South West Yorkshire Partnership NHS Foundation Trust

Patient safety incident response plan

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1) Introduction

The Trust is committed to providing high quality, safe, effective and accessible care to help people reach their potential and live well in their community. Delivering services safely is our key priority and the vision of our patient safety strategy and the NHS Patient Safety Strategy (2019)[1]; where we continuously improve patient safety through developing a patient safety culture and a patient safety system.

This document supports the requirements of NHS England's Patient Safety Incident Response Framework (PSIRF)[2] and the NHS standard contract. This patient safety incident response plan sets out how South West Yorkshire Partnership NHS Foundation Trust (the Trust) intends to respond to patient safety incidents over a period of 12 to 18 months. Patient safety incidents are defined as any unintended or unexpected events which could have, or did, lead to harm for one or more patients receiving healthcare.

PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. Its four key aims are:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

The plan is not fixed and can be reviewed or changed to consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

2) Scope

There are many ways to respond to a patient safety incident. This document covers learning responses (see Appendix A) conducted only for system learning and improvement.

[1] https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/
[2] https://www.england.nhs.uk/patient-safety/incident-response-framework/

For clarity, other reviews, investigations and responses that are conducted for the reasons listed below, differ from the aims of a patient safety response and are therefore outside the scope of this plan, but we acknowledge a learning response may be shared to support other processes as needed.

- Complaints management
- Claims handling
- Human resources investigations into employment concerns
- Professional standards investigations
- Coroner's inquests
- Criminal investigations

This plan should be read in conjunction with the Trust's Patient Safety Incident Response Framework (PSIRF) Policy. We are developing procedures to support the policy, including incident reporting and management, and responding to incidents. A glossary of terms used in included at the end of this document.

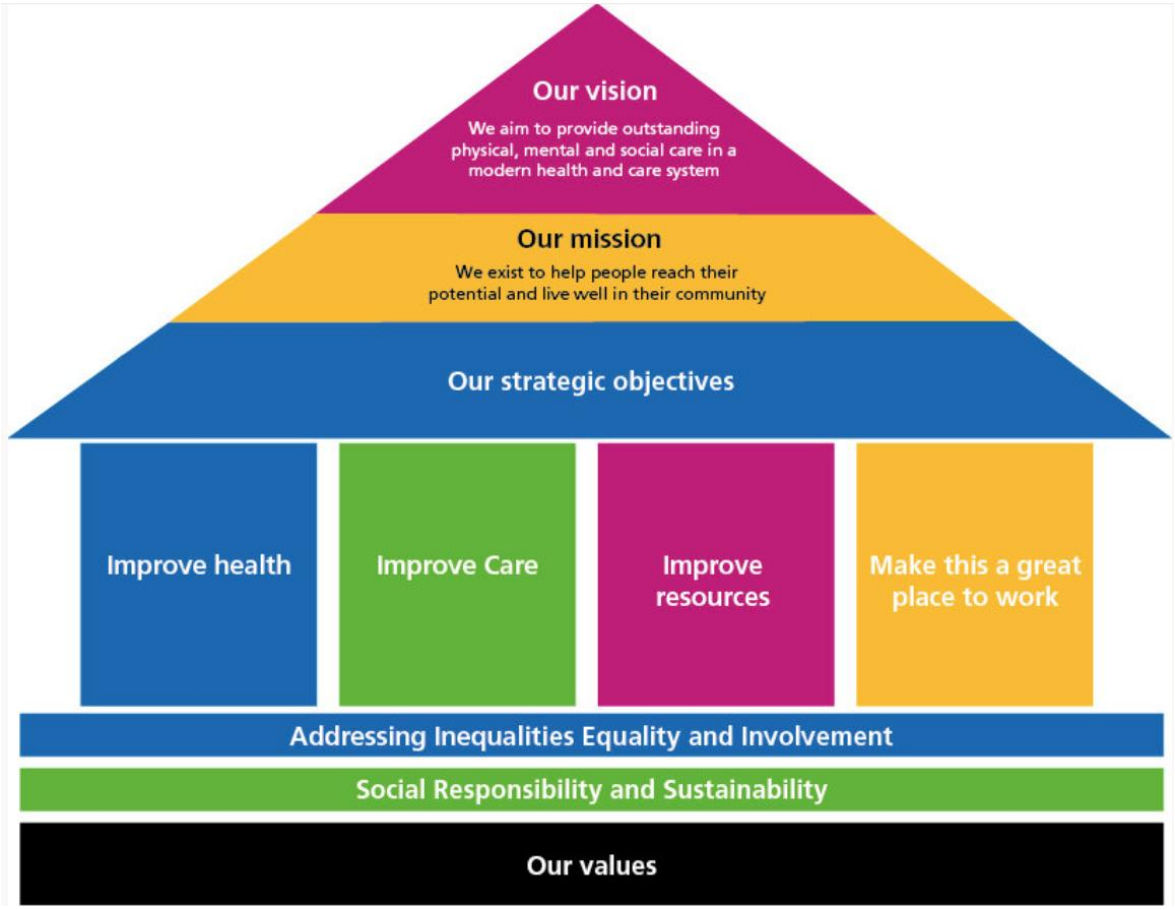
3) Our services

South West Yorkshire Partnership NHS Foundation Trust (the Trust) provides community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. We also provide medium secure services for West Yorkshire and local low secure services.

Our vision, mission, values and strategic objectives

PSIRF aligns closely with the Trust's approach to be a values-led organisation. Our vision, mission and values (figure 1) are well established and are recognised and endorsed by the people we work with and the people who work in the Trust.

