NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Patient Safety Incident Response Plan

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	NAME	TITLE	DATE
Author	**Mandy stevens**	**Interim Head of Patient Safety**	**18/01/2024**
Reviewer	**Jacky Vincent**	**Chief Nurse**	**18/01/2024**
Authoriser	**Natalie Hammond**	**ICB Director of Nursing and Quality**	**19/012024**

Our Values
Welcoming Kind Positive Respectful Professional

Foreword

Our commitment to support people living with mental illness, learning disabilities and neurodevelopmental needs is at the heart of our Trust strategy, Great Together. Our ambition is to support people to live their best lives, safe from avoidable harm, consistently providing the highest quality and experience of care. Our approach to responding to patient safety incidents, within an open learning culture, will support us to achieve this.

The Patient Safety Incident Response Framework (PSIRF) is a different and exciting approach to how we respond to patient safety incidents. It's a complete rethink, so that we can all learn from incidents and continually improve the care we provide.

Previously, our focus was often on formally investigating incidents which were declared as 'serious'. Now, with PSIRF, every recorded patient safety incident can be considered. Our near misses and those incidents resulting in no harm or low harm can all provide an opportunity to learn. PSIRF will ensure we involve all those affected - inviting staff, service users and carers to be a part of the solution and ensuring their experience informs our learning and improvement.

What's important to me with PSIRF, is that there is an understanding that we are all human and that we're not always working in perfect circumstances. When a patient safety incident occurs, we can ensure everyone is treated with compassion. PSIRF asks that we have empathetic and sensitive conversations with those affected by a patient safety incident, to ensure that they feel involved, no matter how difficult that may be. We will continue to establish facts and identify solutions, but most importantly, ensure those affected feel supported.

We will continue to build on our existing processes, engaging meaningfully with our staff, our service users and their carers to ensure that their voice is the golden thread running through our response to patient safety incidents. Our appointment of Patient Safety Partners will ensure that the voice of service users and carers is clearly heard at all stages of our patient safety processes. This partnership approach will help us ensure that we work together to ensure that the same problems are less likely to occur in future – helping make our services safer for everyone.

We are also supported on our journey by our commissioners, partner providers and other stakeholders to allow us to transition and implement this nationally driven change. We certainly welcome PSIRF's implementation and are ready for the challenges ahead.

This is a new era, and I am grateful to all the staff who have led the implementation of PSIRF over the past few months. To make this a success now, we need to ensure everyone is aware of the importance of this change and that we're all ready and willing to work together in a new way to improve the care and outcomes of all those who use our services.

If you would like further information or have any questions,
please contact the PSIRF project team on: hpft.psirf@nhs.net

Dr Asif Zia
Executive Director, Quality and Medical Leadership

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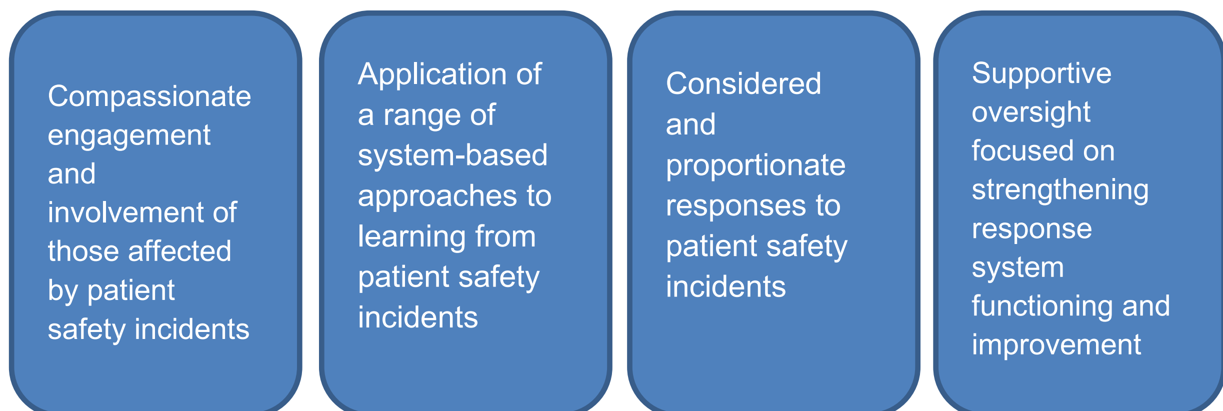
Introduction

