PATIENT SAFETY INCIDENT RESPONSE PLAN
(PSIRP)

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1.0	04-03-24	New document	Head of Governance & Quality
1.1	28-06-24	Updated to include Thames Valley and West Midlands Adults SARC locations. Removed West Midlands Police.	Head of Governance & Quality

INTRODUCTION

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF is not a different way of describing what came before – it fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate. Instead it:

- advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents
- embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This document is Mountain Healthcare's (MH) Patient Safety Incident Response Plan (PSIRP). This PSIRP sets out how MH intends to respond to patient safety incidents over a period of 12 to 18 months. The Plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

This Plan is underpinned by our policies and procedures on incident reporting and investigation available via The Peak (MH intranet) (available to staff only). It also incorporates our requirements under ISO15189:2022.

This Plan will provide further clarity for staff on the various incidents and appropriate templates for review or investigation to achieve the best systems and organisational learning. Additionally, the policy will enable the staffs' understanding on pathways for escalation safety action development plans and monitoring improvement.

Unlike previous frameworks, PSIRF is not an adaptation of what came before. PSIRF is a whole system change to how we think and respond when an incident happens to prevent recurrence. Previous frameworks have described when and how to investigate a serious incident, PSIRF focuses on learning and improvement. With PSIRF, we are responsible for the entire process, including what to investigate and how. There are no set timescales except for the completion of a Patient Serious Incident Investigation (PSII) or submitting reports for external agency to approval. There are a set of principles that MH will work within but outside of that, it is up to us in MH. This will require strong communication with our staff and stakeholders to ensure everyone is assured that MH has implemented PSIRF.

MH completed a soft launch of PSIRF in September 2022 to coincide with our new online incident reporting tool. This enabled us to introduce our staff to the new framework as part of our new reporting tool.

One of the underpinning principles of PSIRF is to do fewer 'investigations' and to do them better. Better means taking time to conduct systems-based investigations by people who have been trained to do them. Carrying out investigations for the right reasons can and does identify learning. Removal of the serious incident process does not mean 'do nothing', it means respond in the right way depending on the type of incidents and associated factors. It means we respond in a timely way, working even more closely with the patient/families and staff to achieve effective sustainable learning and change, where appropriate.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, 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 incidents and the insights this will provide the organisation in terms of learning and any recommendations for quality improvement.

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

There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of systems-based learning and improvement. 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 of the scope of PSIRF to review matters to satisfy processes relating to complaints, Human Resources (HR) matters, legal claims, and inquests.

The PSIRF's core document brings together the following four main aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents. Compassionate engagement and involvement mean working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.
2. Application of a range of system-based approaches to learning from patient safety incidents. Those leading patient safety incident responses (learning response leads) and those involved in the oversight of learning and improvement emerging from patient safety incident response require specific knowledge and experience.
3. Considered and proportionate responses to patient safety incidents. The PSIRF supports organisations to use their incident response resources to maximise improvement, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.
4. Supportive oversight focused on strengthening response system functioning and improvement. All healthcare organisations providing and overseeing NHS-funded care must work collaboratively, with a common understanding of the aims of this framework, to provide an effective governance structure around the NHS response to patient safety incidents.

OUR SERVICES

Mountain Healthcare's vision is to be the centre of excellence in Health and Justice by delivering the best quality patient care. We work hard to provide trauma-informed services that ensure equal, effective, and efficient care to all our patients.

A partner of NHS England and the Police, our unique services include healthcare in Sexual Assault Referral Centres (SARCs), Police Custody and Secure Environments.

SEXUAL ASSAULT REFERRAL CENTRES (SARC)

Mountain Healthcare is the largest provider of Sexual Assault Referral Centre (SARC) services in the UK. A SARC is a specialised medical clinic for children, young people and adults that have been sexually assaulted including rape. We partner with the Police and NHS England to ensure public access to expert trauma-informed care 24 hours a day, every day of the year.