Figure 1 South West Yorkshire Partnership NHS Foundation Trust strategy house and 2023/24 strategic objectives and priorities



Our values guide us each day to ensure we provide the best possible care for local people and underpin the approach of our staff in providing this care. Our values reflect the openness and transparency of the organisation, clearly and succinctly:

- We put the person first and in the centre
- We know that families and carers matter
- We are respectful, honest, open and transparent
- We improve and aim to be outstanding
- We are relevant today and ready for tomorrow

We have ensured alignment with the Trust's strategic objectives and priorities. We believe that PSIRF will enhance our work to improve safety and quality, improve the use of our resources where opportunities for learning and improvement at the greatest, improve engagement and involvement of those affected by patient safety incidents, thereby improving staff experience of being involved in incidents. PSIRF will also support work towards quality priorities, in particular learning from incidents and work on clinical risk assessment and risk management. We will work closely with colleagues in quality improvement to ensure alignment with patient safety.

Our organisation

The Trust is a complex system with many interrelated components that are crucial in ensuring that everything works well. We reviewed our local system to understand the people who are involved in patient safety activities across the Trust and those who work with us (external stakeholders), as well as the systems and mechanisms that support them.

Our clinical services are structured into five care groups consisting of:

- Barnsley integrated services care group
- CAMHS and children's care group
- Adults and older people mental health care group
- Forensic care group
- Learning disabilities and adult Autistic Spectrum Disorder ASD)/Attention Deficit Hyperactivity Disorder (ADHD) care group

Our place in the health and care systems

To help people live well in their communities we understand that services need to be joined up, responsive and delivered as close to people's homes as possible. We know that to achieve this, we need to work together across the whole health and social care sector. We are committed to helping join up care wherever possible and are working in partnership on a local level in each of our areas to make this happen.

The map below (figure 2) shows the areas we operate in and the partners we work with:

Figure 2 Trust geography and partners

Integrated care systems

We are partners in the West Yorkshire Health and Care Partnership and the South Yorkshire Integrated Care System. Integrated care systems (commonly referred to as ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, to improve the lives of people who live and work in their area. Integral to the smooth running of ICSs are Integrated Care Boards (ICBs), which provide a local focus and help commission and support local services. We are part of the ICBs in our geographical areas.

Provider collaboratives

NHS-led provider collaboratives are a new way of planning and providing the mental health, learning disability and autism services that have previously been commissioned by the NHS England Specialised Commissioning team.

Each NHS-led provider collaborative is formed of a group of providers of specialised mental health, learning disability and autism services (sometimes including the

independent sector) who have agreed to work together on specific services to improve the care pathway for their local population by taking responsibility for the budget and pathway. The Collaborative is led by an NHS provider (coordinating provider) who remains accountable to NHS England for the commissioning of high-quality, specialised services. Figure 3 sets out the provider collaboratives we are part of or have a role in coordinating.

Figure 3 Provider collaboratives in South and West Yorkshire

Provider collaborative	Coordinating provider	Date effective
West Yorkshire provider collaborative		
Adult Low and Medium Secure Services	South West Yorkshire Partnership NHS Foundation Trust	1st October 2021
Children and Young People Mental Health (CYPMH) inpatient services (Tier 4)	Leeds and York Partnership NHS Foundation Trust	1st October 2021
Adult Eating Disorder Services	Leeds and York Partnership NHS Foundation Trust	1st October 2020
South Yorkshire and Bassetlaw, Provider Collaboratives		
Children and Young People Mental Health (CYPMH) inpatient services (Tier 4)	Sheffield Children's Hospital	1st October 2022
Adult Eating Disorder Services	Rotherham Doncaster and South Humber NHS Foundation Trust	1st October 2022
Adult Secure Services	South West Yorkshire Partnership NHS Foundation Trust	1st May 2022

Provider alliances

We are committed to the drive to join up care on a local level. We are a leading partner in a number of provider alliances across our areas. Provider alliances bring together partners in local areas who are committed to joining up services across different organisations to create a more seamless patient journey.

These include:

- Barnsley community health and care alliance
- Calderdale cares
- Wakefield integrated care partnership
- Wakefield mental health alliance

We work in a partnership system and aim to always be a good partner. Our commitment to working collaboratively with our partners is reflected in our strategic ambitions.

Patient safety

The Patient safety support team works within the nursing, quality and professions directorate to support the Trust's systems and processes for patient safety. This includes:

- Management of the Trust's Datix risk management system
- Administration of patient safety alerts
- Data analysis and performance reporting on patient safety related data to fulfil our internal and external reporting requirements
- Leadership and advice for incident reporting and learning responses
- Patient safety investigation team for conducting patient safety incident investigations (formerly serious incidents)
- Provision of training and guidance to support staff with reporting and reviewing incidents, analysing data using systems analysis techniques and producing reports
- Support our corporate learning processes
- Offering ongoing support and guidance for managers on patient safety related subjects

Patient safety activity spans a wide range of corporate teams, services and governance structures across the Trust.

As a Trust, we developed our first patient safety strategy in 2015 along with an extensive improvement plan. This was reviewed in 2019 through consultation and collaboration with services and patient volunteer/family groups. This was through a range of workshops, meetings and focus groups. At this time, the NHS patient safety strategy was incorporated into our own strategy as we reflected our direction of travel was in line with new developments. We streamlined our improvement plan at this time for focus on a smaller range of subjects and national priority work. Our former approaches fit well with PSIRF principles.

Processes undertaken in the Trust that provide insight into patient safety include:

- Just and learning culture
- Patient safety incident response framework
- Patient safety partners involvement
- Incident reporting and management
- Engaging and involving those affected by patient safety incidents
- Patient safety training
- Patient safety strategy improvement work
- Learning network and our learning approaches
- Clinical risk panel (will be known as Patient Safety Oversight Group)
- Clinical environment safety group
- Supporting patient safety improvement
- Various Trust action groups and committees

Patient safety incident response plan

- Learning from deaths
- Complaints and feedback
- Inquest responses

The operational work for many of these patient safety processes are predominantly owned by our colleagues on the front-line, supported by specialist advisors who offer expert advice and support.

