PATIENT SAFETY INCIDENT RESPONSE PLAN

2023
2025

NHS
Essex Partnership University
NHS Foundation Trust

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The Implementation of the Patient Safety Incident Response Plan (PSIRP) sets out how our Trust will respond to incidents in a way which is timely with care, compassion at the heart of the way in which we respond to patient safety incidents as well as identifying the need for effective communications so that learning can be shared.

In Essex Partnership University Foundation Trust (EPUT), we have recruited five Patient Safety Partners (PSP) to be the voice of patients, their carers and families across the Trust. They have a key role in the implementation of Patient Safety Incident Response Framework (PSIRF) and its continuous evolution across the Trust, by making sure that the plan represents the needs of patients and their families and delivers improved safe and therapeutic care. EPUT was an early adopter of PSIRF and the plan builds on our initial learning and experience to create a clear direction to ensure we continue to react to and learn from patient safety incidents.

The plan supports the creation of a safe, compassionate, and quality environment for all; where the policies of the Trust represent the voices of patients, carers, and families. The plan will also represent the diversity of the populations that the Trust serves both in service, demographics and geography – as captured in the multi-disciplinary care unit structure that the Trust has put in place.

Essex itself has changed, our communities have changed and our health and social care have changed; so with this in mind we need an effective plan for responding to patient safety incidents that reflect these changes.

It is an exciting time to be a Patient Safety Partner, our roles are unique but our own experiences allow that uniqueness to also enrich the PSIRP and bring a new perspective to quality improvement and patient safety.

Mark Dale
Patient Safety Partner

INTRODUCTION

Essex Partnership University NHS Foundation Trust (EPUT) was part of the Patient Safety Incident Response Framework (PSIRF) early adopter programme in 2020 and our initial Patient Safety Incident Response Plan (PSIRP) was implemented in May 2021.

NHS England and NHS Improvement evaluated the early adopter programme and a number of changes to the revised PSIRF (August 2022) were made. The changes to the patient safety incident response standards and accompanying guidance documents have been incorporated into this updated PSIRP.

This PSIRP sets out how EPUT intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. The plan will remain agile and dynamic and consider the specific circumstances in which patient safety issues and incidents occur; this will include the needs of those affected.

INVOLVEMENT OF PEOPLE WHO USE OUR SERVICE

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We recognise the significant impact patient safety incidents can have on patients, service users, their families and carers. Getting involvement right with people who use our service and families in how we respond to incidents and safety events is crucial, particularly to support improving the services we provide.

The NHS Patient Safety Strategy recognises the importance of involving patients, their families, carers and the wider community in improving the safety of NHS care, as well as the role that patients and carers can have as partners in their own safety.

In view of this, as part of our new policy framework, we have developed procedures and guidance to support staff in how to discuss incidents with patients, service users and family. The voice of the people who use our service is very much an integral part of our work at EPUT.

The importance of the involvement of the patient and their families in any incident/investigation into their treatment and care cannot be underestimated.

The service user and family voice are vital for both learning from incidents and for putting improvement plans in place to reduce the risk of them occurring in the future. It is also key in finding closure, aiding recovery and healing for those involved in the incident together with their families. This is why it is of huge importance to involve past and present patients together with carers, in order to give them a voice within the Trust at the highest level participating in committees etc. to assure patients and families that independent oversight is in place, whilst being a critical and constructive friend.

EPUT has been ahead of the curve in this regard with the recruitment of 5 Patient Safety Partners. Our Patient Safety Partners who are people with lived experience of using our services are embedded into the trust governance processes and assurance visits.

The opportunity for patient/family engagement in our learning response will take place at the early stage of the learning response process to ensure they have the opportunity to ask questions, raise queries and to provide information regarding the type of learning response, expected timeframe etc. A Family Liaison Officer will be allocated to all patients/families involved in learning responses to facilitate engagement with the process and to provide support as required.

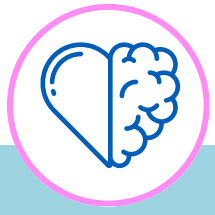
OUR SERVICES

EPUT provides community health, mental health, learning disability and social care services to over 3.2 million people across the East of England in Bedfordshire, Luton, Essex, Southend, Thurrock, and Suffolk. More than 5,500 staff work across more than 200 sites delivering the Trust services. At any one time, we care for more than 100,000 people.

Our approach is underpinned by our aim to provide individualised care that supports people to live independently and within their own homes for as long as possible.

Community health services

Our diverse range of community health services provide support and treatment to both adults and children. We deliver this care in community hospitals, health centres, GP surgeries, and in people's homes.



Mental health services

We provide a wide range of treatment and support to adults, older people, children and adolescents experiencing mental illness within primary care, community and in secure and specialised inpatient care settings. We deliver a range of tertiary services including forensic services and specialist health outreach services to marginalised communities.

Learning disability services

We provide inpatient learning disability services, working in partnership with Hertfordshire Partnership University NHS Foundation Trust, as part of our commitment to driving up quality in services for people with learning disabilities.

Social care

We provide individualised social care to people with a range of needs, including people with learning disabilities or mental illness, supporting people to live independently.

We work in partnership with the local authority partners to deliver social care as there are 3 different arrangements in place; which means some statutory social care responsibilities are delegated to EPUT, and some functions are delivered in partnership.

