Leicestershire Partnership NHS Trust

Patient safety incident response plan (PSIRP)

2023-2024

Contents

Foreword

"The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them."
Aidan Fowler, National Director of Patient Safety, NHS England

Leicestershire Partnership Trust (LPT) have welcomed and embraced the theories and principles of the Patient Safety Strategy of which the Patient Safety Incident Response Framework (PSIRF) is one area. This is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves us doing the same thing but calling it something different. It is a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again. Our challenge is to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and towards an emphasis on the outcomes of patient safety incident learning responses that support learning and improvement to prevent recurrence.

Where previously we have had set timescales and shared with external organisations to approve what we do, PSIRF gives us a set of principles to which we will work. Although this could seem scary, we welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents, with the aim of learning and improvement. We know that we investigate incidents to learn, however we acknowledge that we have been distracted by the previous emphasis on the production of a report, as that is how we have been measured, rather than on showing how we have made meaningful changes to keep our patients safe.

We need to engage meaningfully with our patients, their families and carers and our staff, to ensure that their voice is heard in patient safety investigations. PSIRF sets out best principles for this engagement and our move to appointing patient safety partners will ensure that the patient voice is involved at all stages of our patient safety processes.

We will work towards a restorative and just culture to underpin how we approach our incident responses and continue to foster a culture in which people feel invited and supported to highlight incidents, knowing there is psychological safety. PSIRF asks that we have conversations where people have been affected by a patient safety incident, no matter how difficult and continue to equip, support and hear the voices of those involved. The process of reviewing an incident can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure, and these are part of our PSIRF core objectives.

As we move into adopting this new way of managing our patient safety learning reviews, we accept that we may not get it right at the beginning. However, we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to. This plan sets out a high level series of principles we will work to using a Quality Improvement approach.

In this, we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Most importantly though, PSIRF offers us opportunities to learn and improve to promote the safe, effective, and compassionate care of our patients, their families and carers while also protecting the well-being of our staff.

Dr Anne Scott
Executive Director of Nursing/AHP's & Quality

Dr Saquib Muhammad
Acting Medical Director

Introduction to the Patient Safety Incident Response Plan

The NHS Patient Safety Strategy was published in 2019 and describes the PSIRF, a replacement for the NHS Serious Incident (SI) Framework. This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have done at LPT to prepare for “go live” with PSIRF, and what comes next.

The NHS Serious Incident Framework: Supporting learning to prevent recurrence (2015) provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF 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.

PSIRF removes the requirement that all/only incidents meeting the criteria of a ‘serious incident’ are investigated. This enables resources to be focused more effectively on the identified areas with the greatest potential for patient safety improvement; and enable responses to look at incidents that would not have met the SI criteria, but where important learning can still be gained.

One of the underpinning principles of PSIRF is to do fewer “investigations” and to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This plan and associated policies and guidelines will describe how it will work. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for an NHS provider healthcare organisation.

Carrying out investigations for the right reasons can and does identify learning. Removal of the SI process does not mean “do nothing” it means respond in the right way depending on the type of incidents and associated factors.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, but simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from the other patient safety insights.

PSIRF recognises the need to ensure we have support structures for staff, patients and families/carers involved in patient safety incidents. Part of which is the fostering of a psychologically safe culture shown in our leaders, Trust-wide strategy, and reporting systems.

We have developed our understanding and insights over the past year, including regular discussions and engagement through our committees and groups. Most recently in June 2023, we held a PSIRP Planning Day which was attended by staff representatives from across the Trust, patient partners, commissioners (Integrated Care Board or ICB), Provider Collaboratives (PCs) and Public Health Local Authority (PHLA) as well as members of our Trust Board and executives. The Trust's directorates presented a review of their patient safety information and identified patient safety priorities following analysis and synthesis of the data. These priorities were triangulated and challenged where appropriate and have informed our Trust's local patient safety priorities for PSIRF.

This plan provides the headlines and description of how PSIRF will be applied at LPT and sets out how we intend 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: we will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred, significant opportunities for learning and the needs of those affected. This is a key feature of our approach to continuous learning and allows us to use a Quality Improvement (QI) approach to both the plan and our learning responses.

