BMC Health Services Research

RESEARCH Open Access

Involvement in serious incident investigations: a qualitative documentary analysis of NHS trust policies in England

Siobhan McHugh[1*], Gemma Louch[2], Katherine Ludwin[3], Laura Sheard[4] and Jane K. O'Hara[5]

Abstract

Background The considered shift from individual blame and sanctions towards a commitment to system-wide learning from incidents in healthcare has led to increased understanding of both the moral and epistemic importance of involving those affected. It is important to understand whether and how local policy describes and prompts involvement with a view to understanding the policy landscape for serious incident investigations in healthcare. This study aimed to explore the way in which involvement of those affected by serious incidents is represented in incident investigation policy documents across acute and mental health services in the English NHS, and to identify guidance for more effective construction of policy for meaningful involvement.

Methods We conducted a documentary analysis of 43 local serious incident investigation policies to explore the way in which involvement in serious incident investigations is represented in policy documents across acute and mental health services in the NHS in England.

Results Three headline findings were generated. First, we identified involvement as a concept was conspicuous by its absence in policy documents. Direct reference to support or involvement of those affected by serious incidents was lacking. Even where involvement and support were recognised as important, this was described as a passive process rather than there being moral or epistemic justification for more active contribution to learning. Second, learning from serious incidents was typically described as a high priority but the language used was unclear and 'learning' was more often positioned as construction of an arbitrary set of recommendations rather than a participatory process of deconstruction and reconstruction of specific systems and processes. Third, there was an emphasis placed on a just and open culture but paradoxically this was reinforced by expected compliance, positioning investigations as a tool through which action is governed rather than an opportunity to learn from and with the experiences and expertise of those affected.

Conclusions More effective representation in policy of the moral and epistemic reasons for stakeholder involvement in serious incident investigations may lead to better understanding of its importance, thus increasing potential for organisational learning and reducing the potential for compounded harm. Moreover, understanding how structural elements of policy documents were central to the way in which the document is framed and received is significant

*Correspondence:
Siobhan McHugh
Siobhan.McHugh@leedsbeckett.ac.uk

Full list of author information is available at the end of the article

for both local and national policy makers to enable more effective construction of healthcare policy documents to prompt meaningful action.

Keywords Healthcare policy, Patient and family involvement, Incident investigation, Patient safety

Background

The publication of *To Err is Human: Building a Safer Healthcare System* [1] was influential in prompting significant and sustained prioritisation of learning from safety incidents in healthcare. Consequently, in the United Kingdom, the Department of Health sanctioned a specific report [2] to understand the scale of serious incidents in the National Health Service (NHS) (broadly defined as unexpected or avoidable harm or death [2]), and to demonstrate a commitment to capture and respond to learning. Serious incident investigations have become a prominent component of both national and local healthcare safety management, reporting, and governance systems worldwide [3, 4]. However, healthcare governing bodies and organisations have grappled with incident reporting and investigation systems that promote transparency and openness to learning about safety, and to more broadly embrace a participatory approach to investigations [3, 5].

Involvement of multiple stakeholders in serious incident investigations

Increased focus on principles of transparency and openness in incident reporting and investigation ostensibly means healthcare organisations have a duty to involve multiple stakeholders where appropriate. However, there is little evidence to suggest that involvement is embedded in current investigation practice [6–9]. Arguments for involvement of patients and their families are often presented from a moral standpoint, seeing involvement as a mechanism by which organisations can demonstrate commitment to openness and accountability, support individual needs and re-establish trust [8, 10]. Notwithstanding this, research has revealed that even when patients and family members are routinely involved in investigations their contributions are often minimised, particularly when they contradict the perspectives of healthcare professionals [8]. Thus, involvement based solely on moral justification might be experienced as performative if patient and family contributions are minimised or omitted with respect to potential for learning, and more generally where the needs of patients and their families are minimised in comparison to those of the organisation [9]. This may be particularly relevant if emotional exchanges are discredited, with strong emotion assumed to cloud vision and minimise the value of any experience or testimony [3]. Inclusion of all stakeholders because it is the 'right' thing to do is important, but an unintended consequence of involvement based on this alone is compounded harm, where patients and families feel there is little, or no value assigned to their experience.

Increasingly, evidence suggests that there is also considerable epistemic justification for involving multiple stakeholders in incident investigations; justification based on contribution to knowledge of, and learning about, an incident. Traditionally, healthcare staff are assumed to provide valuable knowledge and insight which can inform learning about serious incidents and healthcare service improvement [3, 11]. However, there is increasing recognition that where incident investigation systems are designed to prompt organisational learning, all stakeholders should be considered as experts who can provide valuable knowledge and experience even (and arguably especially) where those experiences might be divergent [3, 6, 11]. Where learning is understood to be a social and participative process that involves people deconstructing and reconstructing their understanding of shared knowledge of different aspects of the system [5], consideration of different experiences is imperative to this process. As such, creating space for multiple perspectives without prioritising specific voices arguably may provide opportunity for effective and meaningful organisational learning in addition to the moral justification of facilitating reparation and trust-building [8, 10, 12].

Despite recognition that involvement of multiple perspectives in serious incident investigations can be a challenging undertaking, especially where those perspectives are divergent [3], the consequences of not doing so can be significant. Silencing or minimising particular voices during the investigation process can hinder learning, and the feeling of not being heard or valued can destroy opportunities for reparation, and intensify grief, harm, isolation and anger for all involved [3, 10]. Thus, the risk of compounding harm through moral injury or 'epistemic injustice' [13] suggests that the benefits of embedding active involvement of all those affected in incident investigation practices and procedures far outweighs the challenge.