The Patient Safety Incident Response Framework (PSIRF) is a key part of the National Patient Safety Strategy. Published in August 2022, it outlines how healthcare providers should respond to service user (patient) safety incidents, for the purpose of learning and improvement.

PSIRF supports the development and maintenance of an effective patient safety incident response system, that integrates four key aims:



PSIRF focuses on how patient safety incidents happen and, using a systems-thinking approach, enables effective learning and improvement. It builds on how the Trust responds to patient safety incidents, replacing the current Serious Incident Framework and supports the development and maintenance of an effective patient safety incident response system.

This Patient Safety Incident Response Plan (PSIRP) outlines how Hertfordshire Partnership University NHS Foundation Trust (the Trust) will seek to learn from patient safety incidents reported by staff, our service users, their families and carers as part of our work to continually improve the quality and safety of the care we provide.

This PSIRP outlines the Trust's patient safety incident profile and the Trust's patient safety improvement profile, outlining five priority areas for improvement: unexpected deaths; self-harm; violence and aggression; inpatient falls and medicines safety.

This plan details how the Trust will respond to patient safety incidents, giving details of learning responses and Patient Safety Incident Investigations (PSIIs).

This plan also explains the Trust's oversight, key responsibilities, and governance around PSIRF, ensuring that the principles of PSIRF are fully embedded across the Trust and that the learning from patient safety incidents are linked to the Trust's quality improvement programmes.

Setting out how the Trust intends to respond to patient safety incidents over the first year, this plan is not a permanent rule that cannot be changed. We will remain agile and dynamic and consider the specific circumstances in which patient safety incidents occurred, alongside the needs of those affected.

This plan is underpinned by our PSIRF policy which should be read in conjunction with this plan.

Our services

HPFT supports people with mental ill health, learning disabilities, and autism across Hertfordshire, Buckinghamshire, Norfolk and Waveney and Essex. We employ around 4,000 people who deliver these services within the community and in inpatient settings.

We also deliver a range of nationally commissioned specialist services including Tier 4 services for children and young people, perinatal services, and medium and low secure learning disabilities services. Our mission is to support people live their lives to their full potential, by enabling them to keep mentally and physically well and our work is underpinned by a very strong set of values. Co-designed and developed with our service users, carers and staff, our values are embedded across the organisation. They guide our behaviours and actions, ensuring we treat each other with compassion and care, supporting us to provide the highest quality care to service users and carers.

We offer a high quality service and are proud to have achieved an overall rating of 'Outstanding' from our regulators, the Care Quality Commission (CQC).

Our partnerships with other organisations are very important to the way in which we work. We play a full part in the local health and social care economies by promoting greater integration between mental and physical health and social care. These include working with local authorities and commissioners. We work closely with our commissioners in four integrated care systems. Our largest contracts are with the Hertfordshire and West Essex Integrated Care System and Hertfordshire County Council to deliver integrated health and social care services for people with mental health needs, learning disabilities and autism.

The Trust is a lead partner in the Hertfordshire Mental Health, Learning Disability and Autism Health and Care Partnership, working with a range of partner organisations from the voluntary sector, local government, and the NHS to shape the future of services for people with mental health needs, learning disabilities and autism across the county. The Trust is the lead provider for child and adolescent mental health services in the NHS East of England Provider Collaborative, helping to join up and integrate the commissioning of specialist services across the East of England region.

As a University Trust, we have close links to the University of Hertfordshire, providing excellent learning and development opportunities for staff and strengthening our clinical research.

