Bradford District Care
NHS Foundation Trust

Patient safety incident response plan 2024 - 2025

Effective date: 01 April 2024 (Official Launch of PSIRF following transition work 2023/24)

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Authoriser(s)	Trust Board		09/11/2023

Foreword

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as “a foundation for change” and as such, it challenges us to think and respond differently when a patient safety incident occurs.

PSIRF is very different to the way the NHS has approached patient safety in the past. It is also very exciting because, unlike previous frameworks, it is not a tweak or adaptation of what came before but a whole cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent recurrence.

Our challenge is to shift the focus away from investigating incidents because they meet specific criteria in a framework, and towards an emphasis on the outcomes of patient safety incident response that support learning and improvement to prevent recurrence.

With PSIRF, Bradford District Care NHS Foundation Trust (BDCFT, also referred to in the plan as ‘the Trust’) is responsible for the entire process, including what to investigate and how. There are no set timescales or external organisations to approve what we do. PSIRF gives us a set of principles that we will work to, and we welcome this opportunity to take accountability for the management of our learning responses to patient safety incidents with the aim of learning and improvement.

Investigating incidents to learn is not a new concept, however we acknowledge that in the past we have been distracted by the emphasis on identifying what happened and the production of a report, as that is how we have been measured and monitored, rather than on showing how we have made meaningful changes to what we do to keep patients safe.

We will engage with our patients, families and carers to ensure that their voice is central in all of our patient safety investigations. PSIRF sets out best principles for this engagement and our aim is to ensure this is embedded at all stages of our incident response processes.

Embracing a restorative and just culture underpins how we will approach our incident responses. We will foster a culture in which people are encouraged to highlight patient safety issues and incidents and feel safe and supported to do so. Through PSIRF, we will improve the working environment for staff in relation to their experiences of patient safety incidents and investigations. Our approach must acknowledge the importance of organisational culture and what it feels like to be involved in a patient safety incident to really support engagement in the best way to hear people’s voices and facilitate psychological wellbeing for those involved.

As we move forward into adopting this new way of managing our patient safety learning responses, we accept that we may not get it right at the beginning, but we will closely monitor the impact and effectiveness of our PSIRF implementation and respond and adapt our approaches as needed as we progress on this journey.

In this we are supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Most importantly, PSIRF offers us the opportunity to learn and improve to promote the safe, effective and compassionate care of our patients, their families and carers whilst protecting the wellbeing of our staff.

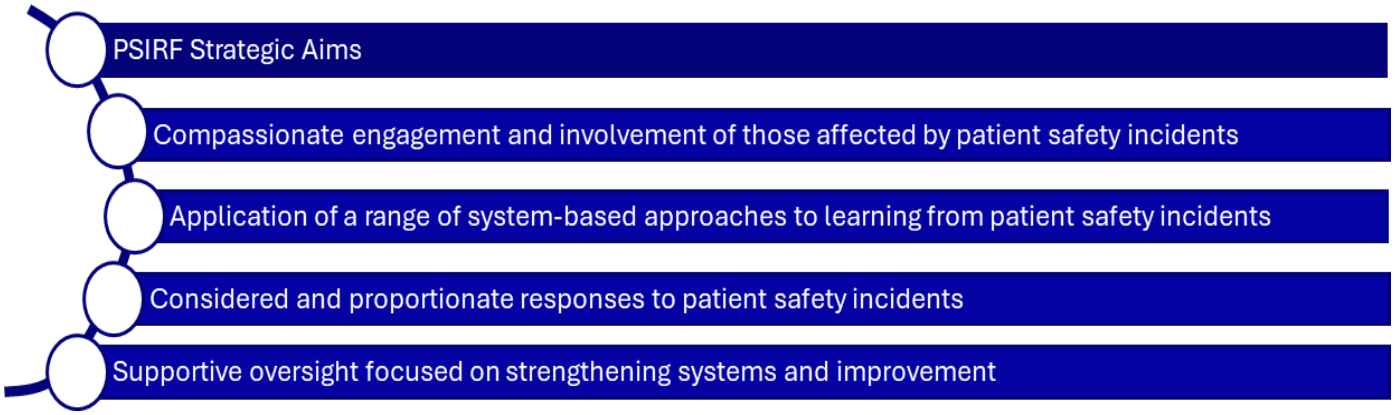
We welcome the implementation of PSIRF and are ready for the challenges ahead.