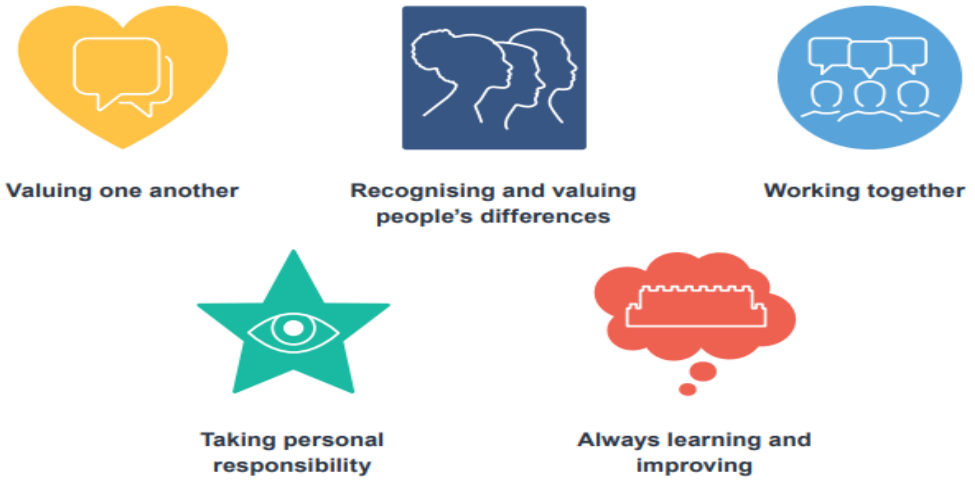
The scope of the PSIRP and our vision

It is recognised that there are many ways to respond to an incident. This plan covers responses conducted solely for the purpose of systems-based learning and improvement from patient safety incidents. There is no remit within this Plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, human resource matters, legal claims and coroner inquests.

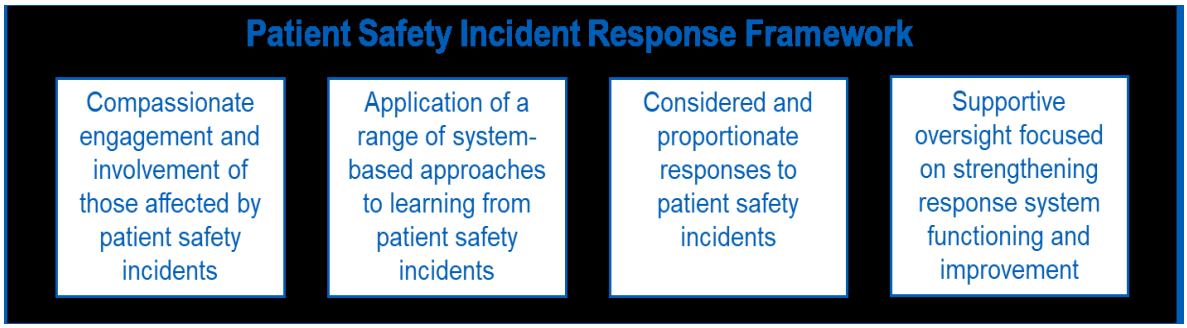
We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of this is explained later within this document.

The implementation of PSIRF will see our Trust vision of "**Creating high quality, compassionate care and wellbeing for all"** embodied in our work.

LPT Values



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



Overview of Leicestershire Partnership NHS Trust services

LPT is the only NHS mental health trust provider in Leicestershire. Our commitment is that each patient is treated with respect and dignity and, most importantly of all, as a unique person. LPT is a complex system with many areas supporting each other. We have reviewed all patient safety activities and our network of key stakeholders across LPT who are integral to the Patient Safety agenda.

About us and the community we serve

In April 2011, mental health and learning disability services in Leicester, Leicestershire and Rutland were brought together with local community services and families, children and young people's services to create Leicestershire Partnership NHS Trust as we know it today.

We provide community health and mental health support to over one million people living in Leicester, Leicestershire and Rutland. Our services touch the lives of all ages (from health visiting to end of life care), from head to foot (from mental health to podiatry) and everything in between. We have over 7,000 staff (including bank staff) who provide this care through three clinical directorates:

- Mental health services
- Families, young people and children's services and learning disabilities and autism services
- Community health services.

Their work would not be possible without our enabling and corporate services staff, alongside our hosted service providers and around 300 volunteers.

During 2022/23 we provided and/or subcontracted 129 relevant health services. Mental health and learning disabilities account for 72 services, and 57 were community health services.

LPT also hosted the LLR staff mental health and wellbeing hub on behalf of the system up to 31 March 2023, at which point the funding was discontinued.

Our population

Our Trust provides a range of community and mental health services from many different locations across the Leicester, Leicestershire and Rutland (LLR) region, including hospitals, longer term recovery units, community and outpatient clinics, day services, GP surgeries, community centres, schools, health centres, people's own homes, and care homes.