4) Defining our patient safety incident profile

Stakeholder engagement

The following stakeholders have been identified and involved in discussions about our methodology and plan development, content, and commenting on our draft plans.

- West Yorkshire Integrated Care Board
- South Yorkshire Integrated Care Board
- West Yorkshire provider collaborative
- Patient safety strategy group
- PSIRF implementation group
- PSIRF operational group
- Patient safety support team
- Nursing, quality and professions directorate
- Legal team
- Patient representatives of the Trust
- Trust staff
- Healthwatch
- Yorkshire Ambulance Service
- Calderdale and Huddersfield NHS Foundation Trust
- Mid Yorkshire Hospitals Teaching NHS Foundation Trust
- Barnsley Hospitals NHS Foundation Trust
- Care Quality Commission

Data sources

In order to identify our patient safety issues (figure 4), we carried out analysis of qualitative and quantitative data including:

- Patient safety incidents for the period 1/4/2019 – 31/03/2022
- Themes from action plans (serious Incident, service level investigations, significant event analysis, structured judgement reviews)
- Complaints from patients, families, and carers

- Claims
- Risk registers
- Strategic risks
- Internal audits
- Freedom to speak up data
- Human resource processes
- Quality improvement and assurance data
- Existing improvement plans

The PSIRF team triangulated the data from these sources in consultation with specialist advisors and the PSIRF implementation group. We considered our existing knowledge by theme against improvement work already in place, to help us identify areas where we wanted to understand more. Colleagues were asked to add other knowledge about current or emerging patient safety risks/issues identified through experience including our clinical risk panel and other forums.

The draft patient safety issues were shared and discussed with our internal PSIRF implementation team, with internal and external stakeholders, before being consolidated into a final list of patient safety priorities and incorporated into this plan. These were agreed at:

- PSIRF implementation group
- Quality and safety committee
- Trust Board

The current local top patient safety issues arising from data analysis are presented in figure 4. It is understood that not every patient safety issue can be included in this version of the plan but may be considered in future versions.

Apparent suicide, whilst identified as a patient safety issue, will be reviewed in line with the learning from deaths national guidance and our policy, with two exceptions. Firstly, where an apparent suicide is found to have been more likely than not to be due to problems in the care we provided, it would meet the criteria for an individual Patient Safety Incident Investigation (PSII) under PSIRF. Secondly, we will conduct a thematic PSII project around suicide prevention.

Data was analysed to care group level to identify any trends specific to one service area. Figure 4 includes detail of where specific areas if relevant.

Figure 4 Patient safety issues

Patient safety issue	Criteria	Service area	Improvement plan in place

Self harm	Inpatient – self harm associated with ligatures or swallowing objects Community – overdose of prescribed medication	Mental health & learning disability inpatient and community settings	Improvement plan in place
Inpatient falls	Learning from well managed incidents and/or near misses	All inpatient services	Improvement plan in place
Medication errors	Administration of insulin Medication storage (fridges/clinic rooms)	All services	Improvement plan in place
Violence and aggression against patients	Violence resulting in moderate harm or above Incidents involving use of force resulting in moderate harm or above Incidents where system issue identified	Mental health & learning disability inpatient & community settings	Improvement plan in place
Pressure ulcers	Category 2 resulting in learning not covered in existing improvement work. Category 2 or 3 deteriorating to category 3 or 4 (unrelated to end of life) Clinical documentation including Waterlow risk assessment	Community physical health services	Improvement plan in place
Apparent suicides	Suicide prevention at team level	Mental health & learning disability inpatient & community settings	Improvement plan in place
Risk assessment	Formulation Informed Risk Management (FIRM) clinical risk assessment and associated record keeping and care planning	All services	Improvement plan in place
Physical health/mental health	Deteriorating physical health of mental health patients Issues with medical devices (eg availability/misuse)	Mental health & learning disability inpatient & community settings	Improvement plan in place
Patient absent without leave (AWOL)	Escape and attempted escapes from the fabric of the building	Mental health and Learning disability inpatient settings	To gather knowledge to inform future improvement plan
Transitions in care	Issues with transitions between: inpatient and community teams between community teams	All services	To gather knowledge to inform future improvement plan

**After the formulation of this table, NHS England have advised that healthcare acquired infection (HCAI) should be included as standard as requiring a local learning response (See figure 7).*

While planning supports proactive allocation of patient safety incident response resources, there will always need to be a reactive element in responding to incidents. If a patient safety incident not included in our plan causes an unexpected level of risk or significant systems learning and improvement opportunities, we will always consider undertaking a learning response. These will be agreed by our patient safety oversight group.

In the following sections we will describe the improvement approach and how we will use learning responses to identify new learning for subsequently improving the safety and quality of care our patients receive.

5) Defining our patient safety improvement profile

As part of the preparation for PSIRF, we have reviewed existing improvement work (described in section 4) related to our identified safety issues and sought areas where improvement work would be beneficial to address known contributory factors. We have incorporated where we have improvement work underway or planned in Figure 4 above. In addition, outputs from our learning responses will be reviewed by our improvement leads.

6) Our patient safety incident response plan: national requirements

In line with the PSIRF guidance, there are a number of patient safety incident types that must be responded to according to national requirements.