We are proud to provide mental health, learning disability and autism services across Hertfordshire, Essex, Norfolk and Buckinghamshire.

Hertfordshire Population 1.2m

- Adult Primary and Community Mental Health Services
- Talking Therapies
- Mental Health Services for Children and Young People (CAMHS)
- Mental Health Services for Older People
- Dementia Diagnosis and Support Services
- Inpatient Services for Adults with Mental Ill Health, Learning Disabilities and Dementia
- Adult Mental Health Social Care support
- Mental Health Crisis Support
- Community Learning Disability Services
- Adult Mental Health Rehabilitation Services
- New Leaf Recovery and Wellbeing College
- Low and Medium Secure services

Essex Population 1.9m

- Community Learning Disability Services
- Inpatient Learning Disability Services
- Talking Therapies (Mid Essex)

Norfolk & Waveney Population 1.0m

- Medium Secure Services
- Community Learning Disability Services
- Inpatient Learning Disability Services

Buckinghamshire Population 555k

- Community Learning Disability Services

We employ **4,121** staff

Our **turnover** for 2022/23 was **£393m**

We are **rated** **'outstanding'** overall by the CQC

We have **56** buildings across **33** sites

We are in the **top 3** **mental health trusts** to work for in the country

27,000 **People supported** through our mental health community services

Through our Trust strategy, *Great Together*, we have committed to always providing high quality care and support that is safe and achieves the best outcomes for service users and carers.

Implementation of PSIRF will further enhance our safety and just culture work by creating stronger links between a patient safety incident, learning and improvement. We aim to support compassionate engagement in collaboration with those affected by a patient safety incident, to inform our learning and improvement journey. This will include transparency and openness amongst our staff in the reporting of incidents and engagement with staff, service users, and families to establish and inform learning and improvements. This will include insight from when things have gone well and where things have not gone as planned.

- In November 2023 the Trust appointed five Patient Safety Partners (PSPs) who are people who have used our services and who are passionate about improving patient safety. Our PSPs will be working to support us on this journey.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoidability or cause of death.

- To enhance our safety culture, safety huddles, hot debriefs, and swarms are already well established across the organisation to provide learning opportunities, reflective practice, and timely support for those affected in a psychologically safe space.

- We are further reviewing and strengthening our staff support offer and the Swarm process through the work of task and finish groups to act on feedback received during our PSIRF implementation phase.

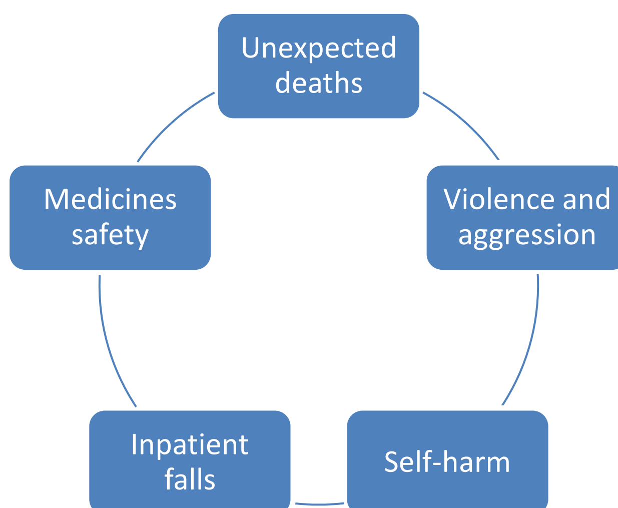
- We will utilise findings from our staff survey metrics based on specific service user and staff quality and safety questions to assess over time if we are sustaining our ongoing progress in continually improving our safety culture.
- The Trust fully supports and embraces the importance of Freedom to Speak Up and listening and acting on patient safety concerns raised by our staff with support from our Freedom to Speak Up Guardian and our Freedom to Speak Up Champions.
- We will also act on recommendations from national enquiries to further strengthen our options for staff to feel supported to raise patient safety concerns.