A small number of specialist services are also provided to service users from wider geographical areas, primarily areas of the East Midlands adjacent to Leicestershire. This includes our Adult Eating Disorders service, male Low Secure forensic mental health care and Huntington's Disease Services. The population of LLR is currently estimated at 1.1million and is expected to grow in the coming years. Just under two thirds of the population live in Leicestershire, just under one-third in Leicester city and approximately four per cent in Rutland. With a population of this scale, our Trust serves more people than the average community and NHS mental health trust.

Situational Analysis of Patient Safety Activity

In the last three years, more than 38,800 patient safety incidents have been reported in LPT with <1.4% of these being investigated as a 'Serious Incident' as per the current Serious Incident Framework (2015).

A significant portion of the work of directorate staff has been carrying out SI investigations. These can be a very time-consuming process impacted by the NHS's ongoing staffing challenges and has resulted in some delayed investigations over recent years.

Arguably, there is a disproportionate amount of time spent on carrying out serious incident investigations, significantly limiting time to learn thematically from the other 98.6% of patient safety incidents. In short, the burden of effort to support patient safety improvement is placed on fewer than 1.4% of all patient safety incidents.

A significant risk to successfully implementing PSIRF is continuing to investigate as many things as within the current SI Framework (2015) and calling them something else. A key part of developing the new national approach is to understand the amount of patient safety activity the Trust has undertaken over the last few years. This enables us to plan appropriately and ensure that we have the people, system and processes to support the new approach.

The PSIRF related activity undertaken at LPT prior to PSIRF can be broken down as follows:

Patient Safety Activities	Activity	Definition	Average of 2020/21 and 2021/22	1 April 2022-31 March 2023
National Priority	Incident resulting in death	Serious Incident (SI) resulting in patient's death, reported to STEIS and requiring investigation within the standard investigation	129	27
National Priority	Never Events	Incident meeting criteria for never events framework, reported and investigated to STEIS as a SI	0	0
Local Patient Safety Activity	Serious Incident Requiring Investigation (SIRI)	Serious incident requiring investigation (SIRI) which met the standard investigation time limit.	301	77
Local Patient Safety Activity	Patient Safety Incident reviews	Including moderate harm incidents meeting the requirement for Statutory Duty of candour, not meeting SIRI criteria	435	319
Local Patient Safety Activity	Patient Safety Incident Validation	Patient safety incidents of low/no harm requiring validation at department/ward level.	23635	13898

Defining our patient safety incident profile

The Trust has a commitment to continuously learn from patient safety incidents and has developed understanding and insights into patient safety activity over a period of years. We have committed to the recruitment of corporate patient safety investigators to ensure we have the resource, skill and expertise to undertake system reviews using investigation science. We have links from each of our directorates into the Trust's Patient Safety Improvement Group (PSIG), where learning is shared and oversight and support is provided to their subgroups who are undertaking improvement work. This improvement work is designed based on national NHS and regulatory requirement or local learning. This learning activity was considered as part of our plan.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement, apart from the national requirements listed on p13 below.

To fully implement PSIRF and to understand what needs to be learned from in order to improve, the Trust has completed a review and triangulation of:

- What types of patient safety incidents occur
- Themes from complaints
- Themes from claims
- Patient and staff feedback
- Identified risk and audit results.

The Corporate Patient Safety Team (CPST) has engaged with key internal and external stakeholders, and directorates have undertaken a review of data from a variety of sources, to arrive at a safety profile. This process involved:

- Identification of what is working well.
- Where there is good progress with and improvements from quality improvement (QI). projects, as well as where QI projects have stalled or not produced effective improvement.
- Where there are gaps in our understanding of why improvements in certain areas are not happening was also important for us to know.

This has led to the development of the local focus for our incident responses described on p19.

Stakeholder engagement

The CPST commenced planning for PSIRF in advance of the release of NHSE supporting documents in August 2022. We have consulted with and learnt from PSIRF early adopters to enable us to understand the practicalities of planning for and implementation of PSIRF, and their assistance has been invaluable.

PSIRF requires a very different approach to the oversight of patient safety incidents, and we have worked closely with our lead (ICB) commissioners currently responsible for the majority oversight of our application of the current SI Framework. We are a core member of their system Patient Safety Network and PSIRF Operational Group.

Additionally, we have engaged with all our other commissioners who oversee care delivery and management of incidents within some of our services, as well as the Coroner to explore and agree how PSIRF will affect reporting and management for them.