Contents

1. Introduction

The Patient Safety Incident Response Framework (PSIRF)[1] sets out NHS England's approach to creating effective systems and processes for responding to patient safety incidents. It is best considered as a learning and improvement framework with the emphasis placed on the system and culture that support continuous improvement in patient safety through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer investigations but to do them better. This means people who have been trained taking the time to conduct systems-based investigations. This plan and associated policy and guidelines will describe how it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation, with the aims of PSIRF being to deliver a proportionate and compassionate response to incidents.



This patient safety incident response plan sets out how Bradford District Care NHS Foundation Trust (BDCFT, also referred to in the plan as 'the Trust') intends to respond to patient safety incidents for the purpose of learning and improving the care . The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected. We will ensure resources allocated to learning are balanced with those needed to deliver improvement.

The plan is underpinned by our existing Trust Incident Reporting and Management Policy, and the new Trust Patient Safety Incident Response policy (replacing the Serious Incident policy).

A glossary of terms used can be found at Appendix A

[1] PSIRF NHS England https://www.england.nhs.uk/patient-safety/incident-response-framework/

2. Scope

The purpose of the Patient Safety Incident Response Plan (PSIRP) is:

- To describe how we have developed our patient safety profile
- To describe how we will respond to patient safety incidents for the purpose of learning and improvement.

This plan sets out how the Trust will now respond to patient safety incidents.

This plan will be reviewed and updated on an annual basis with a full review at Year 4.

The annual review will incorporate any new learning, any changes to the organisational risk profile and include a review of linked improvement initiatives.

At Year 4, we will conduct a full review of progress. We anticipate PSIRF will become part of the Trust's wider processes and systems to demonstrate learning, improvement and assurance. This is in order to support the Trusts vision "To connect people to the best quality care, where and when they need it, and be a national role model as an employer".

This plan covers responses to patient safety incidents for the purpose of system learning and improvement. This plan does not cover the responses needed for the following processes:

- Professional conduct/competence
- Litigation
- Coronial inquests
- Criminal investigations
- Complaints
  (with the exception of when a Patient Safety Incident is also the subject of a complaint, where possible the terms of reference for investigation will be joint)

3. Our Services

Bradford District Care NHS Foundation Trust (the Trust) is an NHS provider of mental health, community health - including specialist dental services - and specialist learning disability services. We provide 54 different services across approximately 100 sites, including two mental health hospitals, for people of all ages across Bradford, Airedale, Wharfedale and Craven.

Bradford District and Craven stretches from Bradford city centre, past Keighley in the Aire Valley, through the large market towns of Ilkley and Skipton, to Ingleton in the Craven basin. Our community has a population of over 647,000 people in a mixed urban and rural area, covering 595 square miles.

The population we serve is one of the most multicultural in Britain with over 100 languages. Some areas of Bradford are amongst the most deprived in the country, reflected in higher-than-average demand for health services and reduced life expectancy.

Mental Health services include:

The trust has 208 inpatient beds delivering care for those in acute mental health crisis and recovery (adults and older adults) and Assessment & Treatment for those with a learning disability. They are based across two sites; Lynfield Mount Hospital and the Airedale Centre for Mental Health. We also provide low secure services and a Dementia Assessment Unit at the Lynfield Mount site.

Community Mental Health Teams (CMHT) provide specialist support for people with complex and enduring mental health problems in the community, and an acute community service providing urgent mental health crisis support 24 hours a day, seven days a week to vulnerable people in crisis, intensive home support and a liaison psychiatry service.

Our dedicated Child and Adolescent Mental Health service (CAMHS) team supports children and young people in the local area where there are severe and long-standing concerns about emotional well-being and behaviours.

Our learning disability services provide a range of health support for adults with learning disabilities who can't access mainstream services from our Waddiloves Health Centre, and we also have an older people's mental health service providing specialist support, including assessment and treatment of Dementia.

Community Health services include:

The Trust provides a range of community health services for patients at every stage of their lives. Our Children's services provide streamlined support for children from 0-19 years. The Health visiting team supports families and new-born babies with child health and development, and a school nursing team supports health needs in children and young people through the education system education.

The Community Children's Health Services also includes Special Needs School Nursing and a Vaccination and Immunisation Service, and we also provide a Children in Care service, a Youth Justice team and a dedicated safeguarding team.

Our Community Health services are divided into different portfolios; Anticipatory, Planned and Unplanned Care, and cover a wide range of services including Falls, Primary care wellbeing, Proactive Care, Multi Agency Integrated Discharge, Self-Management, Pharmacy, Homeless and New Arrivals Teams.