North East:

Northumbria SARC, Newcastle
SARC Durham, Durham
SARC Teesside, Middlesbrough

Yorkshire and the Humber:

Bridge House, North Yorkshire
Casa Suite, Humberside
The Hazlehurst Centre, West Yorkshire
Hackenthorpe Lodge, South Yorkshire

East Midlands:

Millfield House, Derbyshire
Topaz Centre, Nottinghamshire

West Midlands:

West Midlands Regional Children and Young People Sexual Assault Service (CYPSAS) at Willow Tree, Darlaston
Horizon Sexual Assault Referral Centre, Birmingham, Coventry and Wolverhampton (West Midlands)
Grange Park, Staffordshire
Blue Sky Centre, Warwickshire,
The Glade, Bransford (Herefordshire and Worcestershire) and Telford (Shropshire, Telford and Wrekin)

East Anglia:

The Harbour Centre, Norfolk (Forensic Nurse Examiner services)
The Ferns, Suffolk (Forensic Nurse Examiner and Doctor services)
The Elms, Cambridgeshire
Emerald Centre, Bedfordshire
Herts SARC, Hertfordshire
Oakwood Place, Essex

South East:

Beech House, Kent
The Solace Centre, Surrey
The Saturn Centre, Sussex

Thames Valley

The Solace SARC - Bicester
The Solace SARC - Slough

POLICE CUSTODY

Mountain Healthcare partners with the Police to provide expert Forensic Healthcare services to custody detainees with diverse needs.

The safety and well-being of our patients are our utmost priorities whilst also supporting the criminal justice system.

Our contracts include the Thames Valley Police, Surrey Police and Cumbria Police.

We also provide clinical governance support, training, and telephone advice services to custody healthcare professionals within:

Kent (Support Services)
North Wales (Support Services)
Gwent (Support Services)

SECURE ESTATES:

Mountain Healthcare partners with NHS England to provide a holistic child-centred service at Aldine House, a secure children's home for 11 to 18-year-olds on welfare and justice placements.

We empower the children in our care by providing them with techniques to look after their own physical, mental, and emotional wellbeing during and after they leave the secure home.

DEFINING OUR PATIENT SAFETY IMPROVEMENT PROFILE

The patient safety risk process is a collaborative process. To define the MH patient safety risks and responses for 2024/25 the following list of groups and work was undertaken:

Stakeholders involved:

- Staff: through the incidents reported via the online incident reporting and Mountain Learning Lessons sessions.
- Ongoing discussions received from the Clinical Quality Governance Board meetings.
- Discussions at the Medicines Management and Information Security Data Protection Groups.
- Review of data from complaints.
- Review of data/key themes.
- Discussions with our Freedom to Speak Up Guardian.

Due to the change in incident reporting MH did an analysis of all incidents from September 2022 until December 2023. Overall MH's incident profile is no harm to minimal harm having had no

incidents meeting the patient safety incident investigation threshold. However, we do believe that as a learning organisation there is much to improve and share with our system partners. As such the key areas highlighted were:

- Medication incidents: these incidents are mainly no harm. These are the highest reported incidents within our custody division and as such, the organisation wants to focus on reducing the number of repetitive incidents and improve medications management within MH.
- Incidents pertaining to forensic samples: these incidents are mainly no harm to minimal harm however they provide immense organisational learning which supports our ambition to become ISO15189 accredited.
- Client suicide post contact: 2023 saw an increase in the number of incidents involving death post contact. In all reported incidents there were no concerns noted regarding the healthcare provided however, MH's ambition is to work with the wider systems to support our clients to reduce this incident type.

PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors that result in patient safety incidents.

Investigations analyse the system in which we work by collecting and analysing evidence, to identify systems-based contributory factors.

Safety recommendations are created from this evidence-based analysis, to target systems-based improvement.

Some events in healthcare require a specific type of response as set out in the national policies or regulations. These responses may include review by or referral to another organisation/team, depending on the nature of the event. Incidents meeting the Never Events criteria (2018) and deaths identified more likely than not due to problems in care (i.e. incidents meeting the Learning from Deaths criteria for Patient Safety Incident Investigation (PSII) will require a locally led PSII. The ambition is:

- improving the quality of future PSIIs
- conducting PSIIs purely from a patient safety perspective
- reducing the number of PSIIs into the same type of incident
- aggregating and confirming the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents.