Figure 5 documents how we are expected to respond to the Nationally defined priorities:

Figure 5 National patient safety incident investigations (PSII) or other process

No	Event	Approach
a	Deaths thought more likely than not due to problems in care* (Incidents meeting the Learning from Deaths criteria for patient safety incident investigation (PSII))	Locally led patient safety incident investigation (PSII)
b	Deaths of patients detained under the Mental Health Act or where the Mental Capacity Act (2005) applies (where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	Locally led PSII
c	Incidents meeting the Never events criteria	Locally led PSII

d	Mental health related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII locally led PSII may be required
e	Maternity and neonatal incidents	Healthcare Safety Investigation Branch (HSIB) criteria. Contribute to any HSIB investigation as required
f	Child deaths	Refer for Child Death Overview Panel review locally led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel
g	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this
h	Safeguarding incidents in which: babies, children or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence adults (over 18 years) are in receipt of care and support needs from their local authority the incident relates to FGM, Prevent, modern slavery, human trafficking or domestic abuse/violence	Case referred to local authority safeguarding lead. Trust must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adult boards *there are discussions underway at national level regarding reviewing low level concerns under PSIRF. We will review in line with national guidance as it is released
i	Incidents in NHS screening programmes Consideration may be related to: • whether individuals, the public or staff would suffer avoidable severe harm or death if the root cause is unresolved • the likelihood of significant damage to the reputation of the organisations involved	Refer to local screening quality assurance service for consideration of locally led learning response See guidance Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)
j	Deaths in custody eg police custody, in prison, etc where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct) to carry out the relevant investigations. See (b) above for deaths under Section of the MHA. The Trust will fully support these investigations where required to do so
k	Domestic homicide	A domestic homicide is identified by the police usually in partnership with the Community

		Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case

7) Our patient safety incident response plan: local focus

Capacity to respond

A review has been undertaken of the current resource and activity associated with existing serious incident investigations, this was assessed against the patient safety incident investigation standards. We have a well-established investigation team within our patient safety support team, and our investigators will lead individual patient safety incident investigations and advise and support care groups with other learning responses. We have adopted learning from pilot organisations and our PSIRF trainer, to start with a small number of PSIIs as we establish our new methodologies and processes in the first year.

In addition, a review has been undertaken to determine the Trust's level of resource for carrying out non-serious incident patient safety related activity. Historically, this included service level investigations, significant event analysis, structured judgement reviews, learning library/SBAR summaries etc. Service level investigations and significant event analysis will cease under PSIRF. Other team focused learning responses will be used in line with this plan (see Appendix A).

PSII selection criteria

Based on the data analysis described in figure 4 and our available resource we have identified the areas below (figure 6) for local patient safety incident investigations (PSII). These are system-based responses to a patient safety incident for learning and improvement.

In line with our PSII training, we have identified two types of patient safety incident investigations (PSII) which both include in-depth systems analysis:

Individual PSII – for cases meeting the national priorities for PSII or a small number of locally defined individual patient safety incidents. These will be led by a Patient Safety Incident Investigator with relevant subject matter experts.
Thematic PSII project – systematic safety improvement project (regarding a broader theme or safety concern). These will be led by an Assistant or Associate Director from the nursing quality and professions directorate, supported by a patient safety incident investigator and project team. The scope of each thematic PSII project will be defined by the project lead and team.

All PSIIs will be led by those appropriately trained in line with the PSIRF standards.

Approach to local PSII selection

Individual PSIIs will be selected from relevant incidents by the patient safety support team and information shared with the patient safety oversight group for decision making. We will always attempt to allocate PSII investigations to our investigators so they can bring fresh eyes to a case.

Incidents not selected for PSII, may require a local learning response. These will be in line with Appendix B and figure 7. Concerns will be escalated initially through the care group governance structure to the patient safety oversight group.

Timescales for PSIIs

Where an individual PSII is required (as defined in this plan for both local and national priorities), the investigation will start as soon as possible after the patient safety incident is identified and a PSII has been agreed.

Each individual PSII will be scoped initially to understand the circumstances and key lines of enquiry. This will enable the lead investigator to discuss the case with the patient and/or their family/carers to agree the timescales for completion. The patient and/or family/carers will be kept informed of any delays that may occur.

NHS England expect that no individual PSII should take longer than six months. A balance will be drawn between conducting a thorough individual PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure findings remain relevant.

Where the processes of external bodies delay access to some information for longer than six months, a completed individual PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

Figure 6 Local priorities for PSII for the coming period of one year

Patient Safety issue	Description of areas to identify new learning	Service	PSII criteria
Clinical risk assessment	**Thematic PSII systematic safety improvement project** Clinical risk assessment, specifically formulation informed risk management (FIRM) and related record keeping, care planning and involving patient, family and carers are common contributory factors seen in our data. We will conduct a PSII systematic safety improvement project to analyse the context	Mental health and learning disabilities	Any further data gathering requirements will be defined in the design of the PSII project

	and underlying factors to aid our learning for improvement		
Suicide prevention	**Thematic PSII systematic safety improvement project** Our data analysis showed that apparent suicide of patients was the highest type of serious incident. We aim to reduce the loss of life to suicide and support those affected by suicide or suicidal expressions and actions. We will conduct a PSII systematic safety improvement project to help us to learn from work as done to drive improvement	All services	Any further data gathering requirements will be defined within the PSII project
Pressure ulcer clinical documentation	**Thematic PSII systematic safety improvement project** Our data analysis from pressure ulcer investigations over time revealed a main theme around clinical documentation. We will conduct a PSII systematic safety improvement project to help us to learn from work as done to drive improvement	All services	Any further data gathering requirements will be defined in the design of the PSII project
Unplanned events	**Individual PSII** Unexpected level of risk and/or potential for learning and improvement not included in our plan	All services	Individual PSII Maximum 2 per year

Selection of incidents for Local Learning Response (LLR)

All patient safety incidents relating to our safety issues (figure 7) will be reviewed by responsible managers with support from those in quality and governance, specialist advisor or patient safety roles, to make sure we:

- Undertake an appropriate level of engagement with everyone affected
- Ensure requirements of duty of candour are fulfilled for notifiable safety incidents wherever required
- Make any other referrals as needed (eg safeguarding)
- Understand what improvement work is underway in the Trust
- Identify if an individual learning response is needed (as described below) (PSIIs will be identified through the Patient Safety Support Team)

It is expected that most incidents will not require an individual learning response except in cases where:

- Initial review identifies opportunity for new learning not covered in the respective improvement plan
- Potential for new insight in relation to a new/emerging area of risk
- Concern about a cluster of incidents
- System issues/failure
- Learning from well managed incidents and/or near misses

A flow chart has been developed to support staff with understanding how to respond to patient safety incidents (see Appendix B), however this will continue to be developed and the latest version will be held on the Trust intranet pages.