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EPUT has organised its clinical services into a care unit model which allows closer alignment to the needs of the local populations and represents a multi-disciplinary approach. A Clinical Psychology Care Unit has been established and runs as a golden thread through the five care units to strengthen the clinical psychology provision across the Trust.

The PSIRP has been aligned to the EPUT Strategic Plan 2023–2028 as far as possible; to ensure the shape and structure of the plan reflects patient safety concerns for the variety of services our organisation offers.

DEFINING OUR PATIENT SAFETY INCIDENT PROFILE

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In order to define our patient safety incident profile we asked ourselves

'what are the main issues/incident types that need to be better understood (from a systems perspective[1]) to support the delivery of system improvement'.

We drew on our incident response activity from 2019 gathered during the process of becoming early adopters of the introductory PSIRF and then updated our most recent incident and safety data and local intelligence of the Patient Safety Incident Management (PSIM) Team, to include the following sources:

1. Volume of responses to patient safety incidents including serious incidents (previous serious incident framework), patient safety incident investigations (PSIIs) clinical reviews, after action reviews
2. Volume of reported patient safety events by category types and sub categories
3. Volume of reported patient safety events by level of harm
4. PSII reports
5. Corporate and strategic risk identified in the Board Assurance Framework
6. Prevention of Future Death notifications and responses
7. Learning from Death reviews
8. Regulatory feedback

[1] The approach is where the work system is broken down into its components and performance influencing factors. This makes it easier to understand complexity in the healthcare systems, how interactions affect processes and outcomes.

We examined the patient safety incident records and data, considered the safety issues demonstrated by the data and identified improvement work already underway.

To define our patient safety incident profile we collaborated with relevant internal and external stakeholders.

We also incorporated the EPUT Strategic Plan 2023–2028 that describes the Trust's vision, values, purpose and strategic objectives.

The strategic plan was developed with extensive engagement with patients and their carers and families, as well as our staff and partners, to look at what needed to be done to achieve those goals over the next five years through an iterative process of strategy development.

We then agreed the profile and proportionate response methods which balanced our capacity to respond with the needs for learning and improvement as well as the needs of those affected by patient safety incidents.

We considered a number of factors including where there appeared to be the most opportunities or potential for learning and improvement, current risks and where risks may increase in the future.

DEFINING OUR PATIENT SAFETY INCIDENT PROFILE

The high level recurring themes identified from the thematic analysis of historic incidents listed below are relevant for the Trust and the patients we serve:

01 Service wide

- Record keeping
- MDT (multi-disciplinary team) communication
- Patient and service user disengagement
- Policy and standard operating procedure application
- Incidents relating to medication management
- Physical health monitoring and surveillance i.e. use of NEWS2

02 Pathway specific

- Suspected/confirmed suicide of a patient with mental health problems alongside autism
- Suspected/confirmed suicide of a patient under the care of the eating disorder service

OUR TOP SAFETY PRIORITIES

OUR TOP SAFETY PRIORITIES

03 Inpatient

- Mental Health Inpatient Ligature
- Inpatient Falls
- Clinical handover
- Life-threatening accident/injury to an inpatient or where life-saving treatment is required
- Deliberate self-harm resulting in life-threatening/or life-saving treatment required
- AWOL/Abscond – whilst detained under MHA
- Mental health inpatient attempted suicide of patients on leave (both detained and informal)

04 Transfer / Discharge

- Suicide/suspected suicide within 72 hours of discharge from a mental health in-patient ward
- Transition of children and young people to adult services

DEFINING OUR PATIENT SAFETY INCIDENT PROFILE

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The services covered by this plan include the clinical services provided by:

WEST ESSEX COMMUNITY CARE UNIT	The West Essex Community care unit provides adult primary and community mental health services alongside community physical health services across Epping, Harlow and Uttlesford. The West Essex care unit sits within the Hertfordshire and West Essex Integrated Care System (ICS).
MID AND SOUTH ESSEX COMMUNITY CARE UNIT	The Mid and South Essex Community care unit provides adult primary and community mental health services in Mid and South Essex alongside community physical health services across South East Essex. This care unit is part of The Mid and South Essex Community Collaborative, which was formed in September 2020 to review how best community physical health services can best meet the needs of local communities.

NORTH EAST ESSEX COMMUNITY CARE UNIT	The North East Essex Community care unit provides primary and community mental health services across Colchester and Tendring districts, as well as three trust-wide services: perinatal mental health; children's learning disability service (CLDS); and Allied Health Professional (AHP) services. The footprint of the community and primary care services is aligned to the North East Essex Alliance, one of three 'places' in the Suffolk and North East Essex Integrated Care System (ICS). Integrated primary care services are aligned to the six neighbourhoods within North East Essex.
URGENT CARE AND INPATIENT CARE UNIT	The Urgent Care and Inpatients care unit provides urgent and emergency and inpatient mental health services across Essex, Southend and Thurrock. The Trust provides adult (18+) and older adult (70+) inpatient services from 23 wards across Chelmsford, Colchester, Rochford, Harlow, Clacton, Basildon, Thurrock and Epping. There is also a Trust-wide rehabilitation unit and two nursing homes. Urgent care services include mental health liaison teams based within the five acute hospitals in Essex, crisis response services and home-treatment teams.
SPECIALISTS SERVICES CARE UNIT	The Specialist Services care unit provides a varied range of specialised services and serves a large population with many diverse communities across Essex and the wider East of England region. EPUT is the lead provider of forensic psychiatric services, as well as community and Tier 4[2] secure inpatient services. We also provide inpatient Children and Adolescent Mental Health Services (CAMHS) as part of the East of England Provider Collaborative.