Our district nursing team has over 330,000 face-to-face contacts with patients each year. This includes helping patients to manage their long-term health conditions, support with stroke rehabilitation and providing wound care management. We also provide specialised palliative care for people nearing the end of their lives, continence care, podiatry and speech and language therapy, and specialised dental health services.

Most of the care we provide takes place in people's own homes, however we also support patients at local health centres, GP practices, care homes, community venues and schools.

Our Strategic Priorities:

Best place to work

We will continue to strive to be a smarter working organisation where we work together so that everyone is proud to work here, feels that they belong and are valued.

Deliver best quality services

We will consistently deliver good quality, safe and effective services, making every contact count and meeting the needs of our communities, with a focus on reducing health inequalities.

Making best use of resources

We will deliver effective and sustainable services, considering the environmental impact and social value of everything we do.

Be the best partner

We will be at the forefront of the integration, improvement and innovation, working with partners to deliver services that enable our population to live happier, healthy lives.

4. Defining our patient safety incident profile

The Trust has a continuous commitment to learning from patient safety incidents and we have developed our understanding and insights into patient safety matters over a period of years. We have a regular Patient Safety and Learning Group and Director led review groups for deaths and patient safety incidents causing harm, all of which have oversight of the Trust's patient safety improvement and activity. In addition, the Care Groups (Mental Health and Physical Health directorates) have oversight of their own safety activity and management of quality and safety improvement plans.

PSIRF sets no rules or thresholds to determine what types of patient safety incidents need to generate the learning to inform improvement apart from the national requirements listed on p10-11 below. To fully implement the Framework the Trust has completed a review of all our sources that provide insight into patient safety to understand where we can gain the most meaningful learning for improvement.

The Trust's PSIRF Implementation Group has engaged with key stakeholders, both internal and external and undertaken a review of data from various sources to arrive at a safety profile. This process has also involved identification and specification of the methods used to maximise learning and improvement. This has led to the development of the local focus for our incident responses listed on p12-15.

4.1 Stakeholder engagement

The Patient Safety team commenced planning for PSIRF in advance of the release of documents in August 2022. We have consulted with PSIRF early adopters, the NHS England Regional team and our commissioners and provider partners to enable us to understand the practicalities of planning for and the implementation of PSIRF.

We are conscious that PSIRF requires a very different approach to the oversight of patient safety incidents. Our discussions and involvement are aligned with our provider partners across Bradford and the Bradford District and Craven Health and Care Partnership (BDCHCP) established in April 2022. Prior to this we had commenced some early engagement and development work in response to the changing nature of responsibilities within PSIRF and the need to work collaboratively on this.

Internally, a paper outlining the major significant differences between PSIRF and the SI Framework was delivered to the Trust Board in September 2021 and subsequent brief updates have been supplied on a monthly basis. A further presentation of the changes has been delivered to Board with the draft PSIRP in September 2023 and also to the Patient Safety and Learning Group, operational services Quality and Operations (QuOps) governance meetings, Professional Boards and through service team meetings where appropriate.

An initial series of engagement meetings were held from May 2023 onwards with key stakeholders from various disciplines to outline the impact PSIRF might have and to explore the nature of incidents reported, what processes are in place to currently manage and review these and what such reviews might look like under PSIRF.

Our data sources and how they were used to define our safety profile is detailed in section 4.2 below. Once the data was collated, we have carried out a series of workshops with our

key stakeholders to review this together to finalise our local risk profile and the focus and priorities for review by PSII.

We also carried out a series of engagement sessions with our clinical services to identify our approach to other patient safety incidents requiring a response.

4.2 Data Sources

To define our patient safety response profile, we drew organisational safety data from a variety of sources from financial years 2020/21, 2021/22 and the first 3 quarters of 2022/23 (April – December). We acknowledge that there may be some potential for variation in data arising from the Covid-19 pandemic during this time, however we have referenced that data analysis against previous safety data and believe this to be minimal. The generated profile has also been 'sense checked' with corporate and clinical services to identify any areas which may not be reflective of current intelligence and insight and post covid data is also included.

Data and information (both qualitative and quantitative) were received from the following sources and included in the analysis:

- Patient safety incidents
- Incident investigation reports
- Complaints
- Risk registers
- Mortality reviews
- Structured Judgment reviews
- Staff survey results
- Legal claims
- Freedom to Speak Up outcomes
- Local learning reviews
- Safeguarding reviews
- Patient experience feedback
- Regulatory Inspections
- Inquest outcomes
- Internal visit outcomes:
  (via the BDCFT 'Go See Framework):
  Quality visits / Patient safety visits
  QAF assessments / Executive visits

In addition, outcomes and learning from subject specific reviews or notifications of concern were also considered (i.e. Restrictive practice / No Force First framework).