Defining our patient safety incident profile

In order to understand our patient safety incident profile, the Trust has analysed quantitative and qualitative data relating to patient safety incidents over the past two years. These exercises have shaped our PSIRP and PSIRF policy and defined our patient safety priorities.
The Trust utilised the patient safety data for engagement meetings with stakeholders. The Trust has also considered the feedback and information provided by internal stakeholders and subject matter experts as part of defining our profile and priorities.
The data used to define our patient safety incident profile is detailed further in Appendix 2. The Trust's data for this has been extracted from the following sources:

- incidents reported on Datix
- Serious Incidents
- patient safety incident reports, for example deep dives
- complaints
- Freedom to Speak Up reports
- Mortality Governance reviews
- Electronic Patient Record (EPR) case note reviews
- Staff Focus Group discussions
- Claims
- Coroners' findings from Inquests
- Safeguarding reviews
- Continuous Quality Improvement (CQI) projects and
- Audits.

As an outcome of this analysis, the Trust has identified five patient safety priorities for the next 12 months. These are:



There are existing or planned CQI workstreams around these five priorities that will be monitored through use of local Safety Improvement Plans, Risk Registers and Trust governance processes.

Defining our Patient Safety Improvement Profile

The Trust has redesigned and strengthened its governance processes to ensure it gains insight and learning from patient safety incidents, to inform quality improvement activity.

The four strategic business units (SBU) within the Trust have identified their local themes, risks and concerns which have been built into their individual Safety Improvement Plans (SIPs). The SBU risk registers have been aligned to reflect the 5 PSIRP priorities and specific SBU risks based on available data from a wide variety of sources. The Trust Safety Group will have oversight of the quality and progress against SIPs through reports from the SBU Management Teams.

SBUs will continue to identify opportunities to inform existing quality improvement work streams and identify new improvement work streams. All learning responses will seek to identify areas of good practice as well identifying areas of learning.

The Trust has adopted the Model for Improvement, based on the Institute of Healthcare Improvement's methodology. Continuous Quality Improvement (CQI) is well embedded in the Trust, with over 1,000 members of staff trained, and with over 300 CQI leaders across the organisation. The Trust is developing and supporting individuals to have the required mind-set, skills, and knowledge of Continuous Quality Improvement to facilitate self-sustaining and ongoing improvements to all the services and functions of the organisation, in order to support the delivery of great care and great outcomes.

To achieve this, the following strategies are underway:

- A clear CQI methodology and principles
- A co-productive and collaborative ethos
- A core CQI enabling workforce offering CQI, data and performance improvement expertise
- A network of CQI enabling staff embedded within services
- An ongoing and sustainable training and development programme
- Supported and monitored delivery of critical change initiatives and CQI projects
- Innovation Hubs as a focal point for facilitated collaboration and 'thinking differently'. The Trust has five CQI Innovation hubs across the geography of the Trust
- An Innovation Fund to provide 'seed funding' for innovative ideas

The SBUs are aligning their ongoing improvement work related to the Trust's five patient safety priorities. Ensuring there are robust improvement plans in these five priority areas will ensure that future learning can be integrated into existing improvement workstreams to maximize shared learning, prevent duplication of work, and strengthen work already happening.

The Trust will remain flexible and consider improvement opportunities as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

The Trust has adapted and updated its established and well governed process for ensuring any recommendations and actions following patient safety incidents are undertaken. The SBUs monitor and measure improvement activity through their SIPs and within their existing governance arrangements. This process ensures that following patient safety incidents and learning responses, areas of good practice, learning and improvements under PSIRF will be implemented and monitored.

The SBUs report progress against the SIPs to the Trust's Safety Group, which will have oversight of the Trust's learning responses and safety actions. The Trust has established processes in place to check that actions and changes have been embedded and that they are audited to ensure that the improvement has had a positive impact on services.