Serious incident investigation policy and practice

Healthcare policy documents are conceived of as a vehicle through which organisational values can be represented, using specific language to define and legitimise action with respect to these, and broader social, values [14, 15]. Local healthcare safety and investigation policies are most often directed by centrally constructed national policy designed to outline a set of national expected standards for a particular process or course of action. Thus,

development or reform of local policy is expected to both incorporate, and make contextually appropriate, national governance directives.

From March 2015 up until the publication of the Patient Safety Incident Response Framework (PSIRF) in August 2022, the national regulative framework governing investigations after serious incidents in the English NHS (the Serious Incident Framework) specifically centred organisational learning with a view to prevent incident recurrence as the primary focus of an incident investigation [16]. Within the Serious Incident Framework [16] there is some reference to involvement and support of those affected by an incident pertaining to principles of openness, transparency, and accountability, but the policy falls short of underlining the epistemic importance of gathering different perspectives for learning. Despite evidence of both moral and epistemic value in involvement of all stakeholders in incident investigations [3, 11, 17], the Serious Incident Framework investigation policy assigns moral value to patient and family involvement for purposes of reparation, whereby epistemic value is readily assigned to involvement of healthcare staff perspectives to support learning [16].

Although the espoused function of local incident investigation policy is to outline the defined practices and procedures of the investigation process, there is little to support local policy makers to represent and effectively communicate a maelstrom of information that includes organisational values, current evidence, and expectations set by national governing bodies [14]. Despite the expectation that careful, evidence-based judgements are employed when translating organisational values into local governance structures, policy making is often a messy and difficult collective dialogue based on influence, power, and individual and collective interpretations [14]. Moreover, policy making often occurs at a managerial level, and very rarely involves those that are expected to comply with it or those who will be affected by it. Where there is increasing evidence of both the moral and epistemic importance of involvement of patients, families, and healthcare staff when things go wrong in healthcare, it is important to understand whether and how local policy describes and prompts their involvement in serious incident investigations with a view to understanding the policy landscape for this activity. Although we cannot assume that a well-written policy will always be translated into practice (or indeed vice versa) [15], policy documents represent modelling of organisational intentions for those people responsible for their enactment.

Aim

This study aims to explore the ways in which involvement of those affected by serious incidents is represented in investigation policies across acute and mental health services in the English NHS, and to provide guidance for policy makers to prompt more meaningful principles of involvement through effective construction of policy.

Methods

Design

This study uses qualitative documentary analysis [17] of policy documents to map out the policy 'landscape' of involvement in serious incident investigations at a local level under the Serious Incident Framework [16].

Data sampling and collection

To ensure a proportionate representation of NHS trust policies, we randomly sampled 50% of all acute non-specialist and specialist trusts and mental health trusts in England ($n=103$) to include in the documentary analysis from a publicly available list [18]. This approach intended to obtain a sample which reflected variation in a range of criteria from geographic location and trust size, to teaching and foundation status. Through this sampling method we aimed to obtain enough policy documents to facilitate an in-depth synthesis and interpretation.

We requested from trust governance, risk management, or patient safety teams, any current policy documents relating to serious incident investigations or investigations following adverse events. Trusts were asked for their most recent policies, and informed that documentation could be redacted prior to being sent to the research team if appropriate or necessary.

A single researcher (SM) telephoned the clinical governance team at each of the randomly sampled trusts ($n=103$) in the first instance to ensure transparency, provide more information about the wider study, and to obtain the details of the most appropriate contact from whom to request the policy documentation. An email to the named contact directly followed the initial phone call, and non-response was followed by an email reminder one week later. If there was still no response, the researcher made a follow-up phone call one week later, followed by a second email reminder which included a deadline for documents to be returned. Correspondence occurred between November 2019 and February 2020.

Due to a lower response rate than expected from this direct contact with trusts ($n=21$), researchers consulted the project academic Steering Group. Members of the group advised that these policy documents may be publicly available. Three researchers (SM, GL, KL) searched online (search engines and trust websites) for policy documents from trusts that had not responded to the initial contact. This additional search strategy yielded a further 22 policy documents. For all other non-responding trusts, researchers found that incident investigation policies were either not available through the trust websites or were available but out of date. This is

particularly pertinent to report given Bowen [17] noted that the procedures that researchers follow during documentary analysis are often poorly described in applied health research, raising particular questions about incomplete collection of documents. We were thus particularly mindful of 'biased selectivity', but our ability to collect the planned document numbers was restricted by organisational response and management of their public documentation.

Data analysis

Documentary analysis is recommended as a systematic procedure for reviewing and evaluating documents to elicit meaning, gain understanding and develop knowledge [17]. We followed the three steps of a qualitative documentary analysis as instructed by Bowen [17]: *skimming, reading* and *interpretation*.

Three researchers (SM, KL, JOH) identified relevant and meaningful excerpts of text within policy documents, and salient information was separated from that not considered pertinent [17]. For this paper, that meant understanding which parts of the document were both explicitly and implicitly linked to involvement. We were particularly interested in how trusts outlined the process of involvement for patients, families, and healthcare staff in their policies, and more generally how the policy documents were constructed and information about involvement represented within the wider context of the document. A more focused re-reading of the policy documents was then carried out by the same three researchers to explore meaning. To ensure a level of objectivity (fair representation of the policy documents) and sensitivity (representing and responding to subtle cues to meaning) several analysis sessions were held where the research team (including all authors) came together to discuss meaning, structure the emergent findings and refine the headline findings. The analysis was not structured around an existing theoretical framework, thus our exploration of the concept of involvement within the policy documents was wholly inductive. To situate our findings further, a reflexive commentary is provided (at the end of the Results section).