[2] Inpatient Tier 4 services are inpatient services for the most unwell children and young people whose mental health problems cannot be managed on an outpatient basis.

SPECIALISTS SERVICES CARE UNIT	The care unit also provides drug and alcohol misuse services across Essex and the Veterans Service for the whole of the East of England. The Trust also provides inpatient and community learning disability services as part of the Essex Learning Disability Partnership with Hertfordshire Partnership University NHS Foundation Trust, as well as Adult Psychiatric Morbidity Survey (AMPS) and health outreach services for Suffolk health inequalities and inpatient perinatal and health and justice services.
PSYCHOLOGICAL SERVICES CARE UNIT	In addition to working collaboratively across the other five care units through participation in multidisciplinary service teams, the Psychological Services Care Unit holds Essex-wide services across Mental Health and Community Health across Essex and Hertfordshire. These include Eating Disorders, At Risk Mental State (ARMS) for Psychosis, Maternal Mental Health, Parent Infant Mental Health, Personality Disorder & Complex Needs services, Clinical Health Psychology Services, Cancer & Palliative Care Services, a Step 4 direct therapy service, and two large Talking Therapy (formerly IAPT) services. The care unit is also responsible for employing and supporting 96 Doctor of Clinical Psychology Trainees and we employ and train 42 Clinical Associate in Psychology apprentices. We support ACT4You training for all staff, and contribute to management and junior doctor training. We provide staff support and wellbeing services as response to untoward incidents and through our Here for You staff support service. We are assisting in leading the Trust towards to provide Trauma Informed Care and to develop psychologically informed practices.

This plan covers the majority of patient safety incidents as described within our incident profile. Our Patient Safety Incident Framework Policy provides guidance on other patient safety incident types which may have their own specific reporting requirements, for example, those involving blood products, medical devices or health and safety issues.

DEFINING OUR PATIENT SAFETY IMPROVEMENT PROFILE

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In order to define our patient safety improvement profile we considered what improvement work is underway that has/would have an impact on patient safety. This work has been driven by national, regional and locally driven programmes such as the NHS Patient Safety Strategy and wider initiatives under the strategy, including the introduction of patient safety specialists, national patient safety improvement programmes (NatPatSIP), development of a national patient safety syllabus, development of the involving patients in patient safety framework, and introduction of the Learn From Patient Safety Events service.

The NHS Patient Safety Strategy sits alongside and supports the NHS Long Term Plan.

Much of this work has been ongoing and had been initiated and driven following the implementation of the introductory PSIRF. The introductory PSIRF prescribed an approach for 'local priorities' for investigation, where a predefined number of incident types would result in a Patient Safety Incident Investigation (PSII) response and then thematic reviews of those findings would aggregate the data for inclusion into a Safety Improvement Plan (SIP).

The SIP would describe the activities involved in implementing, monitoring and evaluating the effectiveness of any agreed safety actions.

The revised PSIRF advocates a different approach to incident response activity. It focuses on proportionality and improvement, whereby incident types/events are allocated either:

1. 'learning to inform improvement' response
2. an 'improvement based on learning' response
3. 'For assessment' to determine the required response.

The emphasis is on ongoing improvement work rather than repeat learning responses. Numerous evaluations[3] have shown that the previous Serious Incident Framework 2015 and the repeated investigations it mandated have not resulted in the improvements required. Many of the safety issues described in this plan have been subject to multiple thorough investigations followed by thematic reviews in order to achieve sufficient understanding of the underlying contributory factors and interlinked system issues.

[3] https://publications.parliament.uk/pa/cm201415/cmselect/cmpubadm/886/886.pdf, https://www.gov.uk/government/publications/learning-not-blaming-response-to-3-reports-on-patient-safety, https://www.ombudsman.org.uk/publications/review-quality-nhs-complaints-investigations-where-serious-or-avoidable-harm-has, http://www.cqc.org.uk/sites/default/files/20160608_learning_from_harm_briefing_paper.pdf, https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf, https://webarchive.nationalarchives.gov.uk/ukgwa/20200501110534/https:/improvement.nhs.uk/documents/3519/Future_of_NHS_patient_safety_investigations_engagement_feedback_FINAL.pdf

To target and address these factors we created a number of organisation-wide individual medium to longer-term SIPs to take forward this improvement work across the services.

In early 2023, we formalised our governance and oversight process for this improvement work with the board/leadership team directing champions and appropriate resources. This included refocusing activity from individual learning responses to implementation and monitoring of required actions where appropriate.

We are further developing the SIPs alongside Life QI, a leading healthcare improvement platform as a centralised technological system to optimise our quality and safety improvement approach.

All safety actions within these SIPs are developed with relevant stakeholders including those responsible for implementation and efficacy. All safety actions are monitored and a named individual identified with responsibility for this.

At the time of writing, we have the following SIPs identified:

1. **Mental Health Inpatient Ligature (in progress)**
2. **Inpatient Falls (in progress)**
3. **Transition of children and young people to adult services (thematic review underway)**
4. **Record keeping**
5. **Multi-disciplinary Team (MDT) Communication (horizon scanning underway)**
6. **Patient and service user disengagement**
7. **Policy and standard operating procedure application**
8. **Medication incidents**
9. **Clinical handover**

As with the PSIRP, the safety improvement plans are maintained as dynamic and agile documents. They have specific target dates for completion but in order to meet the challenges of maintaining safe systems and responding to emergent issues[4], they may iterate over time.