Using Datix, the Trust's patient safety information reporting system, the Patient Safety team will work with data and performance to support the SBUs with identifying themes, hotspots, and trends. This "helicopter view" will enhance the insights across the Trust.

The Trust will continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work needed to be undertaken.

The Trust has an Innovation Fund available to bid for, with one off funding of up to £25,000 available to staff, service users or carers who have an idea to improve quality. Safety is one of the key focus areas for innovation and improvement.

HPFT launched an innovative training facility, a Simulation Hub which places staff in an environment accurate to scenarios they would face in real life (whether on ward or in the community) alongside trained actors who take on the roles of service users. The training provides staff with a safe, judgement-free, practical space that is almost identical to the working environment, recreating the kinds of challenges that can occur in normal day-to-day work. The training will also incorporate learning from PSIIs and any learning from incidents reported.

Our patient safety incident response plan: National requirements

In keeping with the PSIRF guidance and principles, we intend to use our resources to maximize learning and improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care, will always be considered for a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our service users, a PSII will also be required. These have been determined nationally, but the Trust fully endorses this approach as it fits with our aim to learn and improve.

As well as PSII, some incident types require specific reporting and/or review processes to be followed. All types of incidents that have been nationally defined as requiring a specific response will be reviewed according to the prescribed methods and are detailed in the table below.

Improvement and learning from these incidents will include responding to recommendations from external referred agency organisations as required and feed actions into safety improvement plans where necessary.

From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 25-30 PSII reviews in a twelve-month period.

Patient safety incident type	Required response
Incidents meeting the Never Events criteria	PSII
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII
Death of a patient detained under the Mental Health Act (1983) 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)	PSII
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

<table>
<tr><td>Chid deaths</td><td>Refer for Child Death Overview Panel review.

Locally led PSII or other learning response may be required alongside the panel review</td></tr>
<tr><td>Death of a person with learning disabilities</td><td>Refer for Learning Disability Mortality Review (LeDeR).

Locally led PSII or other learning response may be required alongside the LeDeR</td></tr>
<tr><td>Domestic homicide</td><td>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.