Results

In total 103 randomly sampled trusts were contacted, and documentation received from 21 organisations (response rate = 19.42%). This, combined with our online search (n = 22), resulted in a total sample of 43 policy documents, which represented 19.41% of acute non-specialist and specialist trusts and 25% of mental health trusts. 53% of the policies sampled were from NHS trusts with Foundation status. Geographical spread across the sample was generally representative, with policies from trusts in South East & London (26%), North East & Yorkshire (21%), the South West (19%), the Midlands (14%), the South Coast (11%) and the North West (9%).

Information relevant to our aim of understanding the current 'landscape' of involvement in serious incident investigations was housed in a range of incident reporting and investigation policy documents. Figure 1 outlines the different policy documents and additional documents returned from our initial searches. Our analysis focused

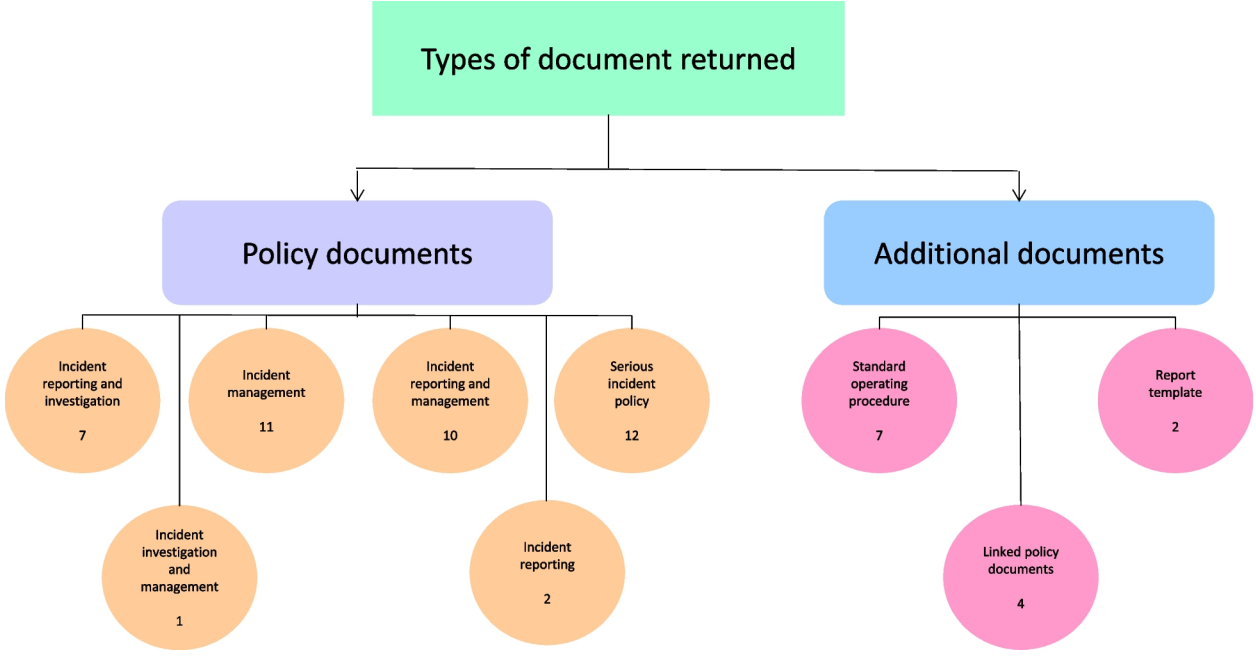

Fig. 1 Policy documents returned from searches. All policy documents returned by Trusts and from online searches, grouped by document type

solely on content relating to the serious incident investigation process, and how involvement was embedded within this, regardless of the scope of the policy document.

Descriptive information for each sample text was captured to contribute to our understanding of where the policies sit at a local level. Figure 2 illustrates the policy authors and the organisational teams or directorates under which the sampled policies sit. Although not specifically drawn into our analysis, we feel this information is particularly pertinent to provide insight into where the responsibility for local serious incident investigations generally sits in NHS organisations, and thus where the responsibility for embedding involvement into local investigation processes commonly lies.

Theme development

Skimming of policy documents identified three initial domains of interest (*patient & family involvement, organisational learning,* and *organisational support for investigative processes*), and further reading of the main body text of each policy document identified another two domains of interest pertinent to the specific aims of the analysis – *staff involvement* and *reputational damage (including reference to legal teams, litigation, and media)*. Initial coding of policy documents was related to these domains of interest (SM, KL, JOH), and researchers subsequently came together in more in-depth analysis sessions. In these sessions researchers articulated their individual coding of specific policy documents, and collectively navigated the coding of all policy documents to construct meaning and generate themes. Three headline findings were identified: '*the conspicuous absence of involvement*', '*learning: ticking a box or a route to meaningful change?*', and '*you must be 'just': being open or a jargon smokescreen?*'.

The conspicuous absence of involvement

When compared to the weight given to the rest of the document, direct reference to support or involvement of those affected by serious incidents was distinctly lacking. Even in those policies that expressly directed continued involvement of patients or family members, and recognised potential support needs, involvement is described as a passive process of providing information to them, rather than inviting them into the investigation as 'experts' or partners in the process, able contribute to organisational learning. There is no reference to this more active involvement across any of the documents; involvement where referenced is something to be done 'to' patients and their families, as opposed to 'with' them.