A PSIRF Project Group was set up to progress preparations for implementation of PSIRF at LPT and met monthly. Core members were from the following teams: patient safety, directorate clinical and quality governance, QI, communications and senior nursing representation. The group has also worked closely with the Human Resources, Organisational Development and Communications teams in relation to a project “Our Future Our Way” (OFOW), working with over 80 change leaders who are supporting the Trust on its culture change journey. It is with this group we will work to support the culture change required to be successful as a trust with PSIRF.

Internally, presentations were made to our Board development day, directorate management team meetings, change leaders forums and other corporate team meetings.

The group made an early decision that to identify our safety profile, each directorate would collate and review their patient safety data from several sources, followed by analysis and synthesis within their teams, to identify local priority areas and present their conclusions to a diverse audience of stakeholders at the Trust-wide PSIRP Planning day.

The process of preparing for the planning day has been a part of our continuing 'culture change' journey. Our change leader programme has patient safety, patient experience and quality improvement at its heart and ensures a shared understanding and appreciation for the role these play in our efforts to step up to great.

Compassionate engagement and involvement of those involved in patient safety incidents (patients, carers, families, and staff) is a key aim of PSIRF. Patients and carer representatives, staff from across the Trust including bank staff, have been engaged and collaborated at the planning day. Our patient experience team are actively supporting this work and supported the recruitment of patient involvement partners to offer challenge where required and add the patient voice to the conversation to agree the Trust's local priorities for the PSIRP.

The PSIRP Planning day took place on 19th June 2023, with attendees including patient/ carer partners, staff from each directorate, bank staff, representatives from corporate teams such as legal, human resources, health and safety, programme management office, pharmacy, patient safety, patient experience, executives, non-executives, communications, organisational development and commissioners.

Our data sources and how they were used to define our safety profile is detailed below.

Data sources
To define our patient safety response profile, we drew data from a variety of sources including the Ulysses incident reporting system. Data was collated on the incidents that had taken place over the period of April 2022 to March 2023. We decided to look at this year to minimise the possibility of any variation in data arising from the Covid-19 pandemic impact.

We have also considered the feedback and information provided by internal stakeholders and subject matter experts as part of our data collation process. Data and information (both qualitative and quantitative) have therefore been received from the following sources:

- Patient safety incident investigation reports
- Complaints
- Freedom to Speak Up reports
- Safeguarding reviews
- Mortality reviews and Structured Judgement Reviews
- Staff survey results
- Claims
- Trust risk profile
- Anonymous CQC concerns
- Quality Improvement projects.

Safety issues and gaps highlighted by the data
Once the data was collated and reviewed, the directorate clinical and quality governance teams carried out a series of engagement with their staff and management teams, to confirm and agree the areas requiring further understanding to support improvement. These were then drilled down to four priorities from each directorate.

The PSIRP Planning day event was a collaborative approach to agreeing and finalising our local focus and priorities for review by patient safety incident investigations (PSII) based on in depth systems-based investigations.

Each directorate presented the process they had used for review and analysis of the data, a summary of the data reviewed and how they identified and prioritised the four priorities for review by PSII. Themes and subcategories were considered to agree the final profile. The audience were then asked to confirm if they were assured by the process and to say how they would order the priorities, to see if it matched the directorate's. The Slido polling platform was used at the event for audience engagement.

One of the aims of the day was to agree five local priorities for review by PSIIs. However, the conversations and some challenges from stakeholders means that six local focus priorities as detailed on page 19 were eventually identified for review by PSII.

Addressing health inequalities
As a large provider of mental health and community services, LPT has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system. For example, our education system; economic and community development in our most deprived neighbourhoods; employment levels; pay and conditions; and availability and quality of housing.

Through our implementation of PSIRF, we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to our Trust Board and partner agencies on how to tackle these. The more holistic, integrated approach to patient safety under PSIRF will require the Trust to be more collaborative with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda. Impact from health inequalities or equality, diversity issues have now been included in the standard terms of reference for all PSIIs.

Our engagement with patients, families and carers following a patient safety investigation, must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour/being open process.

We will therefore be able to better demonstrate how our priorities for the PSIRP reflect our local population's demographics and diversity (EDI) and link to addressing health inequalities for the next review of the PSIRP.

The question of how we will evaluate whether the priorities chosen for focus have resulted in improvements in patient safety and care, was also asked. Guidance within the national

patient safety strategy discourages aiming for “quick wins” as, invariably, they turn out not to address the factors within the system. Ongoing review of the data, trends and improvement work will take place regularly through oversight routes.