ROLES AND RESPONSIBILITIES

The **Management Board** oversees the delivery of clinical services, informed by the outcomes from governance meetings between Clinical Divisions.

The **Clinical Quality Governance Board** will have oversight, review, and act as the approval mechanism for risks, PSII and other types of patient safety reviews.

Governance and Quality Team is responsible for the day-to-day incident management processes. Ensuring investigations and case reviews are implemented as required.

Our **management teams** are responsible for ensuring they support our staff to understand our incident management process and support with their wellbeing.

All our **colleagues** are responsible for reporting incidents as they occur. Ensuring they protect the safety of their colleagues and our patients.

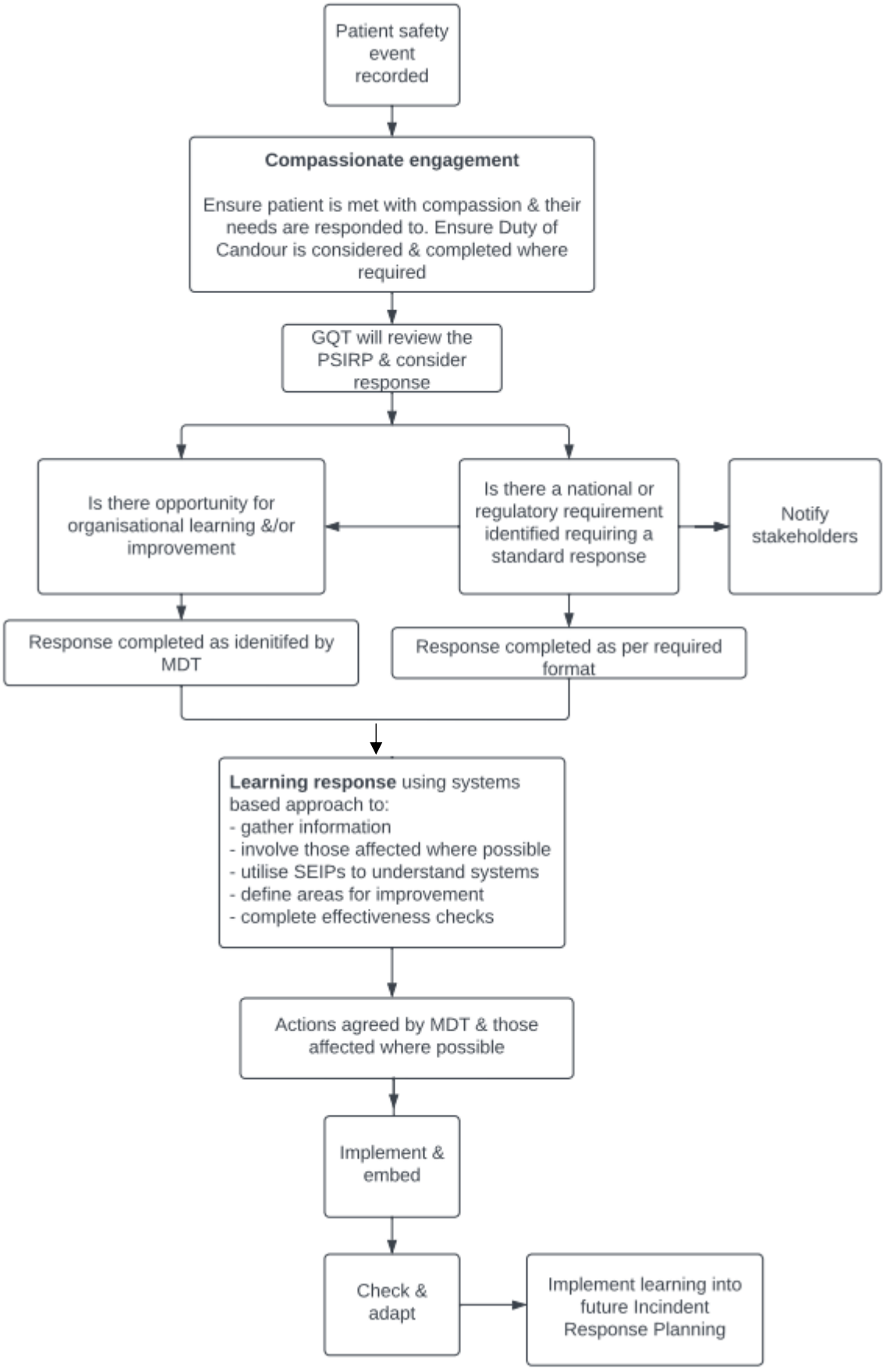
OUR PATIENT SAFETY INCIDENT RESPONSE PLAN ON A PAGE

	EVENT	RESPONSE	LEAD BODY	IMPROVEMENT
NATIONAL PRIORITIES	An incident meeting the Never Events criteria Incidents resulting death due to problems with the care provided	Locally led PSII	MOUNTAIN	Create local organisational recommendations and actions.
	Child Death	Refer for Child Death Overview Panel review. Locally led PSII (or other response) may be required alongside the panel review – Mountain will liaise with the panel	Child Death Overview Panel	Respond to recommendations from external referred agency/organisation as required. Consider review and create local organisational recommendations and actions, if permissible.
	Safeguarding incidents meeting criteria	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults' board. Locally led PSII (or other response) may be required	Refer to local authority safeguarding lead	
	Deaths in custody	Any death in prison or police custody will be referred to the Prison and Probation ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Mountain must fully support these investigations where required to do so. Mountain will conduct an initial review of care to ensure any lessons learnt are captured to prevent reoccurrence.	PPO or IOPC	
	Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	Community Safety Partnership	
MOUNTAIN PRIORITIES	Client suicide post contact Medication incidents Incidents pertaining to forensic samples	IRI Review including SEIPs & thematic analysis Duty of Candour.	MOUNTAIN	Create Mountain-wide recommendations & actions including lessons learnt bulletin
	No harm / low harm patient safety incidents Non-conformance	Duty of Candour Swarm Huddle Thematic review	MOUNTAIN	Local recommendations & actions