Local learning response types

Patient safety incidents that do not require a PSII may benefit from a local learning response to gain insight or address queries from the patient, family, carers or staff.

Different local learning response methods (Appendix A) can be used, depending on the intended aim and required outcome. The most appropriate learning response method will be selected depending upon the circumstances of the incident/s. Figure 7 gives suggested learning response methods for each patient safety priority.

All patient safety incidents which are identified as notifiable safety incidents must meet the duty of candour requirements.

Incidents that meet the criteria for a PSII but were not selected, may have a local learning response in line with Appendix B.

Local learning responses

Based on the analysis described earlier, figure 7 shows suggested response methods for the list of patient safety issues. It should be noted that not all incidents, including those resulting in harm, will require a learning response.

Patient safety incidents which do not appear separately in this plan, which are cause for concern or relate to a new or emerging theme, will be covered by ‘unplanned events’ section of figure 7. Specialist advisors and patient safety support team will support this to agree the most appropriate learning response.

Staff will use figure 7 and detail in Appendix B to conduct the appropriate learning response. Where concerns remain, cases will be escalated through the care group governance structure. Advice and support will be provided by the patient safety support team.

Our suggested local learning responses for our patient safety priorities are set out on the next page.

The table below provides suggested local learning response methods. The method will depend upon the incident and circumstances. If the learning response suggested does not feel appropriate, other tools/methods can be considered (see Appendix A). Patient safety support team can provide advice and support.

Figure 7 Suggested Local learning responses to patient safety issues

Most incidents will not require an individual learning response, unless: • Contributory factors identified with opportunity to identify new learning, not covered in our improvement work • Potential for new insight in relation to a new/emerging area of risk • Concern about a cluster of incidents/theme • System issues/failure • Opportunity for system learning from well managed incidents and/or near misses			**Suggested local learning response where improvement work is not already underway (to be agreed locally dependent upon new learning opportunities and circumstances) (See Appendices A and B)**	
Patient Safety issue	**Service**	**Incident criteria**	**Team review**	**Specialist review**
Self harm	Mental health & learning disability Inpatient	Inpatient – self harm associated with ligatures or swallowing objects	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
	Mental health & learning disability - community settings	Community – overdose of prescribed medication	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required

Medication errors	All Services	Administration errors involving insulin	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
	All community settings	Administration errors involving wrong patient	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
	All inpatient settings	Medication storage issues	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
Violence against patients	Mental health & learning disability inpatient & community settings	Violence resulting in moderate harm or above Incidents involving use of force resulting in moderate harm or above Incidents where system issue identified	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
Pressure ulcers	Community physical health services	Category 2 resulting in learning not covered in existing improvement work. Category 2 or 3 deteriorating to category 3 or 4 (unrelated to end of life)	After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
Physical health deterioration	Mental health & learning disability inpatient settings	Deteriorating physical health of mental health patients Issues with medical devices (eg availability/misuse)	Debrief and/or After action review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required

Transitions in care	All services	Issues with transitions between: inpatient and community teams between community teams	Debrief	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
Patient absent without leave (AWOL)	Mental health & learning disability inpatient settings	Escape and attempted escapes from the fabric of the building	Debrief and/or After Action Review	Retrospective thematic review as agreed by specialist improvement groups. Specialist learning review as required
Healthcare Acquired Infections (HCAI)	All services	Areas of interest in terms of risk and potential learning and improvement being developed	Debrief	After action review led by Infection Prevention & Control Team Specialist learning review as required
Unplanned events (not covered in this plan)	All services	Unplanned events Emerging risk/new insight Significant patient safety concern	Debrief and/or After Action Review	Specialist learning review as required

8) Areas for further development

At the time of publishing this plan, the following areas remained in development:

Development Area	Anticipated completion date
PSIRF training on engagement and involvement of those affected by patient safety incidents by external trainer.	January 2024
Clinical Risk Panel transition into Patient Safety Oversight Group	May 2024
PSIRF Standards – strengthen some areas of compliance with the standards	October 2024
Develop in-house training package on PSIRF principles, local learning response methods and engagement and involvement	Initial delivery by end of March 2024
Patient Safety Partners recruitment process	December 2023

9) Approval and review

Approval of our Patient Safety Incident Response Plan

This Patient safety incident response plan has been considered and agreed by relevant representatives from internal and external stakeholder groups before being approved by the Trust Board. The lead within the integrated care board/s has signed off the documents and agreed a transition date with the PSIRF lead (and other board members as required). On the transition date, we will no longer operate under the Serious Incident Framework other than to conclude ongoing cases. This document will be published on the Trust's website.

A living and responsive plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents.

Issues that emerge that are not currently covered by the plan, will be logged for future review and consideration for inclusion in future versions.

We will evaluate our learning response outputs after a minimum of 6 months of use using a recognised tool for this purpose.

Emerging patient safety risks will be considered for escalation through our local care group governance processes and may be escalated to the patient safety oversight group. The resulting discussion and action may include a range of options:

- Ongoing data collection and monitoring.

- Establish a task and finish group to request further exploration of the concerns and identifying any improvement areas.
- Reviewing findings of task and finish groups to agree next steps and if the patient safety incident response plan will remain unchanged, if additions are required or if further improvement work is needed.