The process of preparing for the planning day has been a part of our culture change journey, as is the work of our change leaders, who have patient safety as integral to the work they are doing. The patient experience and the QI teams have also been key. This is a significant development from previous culture change work.

Whilst the final list of priorities has been agreed, this list is not fixed thereafter. Within our corporate patient safety team of investigators resource, we have also established capacity for a small number of additional ad-hoc PSIIs, where a new risk emerges or learning and improvement can be gained from investigation of a particular incident or theme; this may also include national patient safety steer.

Patient safety incidents not for PSII will be reviewed using other methodologies within PSIRF; these include initially:
Systems Engineering Initiative for Patient Safety (SEIPS)
After Action Reviews (AAR).

Other methodologies can be used where staff have the training and capability, for example:
SWARM
Multidisciplinary meetings (MDT)
Structured Judgement Reviews (SJR)
Thematic Reviews.

The CPST are supporting the upskilling of staff to use human factors approach and system thinking to consider and review all incidents. This will require a long-term approach to develop and build on these skills and competencies across the organisation.

Defining our patient safety improvement profile

Over several years, the Trust has developed its governance processes to gain insight from patient safety incidents and this has fed into QI activity. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.

There is QI work being undertaken across our quality governance groups with PSIG being a key group for the professional discussion/decision and oversight of progress of QI projects. These groups including PSIG report into the Trust level Quality Forum, which will continue to provide assurance that quality improvement measures including any safety improvement plans in use currently, or which require development and implementation in the future, continue to be timely and of high standard.

The Incident Oversight Group (IOG) will be responsible for oversight of the implementation of this plan and the PSIRF approach using a QI methodology to develop and refine the plan as we learn and move forward. This group will also provide assurance during the

development of new safety improvement plans following reviews undertaken within PSIRF, to ensure they have followed robust processes during development, fulfil SMART requirements and are sufficient to allow the Trust's continuous improvement and risk reduction/mitigation in future patient safety.

Our clinical directorates are required to report through our quality governance routes to monitor and measure improvement activity across the organisation.

Governance and oversight
Robust local governance routes have been clearly defined by our directorates which will then feed into the corporate oversight and assurance groups. These will include:

- Weekly clinical huddles to review reported incidents
- Clinical and quality governance team reviews
- Directorate sign off groups
- Directorate management team oversight
- Oversight at directorate management team quality and safety meetings.

Under PSIRF, our commissioners the ICB, Public Health Local Authority (PHLA) and Provider Collaboratives, will be invited to attend oversight meetings; this is a shift, as currently the majority is LPT services being requested to meet with them, often linking in with 'contract monitoring.'

Identification of incidents
Methodologies for identification of incidents have also been agreed and will be reviewed as we learn. The weekly, Trust-wide Incident Review Meeting (IRM) will provide support and advice for directorate teams and a record of discussion and decision making to support a response to those involved in patient safety incidents.

Current patient safety related improvement
We have robust management and oversight of QI activity within the Trust including Clinical Audit, Service Evaluation and PDSA improvement projects. Quality improvement methodology is fundamental to the delivery and continuous improvement of high quality care. Our QI approach empowers all staff to identify changes needed, develop the skills to make and lead the change. Additionally, we are able to use QI methodology when improvements are identified through our quality assurance and control processes. Working collaboratively as part of the Group model with Northamptonshire Healthcare Foundation Trust, three priority areas for patient safety have been identified for 2023/24. The priority areas are based upon patient safety/patient experience data and aligned to those areas that have or continue to be quality priorities in both organisations and provide the opportunity for collaborative working and improvement. The three priority areas are:

- Pressure ulcer prevention, care, and treatment
- Recognition and care of the deteriorating patient
- Mental health safe and therapeutic observations.

Further examples of QI projects supporting patient safety are included in Appendix B. Not all categories we have identified within our Trust incident profile have an impact on patient safety and therefore may not have an associated workstream noted.

During our development of this plan our directorates identified four areas each for consideration as the Trust's local priorities and for review using PSIIs. As previously described, six areas were chosen. The remaining six non-PSII priorities (detailed in appendix D), will be reviewed at directorate level by the clinical and governance teams, utilising other PSIRF methodologies. They will be developed into QI projects to initially scope the learning and identify improvement actions. These will be implemented over the next 12 months and overseen by the PSIG. The results will be considered in the next PSIRP review.