Where the most proportionate PSIRP response is for 'improvement based on learning' pathway rather than 'learning to inform improvement' response pathway, the incident details and initial review findings will always be logged to inform the development of future PSIRP.

[4] A response should always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in an organisation's plan.

The Trust is involved in additional improvement programmes of work, which align to patient safety, these include:

West Essex is an early implementer site for the model described in the Community Mental Health Framework and has shared learning from its transformation journey with services across the country.

We have introduced a new target operating model, which integrates community physical and mental health services in each of our Integrated Care System areas.

In recognising that many people with dementia also live with frailty, we brought our teams together to ensure we plan and deliver our care taking holistic account of all their needs, leading to better care and outcomes.

Through our Clinical Health Psychology team, we offer mental health psychological input into physical health teams in both acute and community settings, recognising the interplay between physical and mental health problems for many people.

We launched our Safety First, Safety Always strategy in January 2021. As part of the strategy, we have invested an additional £20m in our inpatient wards enabling significant improvements in the physical environment, and in safety, across our estate.

We have installed state-of-the-art technology, provided enhanced training programmes for our staff, and changed the way in which we provide supportive observations and engagement for our service users, with care tailored to their individual needs.

We have taken steps to open up our organisation and enable more collaborative working with our partners across the system to improve our integrated care offer to our service users.

We have recently collaborated with those who have lived experience of our services along with patient safety partners.

We have further improved our digital technology and innovation and have implemented a Health Information Exchange to better enable clinical information to be shared across our services and across our local health and care system. There is a plan in place to develop one electronic patient record system for the Trust.

We have launched a Safety Dashboard and Integrated Performance Report on Power Business Intelligence. These ensures data is available to clinical and corporate support functions in real time to support data driven decision making.

We developed our safety approach whilst aligning it with national policy including: NHS Long Term Plan, NHS People Plan, NHS Mental Health Implementation Plan, Community Mental Health Framework, Draft Mental Health Bill 2022 and The Health and Care Act 2022.

To complement the Safety Improvement Plans (SIPs), we are adopting proactive techniques and methods that support an ergonomics and human factors[5] approach to patient safety. These include the use of specific tools such as horizon scanning[6] through to later improvement process areas such as testing the strengths of the controls that exist to reduce the chance of incident recurrence. This proactive approach is consistent with that of high reliability organisations.

[5] Ergonomics/Human Factors is the scientific discipline concerned with the understanding of interactions among humans and other elements of a system, and the profession that applies theory, principles, data, and methods to design in order to optimize human well-being and overall system performance." - The International Ergonomics Association.
[6] See table 3 for a description of horizon scanning.

Further improvement work is underway to ensure that work procedures effectively support colleagues in achieving good outcomes. This will be achieved through the digitalisation of our policies and standard operating procedures. The first phase of improvement programme includes the areas:

Our five recently appointed Deputy Directors of Quality and Safety and the Deputy Director of Safety and Improvement support our improvement profile.

[7] A colour coded traffic light system of Red, Amber and Green is used to signify the level of intervention required to manage the risks. This often referred to as RAG rating.

OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: NATIONAL REQUIREMENTS

This section describes:

- **Our approach to the investigation of deaths process and the Learning from Deaths process.**

- **The patient safety incident types that must be responded to according to national requirements.**

All deaths are reviewed by the PSIM Team and are notified to the Head of Patient Safety Incident Management and Mortality. For every death reported, an initial review is undertaken by the local service via the local risk management system (Datix) - this is a Stage one review. This considers various factors, including diagnosis; whether the death is to be subject to LeDeR[8] review; whether or not the death was expected; any recent in-patient admission; any concerns from staff and/or family and carers, and finally, cause of death.

The Learning from Deaths Oversight Group will commission a Stage two review (casenote review) for cases identified as requiring a more detailed review.

If during these reviews, the findings conclude that the death did not result from problems in care and there were no emergent issues [4] present, then any learning is logged and actioned appropriately and the incident is recorded to inform future PSIRP revisions. In addition, learning is reported to the Trust's Learning from Deaths Oversight Group, Learning Oversight Sub Committee and Quality Committee.

If the reviews identify some learning that falls within the scope of a safety improvement plan, then an improvement pathway response is taken, (Table 4). If at any stage, evidence indicates that a death is thought likely to have resulted from problems in care then a learning response pathway is followed and a Patient Safety Incident Investigation (PSII) is undertaken in line with national event response requirements, (Table 1).

The Trust will always participate and support as required where an investigation is opened by the Coroner to establish cause of death.

[8] LeDeR is a service improvement programme for people with a learning disability and autistic people.

EPUT has a Learning from Deaths Oversight Group, which oversees this process and reports to the Board of Directors via the Learning Oversight Sub-Committee and Quality Committee.

The Learning from Deaths Policy and Procedure has been reviewed and amended to align it with the PSIRF.