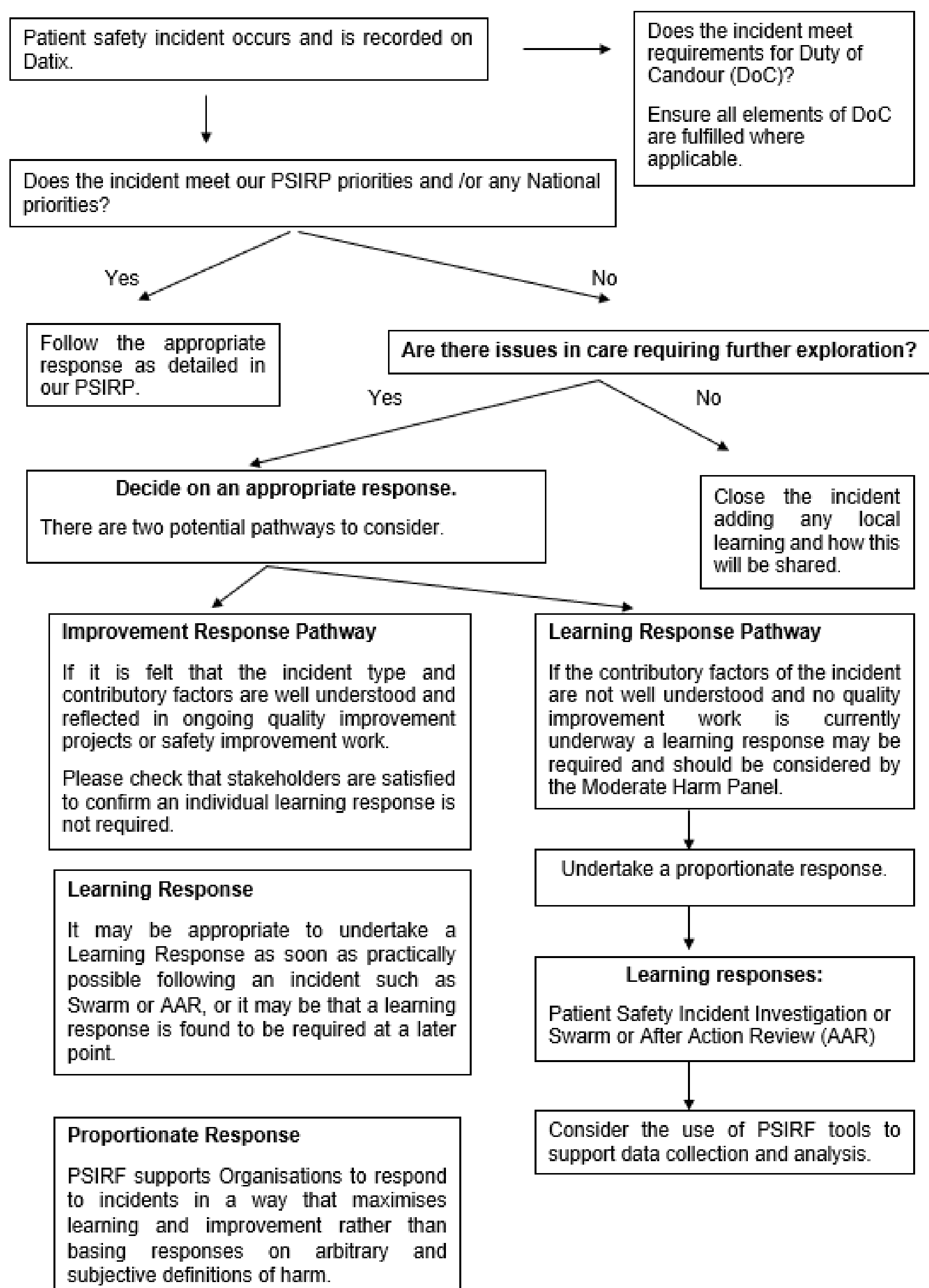
Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel.

The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs</td></tr>
<tr><td>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 old) are in receipt of care and support needs from their local authority.
The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence</td><td>Refer the incident to the local authority safeguarding lead</td></tr>
<tr><td>Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy. (Excludes accidents, incidental or where suicide is the cause of death)</td><td>Refer the incident to the Healthcare Safety Investigation Branch (HSIB) [9]</td></tr>
<tr><td>Death of patients in custody, prison, or probation, where healthcare provision is delivered by the Trust</td><td>Refer to Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC)</td></tr>
</table>

Our patient safety incident response plan: local focus

As one of the key aims of PSIRF, promoting a proportionate approach to responding to patient safety incidents will ensure that resources allocated to learning are balanced with those needed to deliver improvement. In this way, themes and learning from no harm, low harm and near miss incidents can be used, alongside learning from moderate harm or above incidents to support preventative and early detection work.

The flowchart below describes the Trust's approach to decision making under PSIRF.



The methods and ways the Trust responds to patient safety incidents recognises that outcomes in complex systems result from the interaction of multiple factors; learning should not focus on uncovering a (root) cause, but instead should explore multiple contributory factors. The system-based approach to reviewing patient safety incident is Systems Engineering Initiative for Patient Safety (SEIPS). Using SEIPS will allow us to apply a systems-based framework to learning from these incidents, exploring multiple interacting contributory factors.

The four key learning responses the Trust will utilise are:

Method	Description
Patient safety incident investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.
Multidisciplinary team (MDT) review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
Swarm huddle	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
After action review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning?

Some patient safety incidents may also require a separate response that is not focused on learning for patient safety improvement. For example, some incidents where a service user dies may be subject to investigation by a Coroner to determine how, when and where they died. Others may involve the police where there is a reason to think criminal activity may have taken place. Some incidents will lead to concerns about an individual's fitness to practise or ability to do their job, and so may be considered by the Trust or a professional regulator.