Where possible we have considered what 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.

4.3 Outcomes of data analysis

From the incident data extraction, we identified 23 main broad incident categories. All 17,942 patient safety incidents reported within the timeframe considered fell into these broad categories, reflective of the large range of services the Trust provides, and the types of incidents reported. To note; we did not include any non-patient safety incidents in the data analysis.

These are shown in the table below:

Category	Descriptor
Access/Admission	All incidents relating to the stated stages in the patient journey from or between services (includes bed shortages, inappropriate placement, delays,
Accident/Injury (not slips, trips & falls)	Unintended events with potential for harm, or causing harm (includes collisions, bites, exposure to fire/chemical/ liquids, injuries from any causes not related to falls)
AWOL/Missing service	All incidents where a patient was expected to remain within an episode of care but left or

user	did not return from leave (detained and informal service users). Also may include missing community service users.
Clinical assessment (diagnosis, scans, tests)	Incidents related to delays, failures or errors in assessment, diagnosis or assessment interventions
Communication failure	All incidents where there has been a failure in communication affecting patient care or safety
Confidentiality/records	All incidents of information governance breach or record keeping affecting patient safety
Death – unexpected / unknown case	All deaths that were not expected due to clinical condition. Includes accident, overdose, homicide and witnessed or suspected suicide
Discharge / transfer	All incidents relating to the stated stages in the patient journey from or between services. Includes issues with missing or inappropriate information, medication, supplies
Environment	All incidents involving environmental matters or issues (inc. estates or facilities provision affecting patient safety)
Equipment / Device (medical)	All incidents with medical device equipment including failure or difficulties with supply, installation or use
Infection control	All incidents relating to infection prevention and control events or processes. Includes Covid-19, outbreaks, issues with PPE.
Medication incident / error	All incidents across the elements of the medication process including supply, prescribing, dispensing, administration, monitoring, storage.
Mental Health Act Section issue	All incidents relating to the application of sections of the Mental Health Act. Includes documentation, assessment, failure or delays in process.
Physical violence and aggression	All incidents where violence and aggression has been witnessed or experienced by patients. Includes disruptive behaviour, assault, aggression.
Pressure Ulcer	All incidents relating to pressure related skin and deep tissue damage, moisture associated skin damage.
Racial abuse	All incidents of racial abuse witnessed or experienced by service users.
Security	All incidents recording any breach or lapse in security arrangements and processes with potential or actual impact on patient safety.
Self-harming behaviour	All incidents where a patient has attempted to or succeeded in harming themselves. Includes talking of suicide.

These were the themes discussed in our engagement workshops, with further details on the subcategories within the themes considered to identify and refine our overall profile.

This led to the local focus priorities highlighted on p11-15 below and which will be our priorities for PSII review under PSIRF.

Whilst the final list has been agreed we are conscious that this list is not fixed thereafter. Within our resource analysis, we have also established capacity for additional ad-hoc PSII, where a new risk emerges, or learning and improvement can be gained from investigation of a particular incident or theme.

5. Policy Detail

This Patient Safety Incident Response Plan should be read in conjunction with the following BDCFT policy documents:

- Patient Safety Incident Response Policy
- Incident Reporting and Management Policy
- Learning from Deaths Policy
- Being Open and Duty of Candour Policy

And the following National Guidance documents:

- NHS England Patient Safety Incident Response Framework 2022
- NHS England NHS Patient Safety Strategy

6. Defining our patient safety improvement profile

Over a number of years, the Trust has been developing its governance processes to ensure it gains insight from patient safety incidents and this feeds into quality improvement activity.

We are committed to continuously review developments and 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 we need to undertake.

The Quality and Safety Committee (QSC) seeks to obtain evidence of assurance on the effectiveness of the Trust's quality and safety systems and processes, and the quality and safety of the services provided. The QSC responsibilities include reviewing the adequacy of systems and processes to ensure monitoring and assessment of the quality and improvements in services.

The tactical Patient Safety and Learning Group (PSLG) receives actions and reports into the QSC and is responsible for the triangulation of data and intelligence from a number of sources to enable it to confidently identify key areas of risk to patient safety and the quality of service delivery across the organisation. The PSLG ensures that opportunities for learning are appropriately identified, disseminated, and utilised to mitigate current issues or future risks.