Table 1: National event response requirements

PATIENT SAFETY INCIDENT TYPE	REQUIRED RESPONSE
An incidents meeting the Never Events criteria	PSII
A 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
A 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
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
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

PATIENT SAFETY INCIDENT TYPE	REQUIRED RESPONSE
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. 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
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.	Refer the incident to the local authority safeguarding lead
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).	Refer the incident to the Healthcare Safety Investigation Branch (HSIB)[9]

[9]HSIB is now known as Health Services Safety Investigations Body (HSSIB), from late 2023

Anticipated improvement route

The anticipated improvement route for all national required responses will be:

- Creation of local organisational actions feed into the quality improvement strategy.
- Where an overarching safety improvement plan exists, findings will feed into the relevant SIP group.
- Executive oversight.
- Any immediate actions identified as necessary to avoid and/or mitigate further serious and imminent danger to patients, staff and the public.
- Providing more rapid support and signposting for families/carers affected by harm; immediate support and allocation of FLO.
- Working collaboratively with the other agency to ensure any shared learning is adopted.
- EPUT Culture of Learning Strategy and key resources (safety learning alerts, lessons identified newsletter, five key messages and the webinar's Lessons briefing and learning matters) will be used for cascading of learning.
- National reporting requirements to NHS England and other regulators to ensure national learning and direction.
- Shared learning with the quality and safety leads for the respective Integrated Care Board (ICB) to reflect system working.

OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL FOCUS

Why do we respond to patient safety incidents?

The purpose of planning how to respond to patient safety incidents was based on identifying the main issues/incident types that needed to be better understood from a systems perspective, to support learning and the delivery of system improvement.

This section of the PSIRP describes:

1. **What a 'systems perspective' means;**
2. **What the different responses are;**
3. **A table showing the links between the incident types, the planned response and the anticipated route for system improvement.**

What is a systems-perspective?

A systems perspective or system-based approach to learning is one which examines the components of a system (e.g. person(s), tasks, tools and technology, the environment, the wider organisation) and understanding their interdependencies (i.e. how they influence each other) and how those interdependencies may contribute to patient safety.

The 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.

The methods and ways we respond to patient safety incidents recognise 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.

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 patient 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 employer or a professional regulator.

Where a response is required that is not focused on learning for patient safety improvement, relevant referrals should be made to ensure it is conducted entirely separately. Care must be taken not to conflate and combine patient safety incident response activity with other remits.
A system-based approach will identify where changes need to be made and then monitored within the system to improve patient safety.

THE METHODS AND WAYS WE RESPOND TO PATIENT SAFETY INCIDENTS

Table 2: Learning response methods

METHOD	DESCRIPTION
PATIENT SAFETY INCIDENT INVESTIGATION (PSII)	A PSII is undertaken when an incident or near miss indicates significant patient safety risks and potential for new learning. It offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. Investigations explore decisions or actions as they relate to the situation and the goal is to understand why an action and/or decision was deemed appropriate by those involved at the time. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can.
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 through undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.

METHOD	DESCRIPTION
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?

TOOLS FOR CAPTURING EVERYDAY WORK

Everyday work describes the reality of how work is done and how people performing tasks routinely adjust what they do to match the ever-changing conditions and demands of work.

Exploring everyday work is important as it shifts the focus from developing (usually short-term) quick fixes to understanding wider system influences and is central to any learning response conducted to inform (long-term) improvement. The PSIRF provides a learning response toolkit, which can be accessed here.

Table 3: Tools to respond to broad patient safety issues or to supplement improvement work

TOOL	DESCRIPTION
THEMATIC REVIEW	A thematic review may be useful for understanding common links, themes or issues within a cluster of investigations, incidents or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety.
HORIZON SCANNING	The horizon scanning tool supports health and social care teams to have a forward look at potential or current safety themes and issues. The safety themes and issues chosen to explore can be identified in several ways and the versatility of the tools means that numerous system focused methods can be added to the tool in order to explore issues in depth.

TOOL	DESCRIPTION
ERGONOMICS AND HUMAN FACTORS METHODS	There are many numerous tools and methods available which can be applied to improving outcomes by system engineering, these are broadly classified under the following headings: • Data collection; • Task Analysis; • Cognitive Task Analysis; • Process Charting; • Human Error identification/Human Reliability Analysis and Accident Analysis; • Situation Awareness Assessment; • Mental Workload Assessment; • Team Assessment; • Interface Analysis; • Design; • Performance Time Prediction.

Table 4: Planned improvement response method (based on learning previously captured by investigations/learning responses) for incident type or issue and the anticipated improvement route

PATIENT SAFETY INCIDENT TYPE OR ISSUE	PLANNED RESPONSE	ANTICIPATED IMPROVEMENT ROUTE
IMPROVEMENT RESPONSES BASED ON LEARNING		
Mental Health Inpatient Ligature (not triggering a response from table 1 or elsewhere)	• Actions as described in the Safety Improvement Plan • Thematic Review • Continued monitoring of patient safety incident records to determine any emerging risks/issues	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy. Ligature Risk Reduction Forum.
Inpatient Falls	Improvement based on learning • Actions as described in the Safety Improvement Plan • Periodic barrier analysis to assess the strength of controls in place • Periodic observations of falls risk assessment completion and use of equipment, to explore barriers and facilitators • Continued monitoring of patient safety incident records to determine any emerging risks/issues	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy. Harm Free Care Group review triangulation of falls and incident data.