Review date

Our patient safety incident response policy will also evolve over time as we become more familiar with working under PSIRF, and in the spirit of the framework, we will reflect and learn from our experience to make improvements. We will undertake an overall review of the patient safety incident response policy and plan at least every four years to allow time for ongoing improvement work to embed which should then change our patient safety incident profile.

However, we will carry out an interim review of our PSIRF plan around 12-18 months post implementation to reflect on our journey so far and allow us to make any adjustments to our patient safety priorities, improvement work and learning response methods.

As we continue to develop, the related procedure documents will be updated. Updated plans will be published on our website, replacing the previous version.

Appendix A – Patient Safety Learning Responses

Where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome.

Learning Response methods	Description	Lead	Approval	Complete by	Duration
Learning Responses to inform improvement Where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome.					
Debrief (immediate incident review)	A team debrief initiated as soon as possible after an incident whilst staff remain on site or as soon as reasonably practicable. Involves all disciplines/grades of staff present. Staff come together quickly to check how everyone is, gather immediate thoughts about what went to plan and what didn't, identify any immediate actions or changes that need to be made to ensure continued safety and support needs are met. Used where incidents are unexpected or unusual, resulting in patient harm. This will be recorded on Datix. Learning can contribute to an after action review at a later date. Consider staff completing a memory capture document to preserve their recollections at this early stage.	Led by the most appropriate person on duty (supported by managers or other colleagues, those in quality and governance or specialist roles as required and/or available)	No approval required	As soon as possible, within 24 hours	Allow around 15 - 45 minutes (dependant on nature of incident)

Learning Response methods	Description	Lead	Approval	Complete by	Duration
After action review	A structured, facilitated discussion of an incident which gives individuals involved the ability to reflect on and contribute to the understanding about what happened with the aim of learning and improvement. A prompt sheet is available to guide the discussion. A template will be available with prompts for capturing discussions.	Lead to be agreed by the care group quality governance team May involve specialist input as relevant to the incident, if required	Reviewed/ approved within care group	Within 1 calendar month of the incident	Allow around 60 - 90 minutes approximately
Specialist learning review	Supports teams to learn from multiple incidents or a safety theme (e.g. clusters in one team or a single incident that involved a number of teams) that occurred in the past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. Involves staff and any other who could provide meaningful contribution to the review. Uses an open discussion to agree the key contributory factors and system gaps that impact on safe patient care. Can utilise a range of systems tools as relevant. A template will be available with prompts for capturing discussions.	Led by the most appropriate specialist for the incident type (e.g. specialist advisor, patient safety, quality and governance lead/matron (or equivalent). Team of relevant stakeholders support the review	Clusters/incidents within one care group, reviewed/ approved within care group. Clusters/incidents across range of care groups, review and approval by specialist groups	Set-up meeting within 1 calendar month.	Set-up initial meeting within 1 calendar month. Allow approximately 60-90 minutes May lead to multiple follow up meetings to review outcomes, as required. Will be dependent upon the nature of the review.

Learning Response methods	Description	Lead	Approval	Complete by	Duration
Patient Safety Incident Investigation (PSII) (individual PSII or thematic PSII systematic safety improvement project)	An in-depth systems analysis review of specific patient safety incidents which are defined in the Trust's Patient Safety Incident Response Plan. Patient Safety Incident Investigations (PSII) may be: • Individual patient safety incident investigation • Thematic PSII - focussed on systematic safety improvement project (regarding a theme or safety concern) Both investigation methodologies will involve a team approach.	**Individual PSIIs** – lead by patient safety incident investigator **Thematic PSII project** – lead by senior manager from nursing quality and professions directorate, supported by patient safety incident investigator	Chief nurse/Director of quality and professions and chief medical officer (or deputies) on behalf of Trust Board	As agreed in patient safety support team	**Individual PSII:** timescales agreed with the patient/family but take no longer than 6 months from the scope being agreed **Thematic PSII project:** timescales agreed with project group chair and are anticipated to have a duration of 6-9 months from the scope being agreed

Learning Responses for improvement based on learning

Where a safety issue or incident type is well understood (eg because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation.

Retrospective thematic analysis	A retrospective thematic analysis of learning identified through our learning response methods for a patient safety priority. The analysis aims to help understand common links, themes or wider issues from a range of methods and data.	Specialist advisors / patient safety support team	Approved by the commissioning group for the patient safety priority or oversight group	As agreed by specialist group	Dependent upon the nature of the subject/learning responses

Learning Response methods	Description	Lead	Approval	Complete by	Duration
	Outcomes used to identify new system improvement to address key barriers to safety.				