In addition, the group oversees trust-wide quality plans, with specific accountability for the oversight of CQC, Quality Assurance Framework and Clinical Audit action plans, and will commission reviews into specific areas of concern as required to ensure an in depth understanding of systemic contributory factors to patient safety risks or issues. The PSLG will also commission actions to mitigate issues where these are not already addressed in service quality improvement plans, identify items for urgent dissemination and action to mitigate potential patient safety or significant quality issues and lead in developing and overseeing the Trust-wide learning approach.

Our clinical and corporate directorates are required to report to the PSLG in order to monitor and measure safety improvement activity across the organisation as defined in our patient safety strategy and provide assurance during the development of new safety improvement

plans following reviews undertaken within PSIRF to ensure these are sufficient to allow the Trust to improve patient safety in future.

The Medicines Management group will retain oversight and accountability for the oversight of safety incidents in relation to medicines management, and commission reviews and improvement activity which will be shared and aligned with any relevant PSLG activity.

We plan to focus our efforts going forward on development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally. We will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

7. Our patient safety incident response plan: national requirements

Given that the Trust has finite resources for patient safety incident response, we intend to use those resources to maximise 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 require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, 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 within a just and restorative culture.

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

From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 3 - 10 PSII reviews where national requirements have been met per annum.

National Requirements		
Priority Case Type:	**Planned Response**	**Anticipated Improvement route**
Maternity and neonatal incidents meeting HSIB and Special Healthcare Authority referral criteria	Work with partners to ensure cases are referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency/organisation as required and feed actions into quality improvement plans with oversight of action progress through Patient Safety and Learning Group and QSC.
Child death	Refer for Child Death Overview Panel (CDOP) and liaise with panel as locally led PSII may be required	
Death of a person who has lived with a Learning Disability or autism	Refer for Learning Disabilities Mortality Review (LeDeR) liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required	
	Local Learning review by LD Team (see section 6)	
Safeguarding incidents in which: Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect	Refer to local authority safeguarding lead via BDCFT named safeguarding lead	

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.	BDCFT will contribute to 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 the local safeguarding adults boards	
Domestic homicide	Identified by the police usually in partnership with the local community safety partnership (CSP) with whom the overall responsibility lies for establishing review of the case. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met and establishment of a DHR panel, BDCFT will contribute as required by the DHR panel.	
Incidents in screening programmes	Work with partners to ensure cases are referred to Public Health England (PHE)	
Death of patients in custody/prison/probation	Refer to Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC)	
Mental health-related homicides	Refer to the NHS England Regional Independent Investigation Team for consideration for an independent PSII in addition to locally led AAR/PSII where appropriate for early learning	
Patient Safety incidents meeting the Never Event criteria 2018 or its replacement	Patient Safety Incident Investigation Detail included in Trust priorities – see section 6	
Deaths of patients detained under the MHA (1983) or where the MCA (2005) applies, where there is reason to think that the death may be linked to problems in care[2]		
Patient Safety incidents resulting in death where the death is thought more likely than not to be due to problems in care		

[2] 'Problems in care' refers to any event that could be directly linked to the care and treatment a service user was receiving from BDCFT. This will be identified on an initial review/ screen of the incident or by other response methodology and/or further information gathering. The indication for a full PSII will be assessed by the Patient Safety Executive Panel.

8. Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety insights, based on the review of patient safety data and intelligence, and exploration within engagement meetings and workshops we have determined 7 patient safety priorities for the Trust's PSII local focus (see section 8.1).

We have selected this number due to the breadth of services that the Trust provides. We will undertake a minimum of 3 index case PSII in each of the types of incidents proposed.

This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

We will use the outcomes of PSII to inform our patient safety improvement planning and work.

For categories identified within our Trust risk profile but not meeting the PSII criteria, we have planned a regular thematic analysis approach (see section 8.2) to identify learning.

In addition, for other incidents not meeting the PSII or thematic analysis criteria, we will use a specific patient safety review approach to enable a learning response (see section 8.3).

For all incidents, there will continue to be a local level review by operational managers within the service/department of the incident occurring as outlined in our incident reporting policy. Monitoring will continue through safety huddles, daily lean management structures and quality meetings to determine emerging risks/issues and implement escalation in line with current processes.