Having outlined the patient safety incidents that demand a PSII through the national approach, the local response allows Trusts proportionate choice and flexibility. For the first year of working within PSIRF, incidents categorised as resulting in moderate harm or above, or those incidents with the potential for new or significant learning identified through existing processes for local review by each service area, will be discussed at the Trust's Moderate Harm Panel (MHP). The MHP is a weekly meeting where patient safety incidents are discussed; it is attended by the Heads of Nursing and the Clinical Directors from each SBU, along with a range of other senior professional colleagues and the Patient Safety Team. In keeping with PSIRF principles, the MHP will discuss if a learning response is required, that there is existing improvement work or identify that improvement work is needed. For the first year, the panel will consider which learning response will be most beneficial.

Our local response for year one is outlined as:

Patient safety incident type or issue	Planned response
No/ low harm patient safety incident	Validation of facts at local level, learning response and/or thematic analysis where applicable
Patient safety incident resulting in moderate or severe harm to patient	Initial review in the SBU and fact finding 72-hour report. To be discussed at Moderate Harm Panel. Panel decision regarding the review of incident, using most appropriate learning response tool
Patient safety incident resulting in moderate or severe harm, that is related to one of our five patient safety priorities: • Unexpected death • Violence and aggression • Self-harm • Inpatient fall • Medicines safety	Review the patient safety incident against known factors, current improvement work and identify the possibility of new learning. To be discussed at Moderate Harm Panel, with panel decision regarding the review of incident, using most appropriate learning response tool.
An emergent area of risk	Review of incident using most appropriate learning response tool

As outlined in our PSIRF policy, the Trust will respond to cross-system incidents. Where multiple organisations need to be involved in a single learning response, the response will be led by the organisation best placed to investigate the concerns.

Engaging and involving service users, families, and staff following a patient safety incident

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including service users, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

The Trust is firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence. We recognise and acknowledge the significant impact patient safety incidents can have on service users, their families, and carers.

Getting involvement right with service users and families in how we respond to incidents is crucial, particularly to support improving the services we provide. Research and feedback from service users and families has shown that being open when things go wrong can help them cope better with the effects of a patient safety incident. As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our service users, families, and carers regardless of the level of harm.

As part of our new policy framework, we will be outlining procedures that support service users, families, and carers based on our Duty of Candour Policy and our existing processes. This will be underpinned by staff who have undertaken PSIRF engagement training alongside the Safer Care Team, who have expertise and training in this.

The Trust is committed to ensuring that our staff are open, honest, transparent and demonstrate Trust values when communicating with service users, their families or significant others when an adverse incident occurs.

The Trust is also committed to ensure compassionate engagement with staff who are affected by patient safety incidents. Initially staff support following a patient safety incident is held at a local level, by the Team Leader or a nominated healthcare professional; this can either be one to one or in a group with other staff involved, depending on individual preference. There is also the option of facilitated post incident discussion of the patient safety incident. In general, this provides opportunity to normalise reactions and enable recovery.

Oversight and governance

The Trust has clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities, and upholding national standards relating to patient safety incidents. This includes supporting and participating in cross-system/multi-agency responses and/or PSIIs where required.

The Trust's Executive Director Quality & Safety (Chief Nurse) is the Executive Lead responsible for supporting and overseeing the implementation of PSIRF, supported by the Executive Director Quality & Medical Leadership. They also have responsibility for:

- ensuring the Trust meets national patient safety incident response standards
- ensuring PSIRF is central to overarching safety governance arrangements
- quality assuring learning response outputs (PSIIs and other learning responses).

The Trust's Safety Group, will oversee and monitor the PSIRP, reporting into the Trust's Quality and Risk Management Group (QRMG), Integrated Governance Committee (IGC) and to the Trust Board. The PSIRP will be reviewed by the Chief Nurse, through the Safety Group, on a quarterly basis during its first year and then annually approved by the Trust and local commissioners thereafter.