Learning Responses for assessing if a response is required

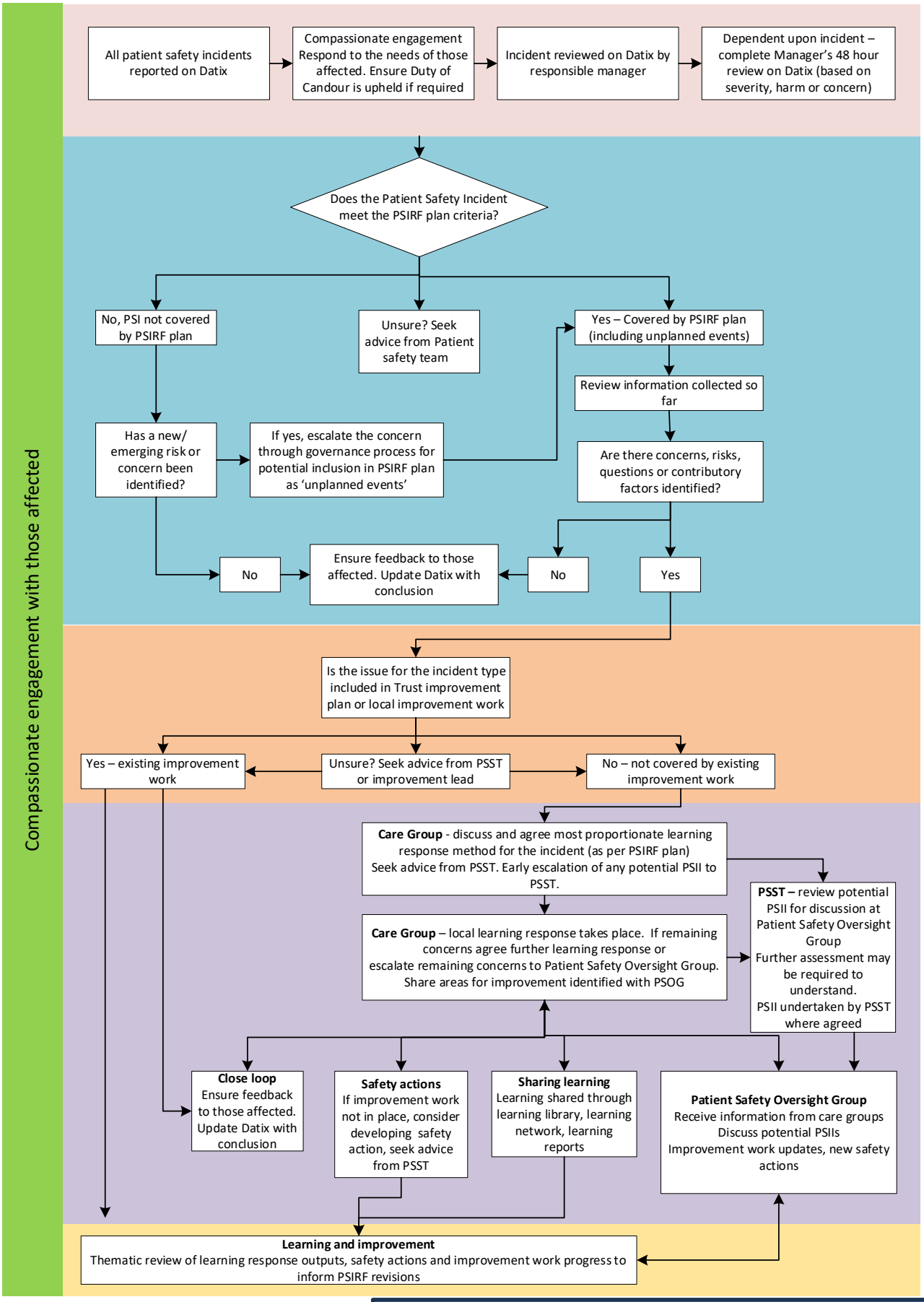
Where we cannot easily identify where an incident fits in relation to our plan (ie whether a learning response is required) we would need to perform an assessment. This is to determine whether there were any problems in care that require further exploration and potentially action.

Manager's 48 hour review	Although not a learning response, our Manager's 48 hour review acts as a first stage case note review for a death under the Learning from Healthcare Deaths policy to help understand the care given and if there were any problems in the care provided. Manager's will review the clinical records to enable the review to be completed within the Datix record. Enables managers to make a safety statement about the care provided.	Completed by the team manager or deputy	Oversight within care group	Within 48 hours of the incident being reported	Dependent upon the nature of the incident
Case note review	Review of care records where the information already provided does not easily identify if there was any problem in care that led to the patient safety incident occurring. It will include a brief timeframe of relevant events dependent upon the incident and care pathway and gap analysis. The output for this review type will determine if a further learning response	Specialist advisor, patient safety investigator or any other who possesses the expertise to complete a meaningful review.	Approved by commissioning groups for the patient safety priority or oversight group	As soon as possible after the incident	2-6 hours

Learning Response methods	Description	Lead	Approval	Complete by	Duration
	or action is required. Guidance and a template/prompt sheet will be available.				
Structured Judgement Review (SJR)	Structured Judgement Review is an assessment tool used where there is a death of a patient, where information already collected does not provide enough information to help determine if there was any problem in care or not that led to the death occurring. It is our second stage case note review under the Learning from Healthcare Deaths policy. This approach will continue under PSIRF. All cases will be allocated to an independent reviewer by the patient safety support team. The outcome of a Structured Judgement review may lead to a PSII or other learning response.	Led by trained SJR reviewer, independent of the service allocated by the patient safety support team.	Review and approval by care group governance leads and patient safety support team	Completed within 4-5 weeks of allocation	Allow around 7-10 hours

Concerns identified through any learning response method should be escalated through the governance structures as needed

Appendix B – PSIRF decision and oversight flowchart



Staff should refer to the intranet for the latest version of this flowchart

Glossary of terms

After action review	A reflective facilitated discussion used by teams when outcomes of an activity or event, have been particularly successful or unsuccessful. Provides individuals involved in an incident with the ability to reflect on and contribute to the understanding about what happened with the aim of learning and improvement.
Care Quality Commission (CQC)	The Care Quality Commission (CQC) regulates all health and adult social care services in England, including those provided by the NHS, local authorities, private companies or voluntary organisation. It also protects the interests of people detained under the Mental Health Act.
Case note review	Review of care records where the information already provided does not easily identify if there was any problem in care that led to the patient safety incident occurring. It will include a brief timeframe of relevant events dependent upon the incident and care pathway and gap analysis. The output for this review type will determine if a further learning response or action is required.
Debrief (immediate incident review)	A team debrief initiated as soon as possible after an incident whilst staff remain on site or as soon as reasonably practicable. Involves all disciplines/grades of staff present. Staff come together quickly to check how everyone is, gather immediate thoughts about what went to plan and what didn't, identify any immediate actions or changes that need to be made to ensure continued safety and support needs are met. Used where incidents are unexpected or unusual, resulting in patient harm.
Duty of Candour	Care Quality Commission Regulation 20 on Duty of Candour describes how providers should be open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things don't go to plan with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things don't go to plan.
Freedom to Speak Up Guardian	Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to do so by other routes. They ensure that people who speak up are thanked, that the issues they raise are responded to, and make sure that the person speaking up receives feedback on the actions taken.
Healthcare	The preservation of mental and physical health by preventing or treating illness through services offered by the health professions, including those working in social care settings.
Integrated Care Board/System (ICB/ICS)	In broad terms, the aim of integrated care is to join up the health and care services required by individuals, to deliver care that meets their personal needs in an efficient way. Under PSIRF, our ICB/s have oversight responsibilities, summarised below: • ICB will collaborate with us in the development, maintenance and review of patient safety incident response policy and plans.