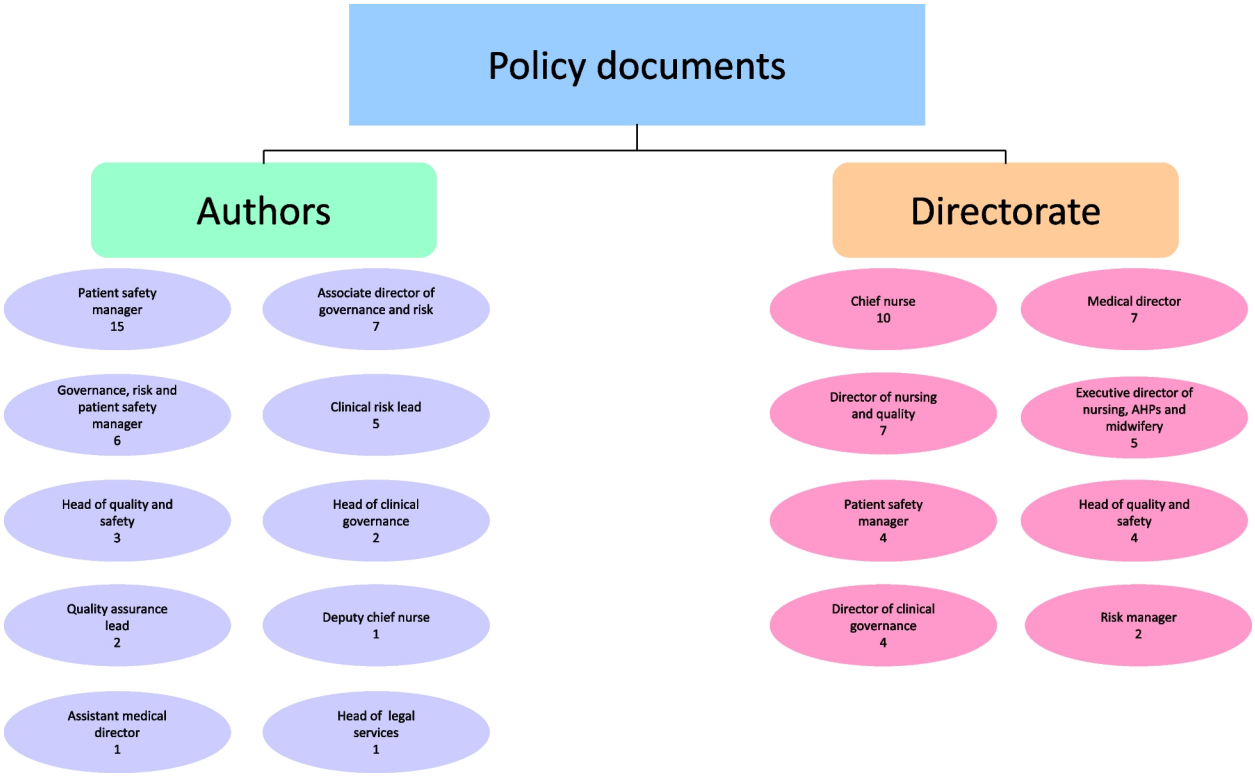

Fig. 2 Policy document authors and directorates. Professional roles of the authors of each of the returned policy documents, and the Trust level directorates under which the serious incident investigation policy documents sit

> *"Patients and their families are to be told about patient safety incidents that affect them, receive appropriate apologies, are kept involved about investigations and are supported to deal with the consequences." Policy A-L-01*

> *"Early consideration must be given to the provision of information and support to patients, relatives and carers and staff involved in the incident, including information regarding support systems which are available to patients, relatives, visitors or contractors…". Policy MH-S-03*

> *"Arrangements may need to be put in place to support patients and family members through the investigation process and sharing of the outcomes of investigations." Policy A-NE-02*

Support for healthcare staff involved in an incident was given increased weighting across the majority of policy documents when compared to that of patients or their family members but was still limited when considered alongside other sections of the document. Despite this extra weighting, staff support was limited in scope, most often focused on support after the incident itself or sharing feedback after an investigation, rather than involvement during the investigation process.

> *"Staff often need support after an incident. It is important that individuals should not feel isolated after an incident. The Lead Investigator must satisfy themselves that the Divisional Management Team have taken steps to ensure that adequate support mechanisms have been made available to staff." Policy A-NW-02*

> *"provide feedback to staff involved in/affected by an incident once an investigation has been completed." Policy MH-SW-01*

In most policies, the language pertaining to involvement or support is technocratic, framed as a passive, didactic process of providing information as opposed to a morally justified collaborative and relational interaction. Despite increasing evidence of the epistemic justification for involvement to support more effective learning through different perspectives of the same incident, very few policies suggested this level of active involvement of patients, their families or healthcare staff. Even for those policies that did reference more active involvement, this was based on patients, families and staff providing a contribution at a specific point in the investigation rather than active and continued involvement throughout. Moreover, some policies suggested that effort to involve patients, families and staff should be proportionate to the level of harm caused by the incident and the learning potential those affected can provide, rather than a fair and equitable process defined by a duty of care.

> *"When the Lead Investigator for the SI (Serious Incident) has been identified the patient or relatives will be offered involvement in the investigation to include their perspective of the SI. This can be in written form or by being offered a face-to-face meeting by the investigation team." Policy MH-YH-02*

> *"Staff, patients, carers and families and members of the public are provided with appropriate support throughout the investigation process and are able to contribute towards learning (effort is proportional to the incident outcome and learning potential)." Policy A-YH-02*

There was absence across all policies of specific justification or guidance to inform those leading investigations as to *why* and *how* to include involvement of any stakeholders in the investigation process beyond the scope of formally sharing experiences. Further, the tone when referencing involvement often represented a specific directive linked to additional governance or mandated processes such as Duty of Candour or complaints and litigation.

