NHS
Oxford Health
NHS Foundation Trust

Patient Safety Incident Response Plan

Effective date: 4th December 2023

Refresh date: initial 12 month review by 31st January 2025

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1. Introduction

Everyone has a role in patient safety and continually improving the safety of care.

Oxford Health NHS Foundation Trust (OHFT) supports the definition of safety as,

> *Delivering care in a way that minimises things going wrong and maximises things going right, continuously reduces risk, empowers, supports and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights, and ensures improvements are made when problems occur.*

We are pleased to share our new Patient Safety Incident Response Plan for the next 12 months, this outlines the local safety priorities identified with our key stakeholders for focus under the Patient Safety Incident Response Framework (PSIRF[1]). These were developed based on the opportunity they offer for learning and to inform improvements to the safety of care. We will transition to the plan from 4th December 2023[2].

This document should be read alongside the Trust's **Patient Safety Incident Response Approach** which sets out how we develop and maintain effective systems and processes for responding to patient safety incidents. This document should be read in its entirely with the incident response plan and includes:

- An analysis of our safety culture
- How we engage and involve patients, families and staff
- How our learning from deaths processes work alongside the incident response plan
- Detail about the different learning response methods we will use
- How we develop and monitor the impact of safety actions
- How we will identify, participate and lead cross-organisational learning responses

Central to our approach and methodologies is the principle that staff do reasonable things given their goal, knowledge, understanding of the situation and focus at a particular moment. When we review what happened before an incident we look at 6 broad elements, often called system factors, to understand how a system works and influences work processes. The elements include; external environment, organisation, internal environment, tools/technology, tasks and persons; further details about this can be found here. This approach is used to understand what we can learn and change, rather than assigning blame. PSIRF is clear that the review of patient safety incidents "are insulated from remits that seek to determine avoidability/ preventability/ predictability; legal liability; blame; professional conduct/competence/ fitness to practise; criminality; or cause of death." [NHS England, PSIRF standards August 2022, page 11]

We recognise the significant impact patient safety incidents have on patients and their families and carers, and also staff. Getting involvement and engagement right with patients and families in how we respond and learn from incidents is essential and an area we will continue to work on, so that we make the changes that matter and improve care. Throughout this document we share how we will involve and engage patients/families when a significant incident occurs or an incident that falls within the remit of this incident response plan. We will always offer patients/families support, ask what concerns and questions they have following the incident and ensure we respond to these. If we are carrying out an investigation or review we will share the findings and actions we plan to take.

PSIRF does not change our obligation or commitment to comply with Duty of Candour requirements, regardless of whether the incident is included or not in our incident response plan. For all incidents that result in moderate or greater harm[3] to a patient we will speak to those affected or their next of kin to say sorry, offer support, a single point of contact in the Trust and detail the next steps and any further reviews planned. The Trust has a

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[1] See the NHS England webpage for more details about the PSIRF.

[2] Cut-off date for accepting incidents for investigation under the previous Serious Incident Framework will be 30th November 2023.

[3] The national definitions for harm, NHS England » Policy guidance on recording patient safety events and levels of harm, with moderate harm defined as a patient needing further healthcare beyond a single professional/hospital or clinic visit, and beyond a dressing change or short course of medication. But less than 2 weeks of additional inpatient care or less than 6 months of further community treatment. A patients independence could be affected but would need to be for less than 6 months to be classed as moderate. If there is permanent harm to a patient, reduced life expectancy or a need for immediate life saving interventions as a result of the incident then the incident has resulted in severe harm.

Duty of candour policy for staff to follow and also training. We monitor the requirements through the incident reporting system and also as part of our oversight process for all learning responses overseen by the central patient safety team.

This plan is a 'living document' that will be kept under review through our weekly and monthly oversight processes at both clinical directorate and Trust-wide level and amended as we use it to respond to patient safety incidents. We will continue to review every patient safety incident to identify any emerging issues and any incidents with the potential for significant learning. In addition we will have regular reviews in year of our plan and approach with our commissioner, the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board. We will formally review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made. Any amendments to the plan will be highlighted and re-published on our website.