Our Patient Safety Priorities

Our patient safety incident response plan: national requirements

The Trust has finite resources for patient safety incident response and we intend to use those resources to maximise learning and improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care, will always require a PSII through which we can 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 and 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 as shown below.

For clarity, all types of incidents that have been nationally defined as requiring a 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, that we will complete approximately 10 PSII reviews where national requirements have been met per annum.

National event response requirements: additional to local priorities

Patient safety incident type	Required response	Anticipated improvement route
Patient safety incidents meeting the Never Events 2018 criteria or its replacement	PSII	Create local organisational actions and feed these into quality improvement
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 (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into quality improvement
Patient Safety incidents resulting in death where the death is thought more likely than not to be due to problems in care (including in patient suspected suicide)	PSII	Create local organisational actions and feed these into quality improvement
Section 42 and other mandated safeguarding enquiries	AAR or similar methodology	Create local organisational actions and feed these into quality improvement

Our patient safety incident response plan: local focus

The type of response to patient safety incidents will depend on:

- The views of those affected, including patients and their families
- Capacity available to undertake a learning response
- What is known about the factors that lead to the incident(s)
- If improvement work is underway to address the identified contributory factors
- If there is evidence that improvement work is having the intended effect/benefit
- If the Trust and its ICB are satisfied risks are being appropriately managed.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Pressure Ulcers (PU) (category 4)	Using SEIPS methodology	Create local safety actions and feed these into the quality improvement plan overseen by the trust PU group
Falls resulting in Harm (where there is opportunity for learning)	After Action Review (AAR) trialling the template from the National Falls audit	Create local safety actions and feed these into the quality improvement plan overseen by the trust Falls group
Infection Prevention and Control (IPC) incidents	Using SEIPs methodology	Inform ongoing improvement projects
Information Governance incidents	After Action Review (AAR)	Identify processes to strengthen improvement
Deteriorating patients	Structured Judgement Review (SJR) type screening and thematic analysis	Reviewed thorough Mortality and Morbidity meetings and learning enacted

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 incidents, engagement meetings and the planning day, we have determined that the Trust requires six patient safety priorities as local focus. We have selected this number based on the services that the Trust provides and outcome from the planning day with input from key stakeholders.

We will undertake five index case PSII in each of the types of incidents proposed (should they occur). 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 quality improvement planning and work.

This was agreed at Executive Management Board (EMB) on 1st August 2023.

Trust Local Priority	Directorate	Patient safety incident type	Planned response	Anticipated improvement route
1	FYPC/LDA	Omissions in care due to communication or information sharing across services where child/ren under 4 years and 10 months old who are open to Healthy Together and there is one or more known significant adult within child/ren's core network open to adult mental health services	PSII	Create local safety actions which will inform the trust quality improvement plan which will have executive oversight
2	FYPC/LDA	Significant incident occurring due to lack of care coordination where there are multiple services (including external partners) involved in a patients care	PSII	Create local safety actions which will inform the trust quality improvement plan which will have executive oversight
3	CHS	Patients who deteriorate within 7 days of transfer to a community hospital and require readmission to an acute bed	PSII	Create local safety actions which will inform the trust quality improvement plan which will have executive oversight
4	CHS	Patients who have been on a community caseload for more than 6 months where deterioration is not recognised and actively managed	PSII	Create local safety actions which will inform the trust quality improvement plan which will have executive oversight
5	DMH	Suicide of an individual where substance misuse is also a risk factor	PSII	Create local safety actions which will inform the trust quality improvement plan which will have executive oversight
6	DMH	Serious patient safety incident where patients are awaiting treatment from community mental health services.	PSII	Create local safety actions which will inform the trust quality improvement plan which will have executive oversight

Standard terms of reference have been agreed for all PSIIs. This will include the gaps that were identified during analysis of incidents for the planning day:

- To establish the impact of any workforce or skills deficit on the incident – this is not about apportioning blame but to review the impact of system issues on staff/staffing.
- To investigate if the patient was in the care of more than one LPT service and to identify any systemic issues or breakdowns in communication between the services.
- To consider if there was an impact on the care or patient experience from health inequalities or the patient's protected characteristics.
- To identify if any electronic system used, impacted on the patient's care and experience.