The Trust's Quality and Risk Management Group reviews patient safety reports and monitors progress on safety initiatives, reporting to the Integrated Governance Committee.

The Safety Group will oversee all work relating to PSIRF, including the PSIRP, PSIIs, and other learning responses, receiving reports from the PSIRF Implementation Group. The Safety Committee will report to the Quality and Risk Management Group (QRMG), into the Integrated Governance Committee (IGC) and the Trust Board on a quarterly basis.

The Safety Group will:

- Design strong/effective improvements to sustainably address causal factors
- Inform a safety improvement plan for implementation of the planned improvements
- Monitor the implementation of the improvements
- Monitor the effectiveness of the improvements overtime

A Moderate Harm Review Panel report will be provided to the Executive Team on a weekly basis, detailing the planned approach for the incidents discussed at panel, with an agreed learning response. An overview of all incidents will continue to be included in future Integrated Safety Reports, along with the data of all reported patient safety incidents, to continue to provide detailed oversight.

The Trust's Patient Safety Team will ensure that learning responses are undertaken for all incidents that require this level of response. They will be responsible for ensuring that the incident reporting systems and processes, to support the recording, sharing, and monitoring of patient safety incidents are in place. They will also continue to support and advise staff involved in the patient safety incident response.

As members of the Patient Safety Team, Learning Response Leads (previously known as investigators) will work with identified individuals in the SBUs to undertake learning responses in line with PSIRF standards.

Appendices:

Appendix 01: Glossary of terms

- **CQI – Continuous Quality Improvement.** The Trust's unique approach to quality improvement, based on the Institute for Healthcare Improvement's methodology.
- **Never Event** - Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
- **PSIRF – Patient Safety Incident Response Framework**. This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.
- **PSIRP – Patient Safety Incident Response plan.** Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.
- **Service User (patient).** It is nationally recognised that people who use services in mental health trusts prefer the term *service user* rather than *patient*. The NHS guidance uses the term patient throughout, such as *Patient Safety Incident Response Plan*. To avoid confusion, in this document the term service user and patient are both used, and are interchangeable
- **SJR – Structured judgement review**. Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

Appendix 02: Data for our Patient safety incident profile

Data sources

To define our patient safety response profile, we drew data from a variety of sources including Datix incident reporting system. We moved to collate data on the actual incidents that had taken place over the period of the two years prior to 2023, to minimise the possibility of any variation in data arising from the COVID-19 pandemic.

Data and information (both qualitative and quantitative) has been included from the following sources:

- patient safety incident reports
- complaints
- freedom to speak up reports
- mortality reviews
- case note reviews
- staff focus group results
- claims
- Coroners' findings from inquests
- safeguarding reviews
- risk assessments
- quality improvement and
- audit

Where possible we have considered what any elements of the data tell us about inequalities in patient safety. As part of our workshops, we have also considered any new and emergent risks relating to future service changes and changes in demand that the historical data does not reveal.

Safety issues highlighted by the data

a) Serious incident Types

Serious incident data was reviewed from 2019/20 to 2022/23 to identify the predominant type of incident resulting in the need for serious incident investigation. The analysis indicates that deaths, self-harm, violence and aggression and falls are the predominant type of incident investigated over the last 4 years.

b) DATIX Incident Data

Incident data recorded by the Trust's incident reporting system, DATIX, was analysed over a two-year period (2021/22 and 2022/23). The most reported types of incident over this period were: violence and aggression; self-harm; practice / clinical care; personal accidents; medication; deaths (all); admission, transfer and discharge.

PSIRF principles allow for a widened focus across all patient safety incidents to ensure learning from all incident themes, including no harm, low harm and near miss incidents and other sources of patient safety data (see below narrative). The table below shows the harm level for all incidents reported through DATIX incident reporting system.

Incident Type	**2021/22**	**2022/23**
No Harm	74%	75%
Low Harm	19%	20%
Moderate Harm	3%	2%
Severe Harm	0.1%	0.1%
Death	4%	3%