** chaired by a Non-Executive Director, will scrutinise quality information provided from the Learning Response Panel alongside additional quality dashboards papers relating to CQC, Audit and Services.

The **Trust Board** seeks assurance that high quality services are being delivered through the Quality & Governance Committee.

The **Patient Liaison Team** overseen by the Head of Business Assurance and Development, will oversee complaints, feedback, and concerns. The team will be a point of contact for direct patient/ carer engagement and support in maintaining an accurate event recording process.

The **Governance XXXXXXXXX** overseen by **XXXXXXXXX** , will oversee incidents (clinical and non-clinical), data breaches and near misses. The team will be a point of contact for staff care and engagement and will support in maintaining an accurate event recording process.

The **Freedom to Speak Up Guardian** will report quarterly to the AD of Governance regarding the number of Speak Up events. Content will not shared however themes will be reported upon.

Glossary of Terms used in this Patient Safety Incident Response Framework Plan

AAR	After action review	A structured, facilitated discussion of a PSI, the outcome of which gives thestaff, patients and carers involved understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various MDT perspectives
	Compassionate Engagement	Engagement that priorities and respects the needs of people who havebeen affected by a patient safety incident.
	Engagement	Everything we do to communicate and involve people affected by a patientsafety incident in a learning response.
	Engagement Lead	The lead person responsible for engaging with the patient/family throughthe learning response process.
	Event	Any unintended or unexpected incident that could have or did lead to harm.
	Human Factors	the understanding of the interactions among humans and other elements of a system, and the profession that applies theoretical principles, data andmethods to design in order to optimize human well-being and overall system performance
	Incident Response Lead	The person leading the learning response for Nimbuscare, whether a PSII, AAR, SWARM etc.
ILR	Initial Learning Review	An initial incident review following a set template developed by AD of Governance providing an initial summary of an incident and any initial learning or outcomes. This should be completed within 72 hours following an incident occurring and should be submitted by the service to the relevant Governance mailbox.
	Just Culture	A culture of trust, learning and accountability. It is particularly important when an incident has occurred; when something has gone wrong.
	Good Catch / Near Miss	An incident that could have occurred, but was realised and prevented from occurring.
	Learning Response	PSIRF encourages organisations to use the national system-based learning responses tools and guides, or equivalents to explore the contributory factors to a patient safety incident or a cluster of incidents andto inform improvement, this could be patient safety incident investigations,AARs, SWARMs or MDT Reviews.
LFPSE	Learning from Patient Safety Event Service	The Learn from Patient Safety Events (LFPSE) service is an improved central NHS service for the recording and analysis of patient safety eventsthat occur in healthcare in England. Receiving records of patient safety events from staff across all parts of the NHS, the LFPSE service provides a national collection of patient safety data to support the NHS to learn and improve, particularly around the identification of new and under-recognisedrisks, so action can be taken to keep patients safe.

	Link Analysis	Link analysis visualises the frequency of interactions in a specific location or environment. It can be used to highlight the frequently used paths taken in an environment and those that are critical for safety.
NE	Never Events	Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
	Observations	Observations help us get a better understanding of work as done.
PLT	Patient Liaison Team	A team to support patient communications on their journey.
PSI	Patient Safety Incident	Any unintended or unexpected incident which could have or did lead to harm for one or more patient's receiving healthcare.
PSII	Patient Safety Incident investigation	Determining the causes of accidents and serious incidents and making safety recommendations intended to prevent recurrence. It is not to apportion blame or liability.
PSIRF	Patient Safety Incident Response Framework	The Patient Safety Incident Response Framework (PSIRF) was published in August 2022, outlining how providers should respond to patient safety incidents for the purpose of learning and improvement., this replaces the Serious Incident (SI) Framework (2015)
	Proportionate Response	PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm.
	Psychological Safety	A shared belief held by members of a team that the team is safe for interpersonal risk taking
SEIPS	"Systems Engineering Initiative for Patient Safety"	SEIPS is the systems-based framework endorsed by PSIRF. It is a framework for understanding outcomes within complex systems which can be applied to support the analysis of incidents and safety issues more broadly. A SEIPS quick reference guide and work system explorer is provided in the patient safety incident response toolkit. All the national PSIRF tools are based on SEIPS.
	SWARM	Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.

	Thematic Analysis	The process of examining and assigning codes to text (e.g., incident narratives), to identify and group information into common themes. This assists in the interpretation across a range of inter-related data and can support learning across multiple investigations
	Walk Through Analysis	Walkthrough analysis is a structured approach to collecting and analysing information about a task or process or a future development (e.g., designing a new protocol).
	Work as Disclosed	Work-as-disclosed is the work that people say that they (or others) do or did, either in formal accounts or informal accounts.
	Work as Done	Understanding how day to day work is actually undertaken
	Work as Imagined	Work-as-imagined is the work that we imagine takes place. Often, the term is used to describe imagination of the work that others do (now or in the past or future). It may also, however, refer to the work that we imagine that we do (or did, or will do). For example in procedures, and guidelines
	Work as Prescribed	Work-as-prescribed is the formalisation, specification and design of work. It is the work that people 'should do', especially according to policies, procedures, rules, and so on.

Useful Links

- Being Human in Healthcare https://being-human.org.uk/
- Future NHS Platform https://future.nhs.uk/
- Health Services Safety Investigations Body https://www.hssib.org.uk/
- The NHS Patient Safety Strategy (including Learning from Patient Safety Events LFPSE) https://www.england.nhs.uk/patient-safety/
- ICO https://ico.org.uk/
- NHSE https://www.england.nhs.uk/
- CQC https://www.cqc.org.uk/