PSII is not the only tool we will use to respond to incidents. Our Responding to Incidents policy will describe other ways staff can respond to incidents. This will detail both how to respond to incidents thematically, but also how to respond to individual incidents. We have outlined several ways we can respond to individual incidents, including:

SEIPS model: System Engineering Initiative for Patient Safety - a human factors methodology
Safety Huddle: Triggered by an event to assess what can be learned
After Action Review (AAR): A structured facilitated debrief
Multi-disciplinary team (MDT) meetings: SJR (mortality/morbidity and learning from deaths)

Involvement of patients, families and carers following incidents

We recognise the significant impact patient safety incidents can have on patients, their families and carers. The statutory Duty of Candour process is still an obligation for the Trust, requiring a meaningful verbal and written apology for the harm resulting from a patient safety incident. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

As part of our new policy framework, we are developing a family liaison and engagement guide to support staff in engaging compassionately with patients and their families, during responses to incidents. We are also developing a process for gathering feedback proactively to allow us to change and develop our response as we learn.

Involvement and support for staff following incidents

We are on an ambitious journey at LPT to ensure it is a safe and fair place, where everyone's voice is invited, valued and listened to, helping us to continually learn, inspire change and improve.

When a colleague reports an incident or is providing their insights into the care of a patient for an investigation, we will actively encourage a safe space to discuss the events, explore the system in which they work and listen openly without judgement.

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. As part of our commitment to staff health and wellbeing, we have a suite of support for our staff which is always being reviewed and added to. Led by the Trust's lead psychologist, we are developing a debrief process to support staff in the immediate aftermath of an incident.

Teams are also implementing Schwartz rounds to allow a safe space for staff to come together to discuss how they are affected by the challenging nature of events in healthcare. This is a proven method of support used widely in healthcare across the world.

Further to this, the methodology for investigation has been developed to be very clearly focussed on learning and not in any way to apportion blame.

Roles and responsibilities in the new system

The Trust Executive Management Team oversees the delivery of clinical services, informed by the outcomes from review meetings between Clinical Directorates and the Executive Team.

The Quality and Safety Committee is chaired by a Non-Executive Director and this bimonthly meeting will receive the assurance of both the process of implementation, the undertaking of learning responses and the associated QI work.

Progress of PSII, risk and other types of patient safety reviews will be overseen by the IOG (Incident Oversight Group). Safety recommendations from PSIIs will be reviewed through PSIG in support of the six patient safety priority improvement programmes.

Appendix A

Glossary of terms

AAR - After Action Review
A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase the occasions where success occurs.

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

PSIRF - Patient Safety Incident Response Framework
This is a national framework applicable to all NHS organisations commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response Plan
Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the Directorates and specialist risk leads, supported by analysis of local data.

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 address those system factors and help deliver safer care for our patients effectively and sustainably.

Schwartz Rounds (NHS)
Schwartz Rounds are group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare.

SEIPS - System Engineering Imitative for Patient Safety
A framework for understanding outcomes within complex socio-technical systems.

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.

SMART
SMART criteria are used to guide how objectives or goals are set to make sure that they achieve what they intend to achieve. SMART is taken from the first letter of a set of 5 criteria or rules to help for the goal setting as follows:

S- Specific – a goal should not be too broad but target a specific area for improvement

M- Measurable – a goal should include some indicator of how progress can be shown to have been made

A- Achievable – a goal should be able to be achieved within the available resources including any potential development needed

R- Relevant – a goal should be relevant to the nature of the issue for improvement

T- Time-related – a goal should specify when a result should be achieved or targets might slip

SWARM
Used within Healthcare in the UK and US, a SWARM approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis and to support those immediately involved.