> *"The Trust meets its obligations under the Duty of Candour in the incident management procedure."Policy MH-M-02*

Interestingly, the positioning of reference to involvement and support across all policies was framed similarly. Policies were generally structured to prioritise scope, purpose, and responsibilities. Thus, reference to involvement and support was often positioned at the end of the policy document, despite openness and transparency explicitly presented as the key values upon which investigations should be undertaken. The juxtaposition between the proportion of the document relating to roles and responsibilities and that relating to stakeholder involvement or support was particularly striking, and suggestive of a hierarchy of importance within the policies.

Learning: ticking a box or a route to meaningful change?

The majority of all policy content focused specifically on the need to learn from incidents. Most policies begin with a similar reference to learning as the most important outcome of the investigation process, often directly mirroring the statement of purpose included in the national Serious Incident Framework [16], despite the otherwise marked variation between local policy documents.

> *"to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again." Policy MH-SW-01*

> *"Serious incidents in health care are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant our particular attention to ensure these incidents are identified correctly, investigated thoroughly and, most importantly, trigger actions that will prevent them from happening again." Policy A-NE-03*

Beyond this statement outlining organisational learning to prompt improvement in services as the primary purpose of the investigation process, policies reference construction of recommendations or action plans as the 'learning' from an investigation.

> *"A clear analysis of the incident then allows for creation of effective recommendations and actions to minimise future re-occurrence." Policy A-L-01*

> *"Oversee the development of action plans that respond to the report recommendations and receive assurance that all actions are complete." Policy A-YH-02*

Policy documents fluidly moved between using learning as a noun (learning as an outcome to be achieved) and a verb (learning as action), resulting in a level of confusion throughout documents about what learning in this context actually means. This lack of consistency perpetuates the idea that the learning output of the investigations process is a set of arbitrary recommendations or actions, rather than learning being central to the process as a collaborative deconstruction and reconstruction of knowledge based on different perspectives. Policies at best suggest material rather than epistemic change, and thus retain power for change and improvement within the organisation rather than making clear the learning potential of active involvement. Moreover, reference to action plans, recommendations and learning across all policy documents was aligned only to organisational staff; there was no reference to patient or family involvement to this process, or the potential for them to be involved in these discussions.

> *"[Staff will] engage in learning and outcomes from investigations." Policy MH-S-01*

> *"[The incident review group will] produce a lessons learnt newsletter setting out key themes, trends and learning from investigations. This will give information on key learning and topics of interest, highlighting key information staff need to be aware of." Policy A-L-02*

You must be 'just': being open or a jargon smokescreen?

All sampled policies included statements pertaining to a 'just and open culture' with exhortations to support staff, often followed closely by reference to expected compliance with investigative process and threat of disciplinary action. The jarring juxtaposition between these two positions, which are not compatible, is indicative of the tonal disharmony throughout the sampled policies. It is also representative of a lack of clarity over what the policy document represents; whether this is a document to support action, or a document that is used to guide judgements on compliance retrospectively.

> *"The policy supports the approach taken by the NHS in changing the culture of blame, to one of promoting learning from a fair and transparent investigation into adverse events." Policy MH-NW-04*

> *"Failure to comply with this policy could result in disciplinary action." [All policies had a sentence to this exact effect]*

Despite reference to just, open and fair culture in all policies, the general tone of the body of policy text was, in parts 'legalese', and bureaucratic throughout. Reference is made in sampled documents to monitoring, compliance and contractual duties, often positioning the policies as mandates from organisational management. Such tonally contradictory language undermines the initial message of the policy, and its espoused aim and purpose, of an open and transparent learning process. In addition, the focus

on compliance, although targeted at staff, removes the idea that involvement of any affected parties is for any reason other than a mandated process.

> *"The incident review group should monitor compliance with Duty of Candour." Policy MH-M-02*

> *"Compliance with this policy will ensure that incidents are systematically identified, recorded, reported to management and appropriately investigated." Policy A-S-03*

This tonal incongruity within policy documents seemed to suggest a policy making process 'by committee' both literally, and figuratively. At a literal level, all policies analysed were managed and sanctioned by a committee of Trust managerial and executive staff so lack of tonal congruence could arguably be due to different perspectives of different individuals, and their individual role within the governance process. At a more abstract level, local incident investigation policies become an amalgam of other local and national policy documents relevant to healthcare incidents and investigations. As such, a 'cut-and-paste' approach to key elements of the policy documents, including the policy purpose and local, national, or legal mandates for learning and involvement, set the tone on which the rest of the policy is then constructed and, to a point, enacted.

Research team reflexivity

By virtue of policies being publicly available documents, the process of gathering sampled trust policies should have been straightforward. However, it represented a strange hinterland of data gathering. Policies were either easily found or quickly and generously provided, or they were shrouded in difficult to navigate websites, intranet files or internal processes such as Freedom of Information or redaction.

As a research team, we assumed that analysis of policies would be a relatively straightforward process, with significant levels of repetitive content. In fact, the process of analysis was an emotional experience. Reading the policy documents was often overwhelming due to their size and tone and led us to reflect particularly on how these documents would be received by members of staff, but also by patients and families going through the incident investigation process given they should be publicly available. The dominance of roles and responsibilities leaves the reader wondering what the purpose of the policy is. Is it to prompt appropriate action following a serious incident, or to assign blame for policy 'violations' after the fact? Certainly, it did make the reader feel the weight of the 'organisational gaze' on activity following serious incidents but left little feeling of care or support. The tonal incongruence also elicited a sense of powerlessness or fear about the process, and about the potential for blame or disciplinary action. Although there was a varied level of emotional response across the policies sampled, there was not a single policy document that did not elicit some level of concern or nervousness.