Local incident management reviews and specific patient safety reviews will feed into the programme of thematic analysis where appropriate. All reviews will be subject to existing Trust assurance processes which may lead to new or supplement existing improvement work. The Trust acknowledges the initial local response plan will be continually reviewed and priorities may be changed in response to emerging conditions and intelligence.

This was agreed by the Executive Management Team (EMT), reviewed by the Quality and Safety Committee and has been verified by the Trust Board.

8.1 Patient Safety Incident Investigation (PSII)

	Trust Local Priority Requirements					
	Priority Case Type:	**Criteria**	**Planned Response**	**Number of responses**	**Lead role**	**Anticipated Improvement route**
1	**Unexpected Death (MH inpatients)**	**All inpatients** (informal, detained under the MHA (1983) and where the MCA (2005) applies) *and* All service users **currently active within IHTT** *when* there is reason to think that the **death may be linked to problems** in care[3]	**PSII**	**ALL cases**	**Patient Safety Team Investigators**	PSII will generate service and organisational recommendations. PSII approval at Patient Safety Executive Panel (PSEP). Service/corporate management response plan will identify actions required to address recommendations. Response plan and actions will be received by QUOPs for implementation and monitoring Progress reports to Patient Safety and Learning group for oversight. Feeds into Quality Improvement Plans and QSC.
2	**Unexpected death due to Suspected Suicide**	**Suspected suicide** where Service User is on an **active caseload** with secondary mental health services[4] or within 1 week of discharge	**PSII**	**3 index cases from each service**	**Patient Safety Team Investigators**	
3	**Self Harm (MH inpatients)**	**Overdose** of substances causing **major/catastrophic harm** during **admission**, on **return from leave or AWOL** *or* within **one week of discharge**	**PSII**	**3 index cases from each inpatient site**	**Patient Safety Team Investigators**	
		Suicide attempt causing **major/catastrophic harm** whilst **on ward** *or* on **leave** *or* **AWOL**	**PSII**	**3 index cases from each inpatient site**	**Patient Safety Team Investigators**	
4	**Self Harm (MH community)**	**Suicide attempt** causing **major/catastrophic harm** within **one week of discharge**	**PSII**	**3 index cases**	**Patient Safety Team Investigators**	
5	**Pressure Ulcer**	**Category 4** Pressure Ulcer **acquired** *or* **deteriorated** due to **identified omission** in care	**PSII**	**ALL cases**	**Patient Safety Team Investigators**	In addition to above: Response plan and actions will be received by the Pressure Ulcer Steering Group for implementation and monitoring of improvement
6	**Violence & Aggression**	All incidents of **violence from SU** to others in **inpatient** settings causing **major or above harm**	**PSII**	**ALL cases**	**Patient Safety Team Investigators**	In addition to above: Response plan and actions will be received by the Positive & Proactive Group for implementation and monitoring of improvement
7	**Exceptional patient safety event**	Any unexpected patient safety incident, group of incidents, or identified emerging risk that doesn't fit within the scope of other priorities but has the potential to generate extensive new learning.	**PSII**	**ALL cases**	**Patient Safety Team Investigators**	Individually determined through PSEP

Consideration for selection of incidents for PSII:

The local plan identifies the number of cases for PSII, however discussion will also be held where appropriate at PSEP to ensure resource is utilised for incidents that:

- will generate the greatest learning and opportunity for influence on wider systems improvement
- are likely to recur and have a great potential for harm to people, service quality, public confidence

Other response approaches will be used to gain insight and learning from incidents not requiring a PSII as identified in sections 8.2 and 8.3.

[3] See footnote 1, page 11

[4] Secondary Mental Health services means: Community Mental Health Teams (CMHT), Early Intervention in Psychosis (EIP), Child and Adolescent Mental Health Services (CAMHS), Integrated Outreach Team (IOT)