METHODS AND TOOLS

Patient Safety Incident Investigation (PSII)	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 PSII's and other responses into a similar incident type. Recommendations and improvement plans are then designed to address those systems factors and help deliver safer care for our patients effectively and sustainably.
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 to occasions where success occurs.
Patient Safety Audit	A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g. in a policy or guidelines).
Thematic Reviews	Analysis of trends to take forward learning and embed as appropriate
Incidents Requiring Investigation (IRI)	A learning response to a quality incident or a trend of non-conformance. These incorporate the Systems Engineering Initiative for Improving Patient Safety (SEIPS) to ensure the investigation is based on reviewing our systems and ensuring any learning is implemented and embedded.
Early Case Review	A multidisciplinary review of a quality incident to agree the terms of reference and scope of the investigation.
Cause and Extent	A review of patient case notes over a period to ascertain whether concerns are isolated or a trend.
Debrief	An unstructured, moderated discussion.
Safety Huddle	A planned team gathering to regroup, seek advice, talk about the day.
Swarm Huddle	Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.

PROCESS FLOWCHART



INCIDENTS THAT MEET THE STATUTORY DUTY OF CANDOUR THRESHOLDS

Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

1. Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
2. Apologise. For example, “we are very sorry that this happened”
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
6. Keep a secure written record of all meetings and communications.

INVOLVEMENT AND SUPPORT FOR STAFF FOLLOWING INCIDENTS

At Mountain we encourage a positive reporting culture and see all incidents and non-conformities as an opportunity to learn and improve. As such it is imperative that we ensure a safe and fair place, where everyone’s voice is encouraged, 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. Our new policy, procedures and guidance will support this in practice.

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. We have a wealth of excellent wellbeing support for all staff. This includes, but is not limited to:

- Wellbeing Ambassadors
- Mental Health First Aid Champions
- Freedom to Speak Up Guardian
- Employee Assistance Program
- Counselling service
- Staff Council.