Although all researchers had a clear understanding that policy documents are organisational documents, minimising the importance of involvement and support of patients, families and staff in the investigative process was particularly stark. Given the perspective gained from our wider research project on the compounded harm experienced by these different groups following serious incident investigations, the lack of understanding of the importance of involvement relative to their needs, or the perspective their input could bring, elicited significant emotional response.

Discussion

Despite local policy being informed by a single national framework document [16], we found considerable variation in the construction of local serious incident investigation policies. Clarity and consistency in both the espoused aim of the policy and specific actions within were generally lacking. The language and ordering of the documents were a powerful indication of the position and motivation of those writing the policy as opposed to publicly professed organisational values e.g., patient-centredness and a commitment to systems-level learning. Policies included only vague reference, if any at all, to active involvement of those affected by a serious incident, more often making passing reference to the importance of support or passive provision of information. Further the juxtaposition between an espoused culture of openness and transparency for the purposes of learning, and the bureaucratic language related to compliance and duty, made it difficult to determine the scope and purpose of policy documents.

Publication of seminal patient safety reports over 20 years ago prompted a national commitment in the UK NHS to move from a culture of punitive individual sanctions following serious incidents in healthcare, towards a culture founded on meaningful organisational learning [1, 2, 19]. However, more recent evidence suggests fear of potential blame and career concerns mean it is still professionally safer for some healthcare staff, particularly those in lower positions within the hierarchy of power, to overlook, distance themselves from or defensively justify safety concerns or serious incidents [5, 20]. The juxtaposition between an espoused commitment to a culture of safety and system-level learning, and the intention of the general body of policy documents being to direct the

behaviour of individuals within the system to produce a set of often arbitrary recommendations, gives insight into the rarity of identifying wider systemic factors related to serious healthcare failures [5, 19]. We would argue that, to demonstrate commitment to organisational learning at a policy level, the linguistic use of the term 'learning' must be transformed, with an explicit definition or outline of what learning in the context of incident investigations means. Rather than learning being represented by delivery of a set of recommendations to be disseminated, learning should be repositioned as a social deconstruction and reconstruction of shared knowledge [5]. That is, we argue that learning should be reframed as a collaborative scrutiny and reconstruction of systems and processes to first understand how care is delivered and experienced, and then try to re-organise it in ways that help to prevent re-occurrence of specific incidents. Making this transformational shift towards systems-level learning naturally requires a level of flexibility which policy often lacks. However, allowing for more flexible and collaborative response to incidents would not only represent a demonstrable shift away from a culture of blame, but it would arguably increase the likelihood of early warning signs and wider systemic issues being identified and rectified.

Such a shift in the use of language would also demonstrate organisational commitment to learning as a participative process. By repositioning what is meant by learning, policy makers have the opportunity to shift the process of information gathering. Traditionally, requiring enough information to deliver a set of often arbitrary recommendations leads investigators to default to information gathered from 'expert' witnesses, or those who can provide locally appropriate and first-hand knowledge about the incident and the specific clinical or care processes related to it [3]. This often prejudices the voices of those who have knowledge of clinical and organisational process over patients and families who are not considered 'expert knowers' in this context. Clearly defining learning as a participative process would arguably give 'permission' to those doing investigations to explore multiple perspectives. That is, it would position all those affected by incidents as 'expert knowers' in their own right, each with potentially valuable insight, without judgement or value based on clinical expertise, local understanding, or indeed their emotional response to an incident.

A more collaborative approach to organisational learning also represents a clear shift towards a 'just culture'. It is widely acknowledged in patient safety research and in both national and local healthcare policy that commitment to a 'just culture' encourages openness, leads to more sensitive treatment of those involved in or affected by safety incidents, and leads to more meaningful learning [21]. Actively involving patients, families and staff can contribute different perspectives on, and knowledge about, the incident and the wider system [8, 22, 23]. However, there is also a moral justification that more active engagement and involvement of those affected by an incident can repair trust and reduce secondary harm [8, 22, 23]. Although we found policies clearly include standard statements of intent towards building a 'just culture' and principles of openness and transparency, we would argue that these principles must permeate the document as a whole. That is, to operationalise policy as an explication of organisational and social values, policy makers must clearly understand their 'justice position' and be willing to understand that of all those affected by incidents. Three key conceptions of justice have been highlighted as particularly evident in, and important for, patient safety and incident response: '*justice as facing sanctions*'; '*justice as no blame or qualified blame*'; and '*justice as repair*' [21]. Although questions remain about how to balance the tensions between, and different interpretations of these different conceptions of justice, this must be acknowledged as a starting point in the demystification of 'just culture' as a tokenistic statement of intent in policy.

Our findings suggest that local policies under the Serious Incident Framework [16] are a conflation of these justice positions. It is unclear whether this is because those writing them do not understand or cannot articulate what their 'justice conception' is, or that indeed, they are currently trying to operationalise activity that cuts across different views of what a 'just' response to incidents in healthcare should be. We contend that those constructing policies would benefit from thinking about how and where to emphasize particular conceptions of justice to construct and deliver policies with 'just culture' at their core, rather than devaluing intentions of 'just culture' through messages of compliance, discipline, and passive involvement. This is particularly important for healthcare staff, who are in the unique position among all stakeholders in that they might be both affected by a specific incident, but also expected to comply with the structures that govern, and activities that guide an investigation. Therefore, contradictory statements on justice and compliance might prompt fear or feelings of disempowerment against the system in a way that would not be true of other stakeholders in the process. However, understanding the significance of different concepts of justice throughout the investigative process also has implications for patients and their families. We assert that policy makers must also consider a 'just' organisation as one that is committed to the moral value of reparation through accountability, openness, active involvement and a willingness to listen, and assign epistemic value to, multiple perspectives.