Transition of children and young people to adult services	Improvement based on learning • Actions as described in the Safety Improvement Plan • Additional periodic thematic work or horizon scanning approaches if required by SIP leads	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy.
Record keeping	Improvement based on learning • Actions as described in the Safety Improvement Plan • Observations to inform understanding of contextual factors influencing equipment, technology selection and use. • Additional periodic thematic work or horizon scanning approaches if required by SIP leads	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy.
MDT Communication	Improvement based on learning • Actions as described in the Safety Improvement Plan • Horizon scanning report safety observations • Continued monitoring of patient safety incident records to determine any emerging risks/issues	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy.

Patient and service user disengagement	Improvement based on learning • Actions as described in the Safety Improvement Plan • Additional periodic thematic work or horizon scanning approaches if required by SIP leads.	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy.
Policy and standard operating procedure application	Improvement based on learning • Actions as described in the Safety Improvement Plan • Ergonomics/human factors method evaluation and safety observations made.	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy. Local safety actions fed into the quality improvement strategy.
Medication incidents	Improvement based on learning • Actions as described in the Safety Improvement Plan • Periodic barrier analysis to assess the strength of controls in place (high risk medications) • Ongoing quarterly incident data thematic work to inform SIP actions	Safety Improvement Plan progression at regular group meetings – fed into quality improvement strategy. Medicines management group. Local safety actions fed into the quality improvement strategy.

Table 5: Planned learning responses for incident types

LEARNING RESPONSES TO INFORM IMPROVEMENT	
PATIENT SAFETY TYPE OR ISSUE	**PLANNED RESPONSE**
Life-threatening accident/injury to an inpatient where life-saving treatment is required	Swarm huddle / PSII (if significant patient safety risks and potential for new learning)
Suspected/confirmed suicide of a patient with mental health problems alongside autism	MDT review / PSII (if significant patient safety risks and potential for new learning)
Suspected/confirmed suicide of a patient under the care of the eating disorder service	MDT review
AWOL/Abscond – whilst detained under MHA	Swarm huddle
Mental health inpatient attempted suicide of patients on leave (both detained and informal)	Swarm huddle
Suicide/suspected suicide within 72 hours of discharge from a mental health in-patient ward	MDT Review/PSII (if significant patient safety risks and potential for new learning)
Deliberate self-harm resulting in life-threatening/or life-saving treatment required	AAR

Near miss ligature incidents on mental health in-patient wards involving a fixed ligature point	Swarm Huddle
Infection Prevention Control incident i.e. COVID outbreak or Hospital Acquired Infections with potential for severe consequences	AAR or PSII (depending on severity and in agreement with DIPC)
Physical health monitoring and surveillance where either NEWS2 application and or high risk medications are a factor.	AAR or PSII (if significant patient safety risks and potential for new learning)
Delay in patient care/treatment resulting in moderate harm or above	MDT Review

Anticipated improvement route

The anticipated improvement route for learning responses will be:

- Continued monitoring of patient safety incident records to determine any emerging risks/issues.
- Any immediate actions identified as necessary to avoid and/or mitigate further serious and imminent danger to patients, staff and the public.
- Creation of local organisational actions from learning responses feed into the quality improvement strategy.
- Sample approach of output documentation review by clinical review group to identify and progress any follow up activity.
- Where learning response outputs cross-scope with an existing overarching safety improvement plan, findings will feed into the relevant SIP group.
- Collaboration between learning groups e.g. following any fixed ligature point incidents, ligature risk assessment processes would be informed via the LRRG.
- Where similar findings are repeated, build case for new improvement plan.
- Working collaboratively with the other agencies to ensure any shared learning is adopted.
- Learning and opportunities for improvement cascaded locally and to care group quality and safety meetings.
- Learning response findings to inform EPUT Culture of Learning Strategy and key resources (safety alerts, lessons identified newsletter, 5 key messages and the webinar's Lessons briefing and learning matters)
- Executive oversight.
- National reporting requirements to NHS England and other regulators via local risk management system) to ensure national learning and direction.

ENGAGING AND INVOLVING PATIENTS, FAMILIES AND STAFF FOLLOWING A PATIENT SAFETY INCIDENT

The Patient Safety Incident Response Framework promotes systematic, compassionate, and proportionate responses to patient safety incidents, anchored in the principles of openness, fair accountability, learning and continuous improvement – and with the aim of learning how to reduce risk and associated harm.

The Trust recognises that meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. The PSIRF supports development of a patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents.

'Those affected' include staff and families in the broadest sense; that is the person or patient to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred.

The Trust is committed to achieving compassionate engagement and involvement by following the national guidance for engaging and involving patients, families and staff following a patient safety incident[10].

[10]https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

ENGAGEMENT PRINCIPLES

1 Apologies are meaningful

Apologies need to demonstrate understanding of the potential impact of the incident on those involved, and a commitment to address their questions and concerns. Ideally, an apology communicates a sense of accountability for the harm experienced, ahead of investigation. Getting an apology right is important – it sets the tone for everything that follows.

Apologising is also a crucial part of the Duty of Candour.