8.2 Planned Thematic Analysis

	Priority Case Type:	Criteria	Planned Response	Number of responses	Lead role	Anticipated Improvement route
Thematic Analysis	**Medication errors**	Quarterly review of all medicines safety incident themes	**Thematic analysis** **Quarterly**	**All cases reviewed by pharmacy**	**Medicines Safety Officer**	Reports into Clinical Board and Patient Safety and Learning Group Feed into medicines management improvement plan
	Unexpected death (Suspected Suicide)	Suspected suicide where Service User has had contact/assessment with crisis Services (First Response, Acute Liaison Psychiatry) within 1 month of death but is not under secondary MH care	**Thematic analysis every 6 months**	**Random selection of 33% of cases** (minimum 3)	**Patient Safety Team Investigators**	Thematic analysis recommendations approved at PSEP. Service/corporate management response to address recommendations. Response plan and actions will be received by QUOPs for implementation and monitoring Progress reports to Patient Safety and Learning group and Suicide Prevention Group for oversight. Feeds into Quality Improvement Plans and QSC.
		Suspected suicide where Service User has been assessed by a community MH team within 1 month of death, where the assessment concluded no further intervention.	**Thematic analysis every 6 months**	**Random selection of 33% of cases** (minimum 3)	**Patient Safety Team Investigators**	
	Self Harm (MH inpatients)	Self-harm using sharps/ligatures causing moderate or above harm whilst on ward	**Thematic analysis every 6 months**	**Random selection of 33% of cases** (minimum 3)	**Patient Safety Team Investigators**	
		Self-harm using ingestion of substance/object causing moderate or above harm whilst on ward	**Thematic analysis every 6 months**	**Random selection of 33% of cases** (minimum 3)	**Patient Safety Team Investigators**	
	Discharge / transfer	Incidents causing low/mod harm due to poor discharge information from BDCFT to other providers or between BDCFT services	**Thematic analysis every 6 months**	**Random selection of 33% of cases**	**Heads of Nursing**	Recommendations to report into Place transfer of care group(s) and QuOps
	Violence and aggression	Incidents of V&A reported between service users in inpatient settings by subcategory (e.g. racial abuse, physical assault)	**Quarterly thematic analysis**	**Random selection of 33% of cases per subcategory**	**Head of Nursing (MH), Head of Psychological Therapies, Clinical Lead for MH**	Recommendations to report into Positive & Proactive steering group
	Pressure Ulcer	Category 2 and above pressure ulcers and/or moisture associated skin damage	**Monthly thematic analysis**	**All cases**	**Tissue Viability Team**	Response plan and actions will be received by the Pressure Ulcer Steering Group for implementation and monitoring of improvement
Structured Judgement Review	**Patient deaths**	**All deaths not within the remit for PSII which have identified any red flag on the initial mortality screening tool.** (as per 4.4.3 of Learning from Deaths Policy)	**Structured Judgement Review**	**All cases**	**Clinical Director for Patient Safety** (allocation and completion) **Mortality and Duty of Candour Improvement Facilitator** (Duty of Candour)	SJR will identify if problems in care exist and feed into PSEP for agreement of next steps in relation to learning and improvement action. Progress reports to Patient Safety and Learning group for oversight.
		All deaths not within the remit for PSII which have NOT identified any red flag on the initial mortality screening tool. (as per 4.4.3 of Learning from Deaths Policy)	**Structured Judgement Review**	**Random selection of 25% of cases**		
PIR	**Healthcare Associated Infections (HCAI)**	All Healthcare Associated Infections (HCAI) and Outbreaks	**Post Infection Review (AAR)**	**ALL individual HCAI and outbreaks**	**Infection Prevention Team**	IPC Committee for review / improvement action / sharing cross district Learning fed into Quality Assurance Framework and individual improvement stream.

8.3 Patient Safety Review approaches

	Priority Case Type:	Criteria	Planned Response	Number of responses	Lead role	Anticipated Improvement route
Local Learning Review	**LeDeR (national priority)**	Deaths of SU's identified with diagnosed learning disability	**Local Learning Review**	**All deaths**	**Community Matron Learning Disability**	LLR's approved at PSEP and learning fed into Place LeDeR programme
		Deaths of SU's identified with diagnosed autism	**Local Learning Review**	**All deaths**	**Clinical Lead/Patient Safety Lead**	
	Documentation/ Records	Incidents of inadequate or retrospective documentation in top 3 service areas highlighted in documentation audit	**Local Learning Review**	**33% sample from top 3 service areas identified in doc. audit**	**Quality Standards Lead**	Informed by clinical audit with outcomes feeding into PSLG for review and improvement plan commissioning / oversight
	Emerging risks	Incidents identified by PSEP as a potential emerging risk or potential significant learning opportunity	**Local Learning Review**	**ALL cases identified by PSEP**	**Patient Safety Lead / Quality Standards Lead / Clinical Leads (MH / PH)**	LLR's approved at PSEP
After Action Review	**Treatment/Standard of care**	Moderate or above harm, or reportable breach of legal requirement, caused directly by treatment/care provision, including use of the Mental Health Act	**AAR**	**ALL cases identified by PSEP**	**Patient Safety Team Investigators**	AAR will identify strengths and areas for improvement. Learning and actions will be fed into the relevant local improvement workstreams and fed up to the PSLG for consideration of wider sharing/action.
	Readmission not an IRE	Patients readmitted to an inpatient bed within a week of discharge (from BDCFT bed)	**AAR**	**ALL cases identified by HoN's**	**Quality Standards Lead / Clinical Leads (MH / PH)**	
		Patients readmitted to a community caseload within a week of discharge	**AAR**	**ALL cases identified by HoN's**	**Quality Standards Lead / Clinical Leads (MH / PH)**	
	Notable patient safety event	Any unexpected patient safety event causing, or with the potential to cause, harm that is outside the scope of other review methods and has the potential to generate new learning.	**AAR**	**ALL cases identified by PSEP**	**Patient Safety Team Investigators/ Patient Safety Lead / Clinical Leads (MH / PH)**	
	Confirmation of PSII	Any incident which may be subject to a PSII but requires exploration prior to decision making to establish if event is linked to care provision	**AAR**	**ALL cases of potential PSII**	**Patient Safety Team Investigators**	As per AAR or PSII routes above
	Pressure Ulcer	All reported pressure ulcers	**PU omissions Checklist (AAR)**	**All cases**	**Incident Managers / Team leaders**	Outcomes fed into TVN thematic review Individual cases identified for full review by TVN