Considering the potential elicitation of strong emotional response to policies, policy makers must consider the power of linguistic strategies that prioritise action

over judgement to demonstrate a commitment to care and system-level learning and avoid contradictory tone and structure that suggest a culture of individual accountability and blame. Where patient and family voices are too often discredited [3], and healthcare staff remain nervous about the consequences of healthcare incidents [5], organisational managers and executives are not likely to be similarly vulnerable [24, 25]. In fact, healthcare managers and executives are more likely to be held to account for not prioritising organisational reputation, CQC ratings or cursory standardised measures of safety (e.g. falls, pressure ulcers) than they are for not prioritising meaningful organisational learning after an incident [25]. Thus, a more considered reflection of justice position in policy becomes a mechanism by which action is directed to protect the well-being of those involved in safety incidents, and to prompt inclusion to achieve organisational learning in its truest sense, rather than simply a tool through which action is governed.

Study limitations

The scope of this analysis is limited as we have focused our exploration on a specific type of healthcare policy document and, relative to the number of potentially available policies, our sample size was small. Broadening the scope would possibly have furthered our understanding of construction of healthcare policy more generally, however we are confident that the focused nature of our analysis provides extensive learning for policy making at both a national and local level related to investigations after serious healthcare incidents. A larger sample size might have increased our understanding of the wider landscape of local policy, but the similarities across policies analysed means we have confidence that our findings can inform development and shaping of local serious incident investigation policy.

Conclusion

Our findings provide insight into the governance of serious incident investigations in NHS acute and mental health trusts under the Serious Incident Framework [16], and how involvement of key stakeholders in the investigation process is represented in policy. As a result of

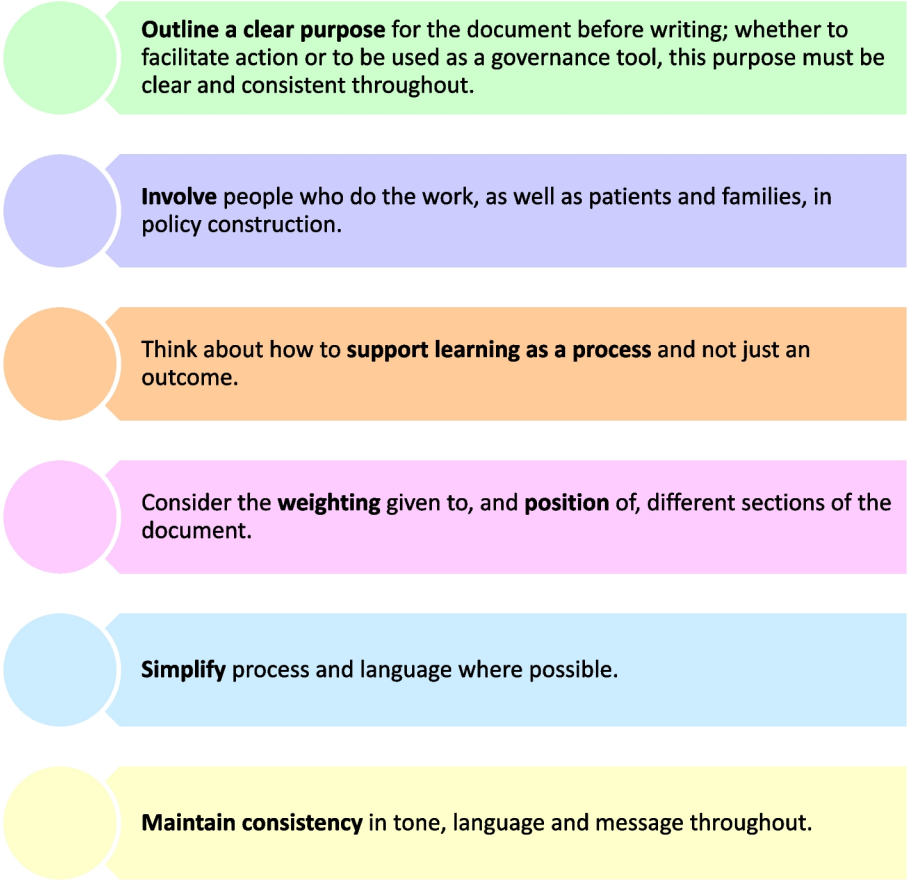

Fig. 3 Recommendations for policy makers. Drawn from this analysis, these recommendations aim to support policy makers to construct and shape more meaningful patient safety policy

our analysis, we have developed a set of key recommendations for healthcare safety policy makers to consider (Fig. 3). Of significance is the juxtaposition between statements pertaining to 'just culture' versus statements of compliance, and lack of reference to involvement and support. Importantly, there was also a lack of clarity about the meaning of 'learning' in context despite it being the espoused aim of the investigation process. More effective representation of the moral and epistemic reasons for stakeholder involvement in incident investigations may lead to better understanding of its importance consequently increasing the likelihood of, and opportunity for, more effective learning.

Understanding how structural elements of policy documents were central to the way in which the document was read and received, regardless of its' intended aim is significant more broadly for both local and national policy makers in constructing more meaningful policy.