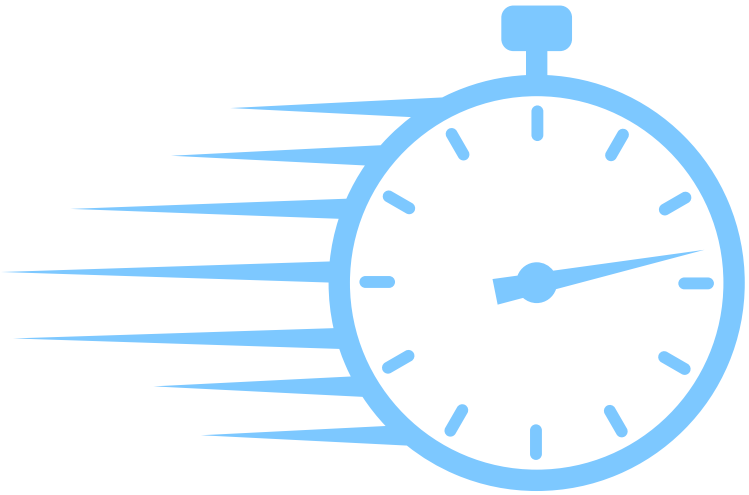
2 Approach is individualised

Engagement and involvement should be flexible and adapt to individual and changing needs. These needs could be practical, physical, or emotional.

Engagement leads should recognise that every response might need to be different, based on an understanding of the different needs and circumstances of those affected by an incident.

3 Timing is sensitive

Some people can feel they are being engaged and involved too slowly or too quickly, or at insensitive times. Engagement leads need to talk to those affected about the timing and structure of engagement and involvement, and any key dates to avoid (e.g. birthdays, funeral dates, anniversaries), particularly where someone has lost a loved one.



4 Those affected are treated with respect and compassion

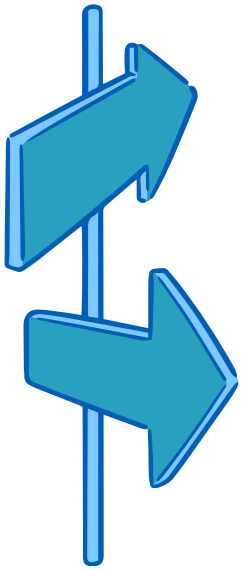
Everyone involved in a learning response should be treated respectfully. There should be a duty of care to everyone involved in the patient safety incident and subsequent response, and opportunities provided for open communication and support through the process.

Overlooking the relational elements of a learning response can lead to a breakdown of trust between those involved (including patients, families, and healthcare staff) and the organisation.

5 Guidance and clarity are provided

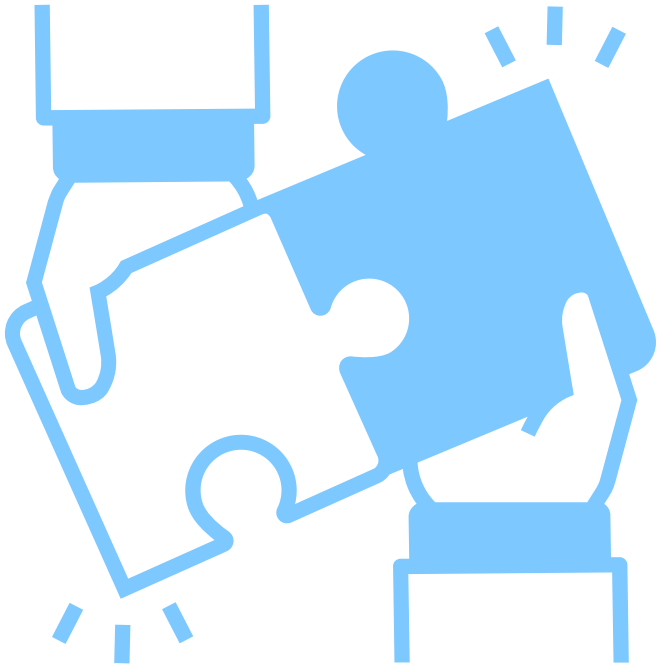
Patients, families, and healthcare staff can find the processes that follow a patient safety incident confusing. Those outside the health service, and even some within it, may not know what a patient safety incident is, why the incident they were involved in is being investigated or what the learning response entails.

Patients, families, and healthcare staff can feel powerless and ill equipped for the processes following a patient safety incident. Therefore, all communications and materials need to clearly describe the process and its purpose, and not assume any prior understanding.



6 Those affected are ‘heard’

Everyone affected by a patient safety incident should have the opportunity to be listened to and share their experience. They will all have their individual perspective on what happened and each one is valid in building a comprehensive picture to support learning. Importantly, the opportunity to be listened to is also part of restoring trust and repairing relationships between organisations and staff, patients, and families.



7 Approach is collaborative and open

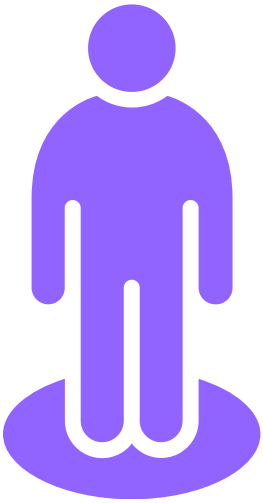
An investigation process that is collaborative and open with information, and provides answers, can reduce the chance litigation will be used as a route for being heard. The decision to litigate is a difficult one.

Organisations must not assume that litigation is always about establishing blame – some feel it is the only way to get answers to their questions.

8 Subjectivity is accepted

Everyone will experience the same incident in different ways. No one truth should be prioritised over others.

Engagement leads should ensure that patients, families, and healthcare staff are all viewed as credible sources of information in response to a patient safety incident.