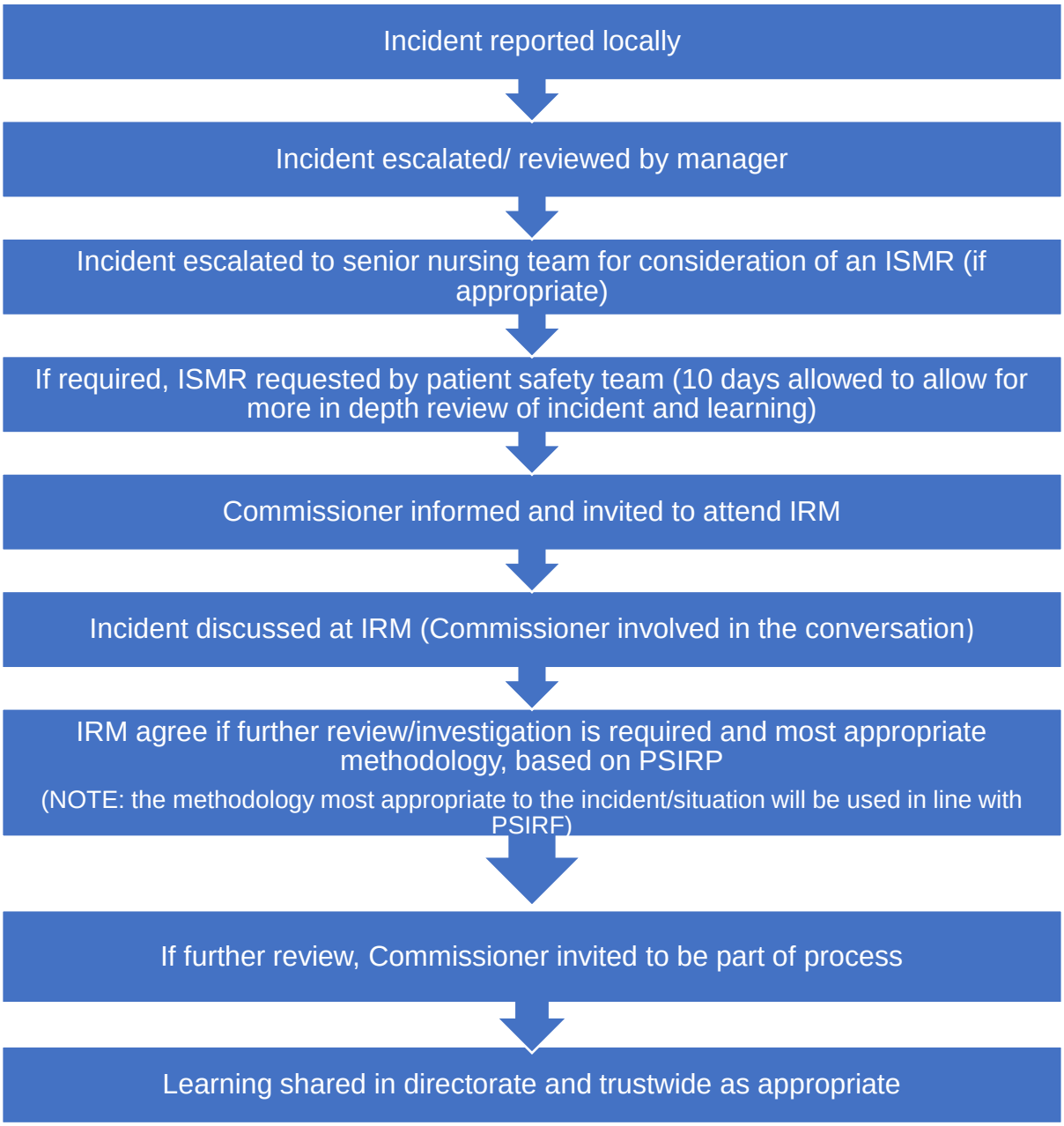
Appendix B

Improvement programmes

Checking and searching of patients in inpatient areas	PDSA
Reducing the dependency of therapeutic observations on MHSOP organic wards	PDSA
Charge Nurse's weekly Environmental Check	Monitoring audit
CHS community therapy clinical observations practice improvement.	PDSA
Improve the use of Sepsis tools and pathways on Community Hospital and Bradgate Mental Health Unit inpatient wards.	PDSA
Reducing the number of pressure ulcer incidents occurring in LPT care (CHS District Nursing)	PDSA
Reducing the number of category 2 pressure ulcers occurring in LPT care	PDSA
Introduction of Falls Huddles	PDSA
Improve identification and management of falls risks	PDSA
The impact of a medications alert tool on falls in a Mental Health for Older People inpatient setting	PDSA
Use of Flat Lifting equipment post fall	PDSA
Best Practice seating	PDSA

Appendix C

Process for local review of patient safety incidents



Appendix D

Non PSII priorities for review using other PSIRF methodologies

Directorate local priority	Non-PSII priorities
DMH	Where there is an incident of significant harm and there was evidence of poor multi-agency communication across directorates or within LPT or with gaining and sharing information with families.
	Patient safety incident where an inpatient come to significant harm whilst under therapeutic observations on the ward
CHS	Near misses and incidents where patients receive inappropriate care due to incorrect positive patient identification
	Patients who are in the care of more than one LPT service who deteriorate in our care
FYPC	Assaults on staff e.g. "Reportable incidents related to assaults on staff (verbal or physical) to ensure staff are supported and to enable the Trust to address issues related to reduced staff wellbeing"
	Record Keeping and Digital Competency e.g. "Serious omissions that occur directly related to documentation in the electronic patient record, including formatting, use of templates and staff competencies around use of electronic systems"