	• Agree our patient safety incident response policy and plan including agreeing a transition date with the Trust. • Oversee and support effectiveness of systems to achieve improvement following patient safety incidents. • Support co-ordination of cross-system learning responses. • Share insights and information across organisations/services to improve safety.
Just Culture / Safety Culture	The Trust aims to work within an open, honest and just culture in which staff can be assured that they will be treated fairly and with openness and honesty when they report incidents or mistakes. We want colleagues to feel confident to speak up when things don't go to plan, rather than fearing blame.
Learning from healthcare deaths	Learning from death in an NHS context refers to the process of examining patient deaths to identify areas where improvements can be made in healthcare practices and patient safety. It involves analysing the circumstances surrounding a death to learn valuable lessons and implement changes that can prevent similar incidents in the future.
Learning From Patient Safety Events (LFPSE)	LFPSE replaced the National Reporting and Learning System (NRLS) in Autumn 2023. Patient safety incidents reported locally are submitted to the national database to aid learning and improvement. It will also replace how we report PSIIs in the future.
Learning Response	Learning responses are different methods of patient safety incident response activity that aim to identify one of the three objectives below: Learning to inform improvement - where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome. Improvement based on learning - where a safety issue or incident type is well understood (eg because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation. Assessment to determine required response – used for issues or incidents where it is not clear whether a learning response is required
Manager's 48 hour review	Although not a learning response, our Manager's 48 hour review acts as a first stage case note review for a death under the Learning from Healthcare Deaths policy to help understand the care given and if there were any problems in the care provided. Manager's will review the clinical records to enable the review to be completed within the Datix record. Enables managers to make a safety statement about the care provided.
Medical Device	Any instrument, apparatus, appliance, software, material or other article (whether used alone or in combination) (including software intended by its manufacturer to be used for diagnostic and/or therapeutic purposes and necessary for its proper application), intended by the manufacturer to be used for: diagnosis, prevention, monitoring, treatment or alleviation of disease; diagnosis, monitoring, alleviation of or compensation for an injury or disability;

	investigation, replacement or modification of the anatomy of a physiological process; control of conception and which does not achieve its physical intended action on the human body by pharmacological, immunological or metabolic means, but may be assisted in its function by such means.
Memory capture	A memory capture document is not a statement. Its purpose is as a tool to help staff preserve their memory about an incident that has occurred. It is a protective factor, and allows the widest appreciation of the situation at the time of the incident occurred.
NHS Funded Healthcare	Healthcare that is partially or fully funded by the NHS, regardless of the provider or location.
NHS Patient Safety Strategy	The strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems.
Patient Safety	Patient safety is about maximising the things that go right and minimising the things that don't go to plan. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience. (NHS Patient Safety Strategy 2019)
Patient Safety Incident	Any unintended or unexpected incident that could have led or did lead to harm for one or more patients receiving NHS funded healthcare.
Patient Safety Incident Investigation	A system-based response to a patient safety incident for learning and improvement. Typically, a PSII includes four phases: planning, information gathering, synthesis, and interpreting and improving
Patient Safety Incident Response Framework	Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for learning and improving patient safety.
Patient Safety Incident Response Plan	Trust specific - In response to the Patient Safety Incident Response Framework (PSIRF). It describes what is being done to prepare for "go live" with PSIRF and what comes next in how we will respond to patient safety priorities.
Patient Safety Partner	Relates to the role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.
Retrospective thematic analysis	A retrospective thematic analysis of learning identified through our learning response methods for a patient safety priority. The analysis aims to help understand common links, themes or wider issues from a range of methods and data. Outcomes used to identify new system improvement to address key barriers to safety.
Serious Incident Framework	Previous framework to manage reporting and investigating of serious incidents. Replaced by PSIRF.
Specialist Advisor	Trust subject matter expert for a range of patient safety and health and safety subjects
Specialist learning review	A reflective facilitated discussion of an incident which gives individuals involved the ability to reflect on and contribute to the understanding about what happened with the aim of learning and improvement.
Specialist learning review	Supports teams to learn from multiple incidents or a safety theme (e.g. clusters in one team or a single incident that involved a number of teams) that occurred in the past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability.

	Uses an open discussion to agree the key contributory factors and system gaps that impact on safe patient care. Can utilise a range of systems tools as relevant.
Structured Judgement Review (SJR)	Structured Judgement Review is an assessment tool used where there is a death of a patient, where information already collected does not provide enough information to help determine if there was any problem in care or not that led to the death occurring. It is our second stage case note review under the Learning from Healthcare Deaths policy. This approach will continue under PSIRF. All cases will be allocated to an independent reviewer by the Patient Safety Support Team. The outcome of a Structured Judgement review may lead to a PSII or other learning response.
Systems Based Approach	A system-based approach recognises that patient safety is an emergent property of the healthcare system: that is, safety arises from interactions and not from a single component, such as actions of people. A system-based approach therefore recognises that it is insufficient to look only at one component, such as only the people involved.
Systems Engineering Initiative for Patient Safety (SEIPS)	A framework for understanding outcomes within complex socio-technical systems.