If you have any questions about the incident response plan please contact Jane.Kershaw@oxfordhealth.nhs.uk or the Patient Safety Team on patient.safety@oxfordhealth.nhs.uk.

2. Our services

The enclosed incident response plan covers all the services provided by Oxford Health NHS Foundation Trust.

The Trust's vision is: **Outstanding care delivered by an outstanding team**. The vision statement is supplemented by a declaration to emphasise the Trust's aims: Working together to deliver the best for communities, our people, and the environment.

The Trust works towards its vision through its values of being **caring, safe and excellent**.

At Oxford Health we provide;

- Mental health services all ages in Buckinghamshire, Oxfordshire and predominantly children's services in Swindon, Wiltshire, Bath and North East Somerset.

- Learning disability services in Oxfordshire, as well as some diagnostic autism services and a reasonable adjustment service to support autistic adults.

- Community physical health services all ages in Oxfordshire, such as district nursing, community dental services, podiatry, community hospitals, health visiting, school nursing, a homeless GP and urgent care services. Along with vaccination services for Buckinghamshire, Oxfordshire and West Berkshire.

Our services are managed through the following clinical directorates;

- Buckinghamshire Mental Health Directorate
- Oxfordshire and BaNES (Bath and North East Sommerset), Swindon & Wiltshire Mental Health Directorate
- Forensic Mental Health Directorate
- Learning Disabilities Directorate
- Primary, Community & Dental Directorate

The services are delivered at community bases, hospitals, clinics and in people's homes. We aim to deliver care as close to home as possible.

To find out more about the Trust and the services we provide go to our website. The Trust's annual Quality Account is published here and provides details about the quality of services provided and our current priorities for quality improvements.

3. Defining our patient safety incident profile

We took the following steps in identifying agreeing the local patient safety issues most important to us and our key stakeholders.

Stakeholder engagement

As part of the preparations to transition to the PSIRF we started by mapping our key internal and external stakeholders. We have used this mapping to guide our engagement work as well as our communication plan to ask for support and to share the changes we have made to improve how we respond and learn from patient safety incidents. The incident response plan being presented here was developed with stakeholders and then drafts were extensively consulted on to help prioritise what safety areas we start on in year 1.

We set up a programme board to oversee and steer the work to implement the PSIRF requirements, which was named by staff as 'Learning together for a safer tomorrow'. Initially the work programme is for 12 months but we expect this to evolve and each year to set out our next ambition. The programme board meets at least monthly and is chaired by the Chief Nurse and Chief Medical Officer. We have people with lived experiences on the board including our patient safety partners[4], clinicians and leaders to maintain positive engagement and communication throughout the changes being made.

We collaborated with key stakeholders in the following ways;

- Joining existing internal and external meetings with staff and patients/families
- Presenting and hearing from staff in Trust-wide leadership webinars
- Hosting bespoke workshops on PSIRF and to develop our incident response plan
- Writing to staff, Foundation Trust members and the Council of Governors for input, as well as sending out information in bulletins and joining forums
- Running a social media campaign to engage with the wider communities we work with
- With our commissioners- the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and the Provider Collaborative leads through our preparations for PSIRF, existing SI closure forums and feedback on this plan and our approach to PSIRF.

This involvement has informed and agreed our key safety issues to focus on in terms of risk and potential for learning and making improvements to care.