9 Strive for equity

Organisations may differ from patients, families, and healthcare staff in what they consider is the appropriate response to a patient safety incident. The opportunity for learning should be weighed against the needs of those affected by the incident.

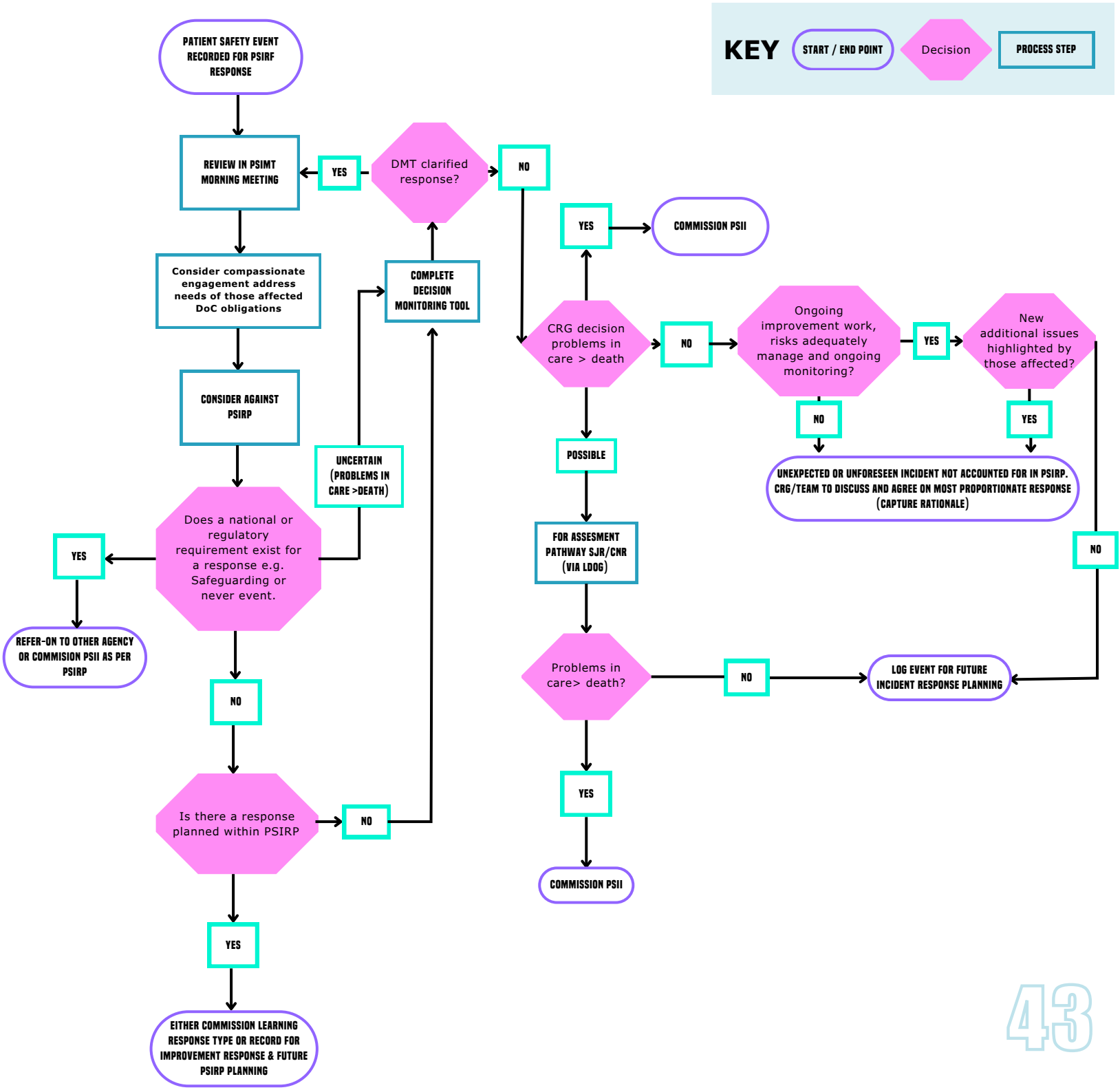
Engagement leads need to understand and seek information on the impact of how they choose response types on those affected by incidents and be aware of the risk of introducing inequity into the process of safety responses

APPENDIX A

STAKEHOLDER FORM			
DATE SENT TO STAKEHOLDER	31ST MAY 2023		
STAKEHOLDER TITLE	COMMENTS RECEIVED	RETURNED NO COMMENT	NOT RETURNED
Patient Safety Partner	☑	☐	☐
Director of Safety	☑	☐	☐
Director of Nursing/DIPC	☑	☐	☐
Leadership Team – Care Unit Leadership triumvirates	☑	☐	☐
Deputy Directors of Quality & Safety	☑	☐	☐
Learning from Deaths Oversight Group	☑	☐	☐
Clinical Review Group members	☑	☐	☐
Executive Team	☑	☐	☐
Integrated Care Board Leads	☑	☐	☐
Learning Oversight Sub-Committee members	☑	☐	☐
Clinical Governance & Quality Sub-Committee members	☑	☐	☐
Chief Pharmacist	☑	☐	☐
Equality and Diversity Manager	☐	☑	☐

APPENDIX B

Patient Safety Incident Response Plan Pathway



NHS
Essex Partnership University
NHS Foundation Trust