Acknowledgements
The authors would like to extend thanks to Dr Lauren Ramsey for carrying out an internal consistency check during the initial stages of data extraction.

Authors' contributions
SM carried out the majority of data collection and extraction activity, analysed and interpreted the data from policy documents, and wrote the main manuscript of the text including figures. GL was involved in the conception and data collection, and provided extensive support for data collection activities. KL performed some of the initial data collection and extraction activity. LS was involved in the conception of the paper, and has provided extensive support on the analysis. JOH is the grant holder, and was involved in the conception, data analysis and interpretation of the data from policy documents. All authors reviewed the manuscript.

Funding
This study was funded by the National Institute for Health and Care Research (NIHR) Health Services and Delivery Research Programme (18/10/02; ISRCTN14463242) and supported by the NIHR Yorkshire and Humber Patient Safety Translational Research Centre (NIHR YH PSTRC).
The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Availability of data and materials
The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Not applicable.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Author details
[1]Leeds Beckett University, PD402, Portland Building, Leeds Beckett University, City Campus, Leeds LS1 3HE, UK
[2]School of Healthcare, University of Leeds, Leeds LS2 9JT, UK
[3]Midlands Partnership NHS Foundation Trust, Stafford, UK
[4]Department of Health Sciences, University of York, York YO10 5DD, UK
[5]The Healthcare Improvement Studies (THIS) Institute, University of Cambridge, Strangeways Research Laboratory, Cambridge CB1 8RN, UK

Received: 25 April 2023 / Accepted: 20 September 2024
Published online: 09 October 2024

References

1. Corrigan J, Donaldson MS, Kohn LT. To Err is human: building a safer health system. Washington D.C.: National Academy Press; 2000.
2. Department of Health. An organisation with a memory: report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer. London: HM Stationery Office; 2000.
3. Kok J, de Kam D, Leistikow I, Grit K, Bal R. Epistemic injustice in incident investigations: a qualitative study. Health Care Anal. 2022;30:254–74.
4. Leistikow I, Mulder S, Vesseur J, Robben P. Learning from incidents in healthcare: the journey, not the arrival, matters. BMJ Qual Saf. 2017;26(3):252–6.
5. Macrae C. The problem with incident reporting. BMJ Qual Saf. 2016;25(2):71–5.
6. Iedema R, Allen S, Britton K, Gallagher TH. What do patients and relatives know about problems and failures in care? BMJ Qual Saf. 2012;21(3):198–205.
7. Iedema R, Allen S, Sorensen R, Gallagher TH. What prevents incident disclosure, and what can be done to promote it? Jt Comm J Qual Patient Saf. 2011;37(9):409–17.
8. Kok J, Leistikow I, Bal R. Patient and family engagement in incident investigations: exploring hospital manager and incident investigators' experiences and challenges. J Health Serv Res Policy. 2018;23(4):252–61.
9. Ramsey L, McHugh S, Simms-Ellis R, Perfetto K, O'Hara JK. Patient and family involvement in serious incident investigations from the perspectives of key stakeholders: a review of the qualitative evidence. J Patient Saf. 2022;18(8):e1203–10.
10. Wailling J, Kooijman A, Hughes J, O'Hara JK. Humanizing harm: Using a restorative approach to heal and learn from adverse events. Health Expect. 2022;25:1192–9.
11. Birkeland S. Health care complaints and adverse events as a means of user involvement for quality and safety improvement. Milbank Q. 2019;97(1):346.
12. Wu AW. Medical error: the second victim: the doctor who makes the mistake needs help too. BMJ. 2000;320(7237):726–7.
13. Fricker M. Epistemic injustice: power and the ethics of knowing. Oxford: Oxford University Press; 2007.
14. Greenhalgh T, Russell J. Reframing evidence synthesis as rhetorical action in the policy making drama. Healthc Policy. 2006;1(2):34.
15. Jones L, Exworthy M. Framing in policy processes: a case study from hospital planning in the National Health Service in England. Soc Sci Med. 2015;124:196–204.
16. NHS England. Serious incident framework. Supporting learning to prevent recurrence. London: NHS England Policy, Patient Safety Domain; 2015.
17. Bowen GA. Document analysis as a qualitative research method. Qual Res J. 2009;9(2):27–40.
18. NHS England. A- Z List of All NHS Acute (Hospital) Trusts in England. Available at: https://www.nhs.uk/servicedirectories/pages/nhstrustlisting.aspx. Accessed 24 Oct 2019.
19. Macrae C, Vincent C. Learning from failure: the need for independent safety investigation in healthcare. J R Soc Med. 2014;107(11):439–43.
20. Dekker S. Just culture: restoring trust and accountability in your organization. London: CRC press; 2018.
21. Cribb A, O'Hara JK, Waring J. Improving responses to safety incidents: we need to talk about justice. BMJ Qual Saf. 2022;31(4):327–30.
22. Busch IM, Saxena A, Wu AW. Putting the patient in patient safety investigations: barriers and strategies for involvement. J Patient Saf. 2021;17(5):358–62.
23. O'Hara JK, Canfield C, Aase K. Patient and family perspectives in resilient healthcare studies: a question of morality or logic? Saf Sci. 2019;120:99–106.
24. Jensen CB. Sociology, systems and (patient) safety: knowledge translations in healthcare policy. Sociol Health Illn. 2008;30(2):309–24.
25. Perrow C. Organizing to reduce the vulnerabilities of complexity. J Conting Crisis Manag. 1999;7(3):150–5.

Publisher's Note