Additional patient safety review approaches may also be employed on occasions where this is deemed through PSEP as appropriate, this may be a patient safety audit using clinical audit methodology to identify opportunities for standardising improvement, or variations on the After Action Review adapted to a specific need.

9 Appendix A: Glossary of terms

AAR – After action review
A structured facilitated method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning and identify the opportunities to improve and give individuals involved in the event an understanding of why the outcome differed from that expected, or worked well. AAR generates insight from the various perspectives of the multidisciplinary team.

Local Learning Review
A shortened investigative review of an incident or cluster of incidents to identify system issues and human factors affecting patient safety outcomes. A LLR generates recommendations for actions to improve patient safety.

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.
https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

PSII - Patient Safety Incident Investigation
PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

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 using a collaborative approach with the operational services, specialist risk and safety leads and supported by analysis of local data.

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.

10 Appendix B: Summary of Learning Response Approaches

Patient Safety Incident Investigation (PSII)

What is it?	Who is involved?	Who Leads it?	What is the output?
An in-depth review of a single patient safety incident, or cluster of events. The key objective is to identify underlying system factors that contributed to an incident, and identify areas for effective, sustainable improvement.	People directly involved in the incident, including clinicians, service users and/or family/carers. Senior clinicians and staff support as required. Subject matter advisors, Non executive Directors as required. External organisations if a joint review is being conducted and/or other service providers	Patient Safety Investigator trained in a Systems approach to learning from patient safety incidents methodology (e.g. SEIPS) as defined by the NHSE PSIRF standards.	Immediate safety actions if a PSII reveals significant safety risks. Identified learning (in a report format) with recommendations for system improvement.

After Action Review (AAR)

What is it?	Who is involved?	Who Leads it?	What is the output?
A structured facilitated discussion of an event when outcomes have been successful or unsuccessful. Aims to capture learning and identify the opportunities to improve and give individuals an understanding of why the outcome differed from that expected, or worked well.	People directly involved in the event, others connected to them, the service user or the patient pathway. May include senior clinicians and managers.	Anybody trained in AAR Facilitation e.g: Patient Safety Investigator / Patient Safety Lead / Quality Lead / Clinical Lead / Incident Manager / Team Leader / Medicines Safety Officer / Medical Devices Safety Officer	Immediate safety actions if significant safety risks identified. Identified learning (in an AAR template) with improvement recommendations and actions to address at local level and/or escalation route for Trust wide or system learning.

Thematic Review

What is it?	Who is involved?	Who Leads it?	What is the output?
A review of an agreed sample or cluster of incidents to identify common links, themes, or issues within a specific area of practice. It will seek to understand key barriers or facilitators to safety using reference cases.	Dependent of the subject of the review; subject matter advisors, senior clinicians or managers from the subject area or connected to the pathway under review.	Anybody trained in Thematic Analysis methodology e.g: Patient Safety Investigator / Patient Safety Lead / Heads of Nursing / Heads of Service / Medicines Safety Officer / Medical Devices Safety Officer	A report outlining the key findings and relevant themes. Thematic review is a diagnostic tool and should therefore be closely linked with quality improvement. Recommendations for future QI work must form part of the report.

Structured Judgement Review

Local Learning Review