Review of data sources

In addition to listening to our stakeholders feedback, we examined our patient safety incidents and a variety of safety data for the last two years to develop a patient safety profile. The sources we have used to look at our profile include;

- Thematic analysis of all patient incidents including serious incidents (we have had 0 never events[5])
- Thematic analysis of learning from past patient safety incident investigation reports and incident learning huddles
- Feedback from the Trust's Family Liaison Service practitioners
- Learning from mortality reviews
- Complaints and informal concerns
- The Trust's quality and safety dashboard which brings together activity, workforce and quality indicators.
- The Trust's annual Quality Account (mentioned above with a link)
- Clinical audits
- Trust's risk register
- Freedom to speak up trends
- Reviews from safeguarding cases
- Themes from Coroner inquests
- Inequalities data

[4] For more details about what are Patient Safety Partners NHS England » Framework for involving patients in patient safety

[5] To find out what is a Never Event click here NHS England » Never events

Regular reports relating to the above safety areas are presented to our Trust Board of Directors and published including learning from patient safety incident investigation reports and deaths, themes from complaints, the current top risks we are managing, themes from Freedom to Speak up concerns, areas of learning from clinical audits, the quality and safety dashboard as well as the annual Quality Account.

Key safety issues

From the outcome of our stakeholder engagement and data analysis below are the local safety areas identified;

Mental Health and Learning Disability services

- Demand for care and treatment above service capacity resulting in waits, delays in seeing patients, missing opportunities for early detection of deterioration, lack of care continuity and patients being lost to follow up
- Use of temporary and agency staff due to vacancies and patient acuity impacting on continuity and quality of care
- Rising incidents of abuse and violence from patients towards staff
- Risk formulation
- Increase in certain groups of people being unable to access the care and treatment they need
- Early deaths of people with a severe and enduing mental illness related to poor physical health
- Involvement and communication with families in their loved ones care
- Patients being actively involved in their care planning and safety planning
- Communication between OHFT teams and with external agencies during transitions
- Use of restrictive practice on the wards, we will always work to reduce this

Community physical health services

- Demand for care and treatment above service capacity resulting in waits, delays in seeing patients, missing opportunities for early detection of deterioration, lack of care continuity and patients being lost to follow up
- Use of temporary and agency staff due to vacancies and patient acuity impacting on continuity and quality of care
- Rising incidents of abuse and violence from patients towards staff
- Timeliness and coordination of end of life care
- Patients being actively involved in their care planning
- Communication between OHFT teams and with external agencies during transitions
- Early identification and escalation of people physically deteriorating, including identifying sepsis
- Quality of safety setting and putting this in writing as part of consultations
- Missed or delayed diagnosis particularly related to wound care

We used the following criteria to prioritise which patient safety areas we should focus on for the next year based on where we could maximise learning;

- Scale and impact
- Frequency of incident or event
- Generalisability to apply learning to other incidents and contexts
- Practicality of improvement (is it within our ability to make a change?)
- Existing improvement work
- Pattern identification
- Effect on healthcare team(s)

As part of developing the incident response plan we identified the existing/planned national and local patient safety quality improvement work, described below, to better balance our efforts towards spreading learning and making improvements. This highlighted the patient safety areas for attention where there was no specific improvement work happening or we felt there was more to understand about underlying system factors to identify meaningful safety actions.

We will not always be able to carry out a learning response to every patient safety incident and will focus our time each year on priority areas to use our resources in a considered and proportionate way. However we will continue to review all incidents and to monitor trends to identify and be able to respond to emerging themes as needed. The Trust will ensure those affected by significant patient safety incidents are still engaged, so we can listen and address any concerns or questions, and offer support. The Trust provides a Family Liaison Service independent to clinical teams to support bereaved families including general bereavement support, signposting to external agencies, providing information and practice advice and support to help raise concerns and questions. We have a separate Post Incident Psychological Support Service for staff to access following an incident or death, alongside the occupational health service, employee assistance programme and in 2023 we have started to trial the peer support approach of Trauma Risk Injury Management (TRiM).

This is our first plan after transitioning to the PSIRF and is focused on learning potential from things that have gone wrong or serious near misses. Future plans will have more of an emphasis on learning when things go right and building on successes by studying more everyday work.

National and local Quality Improvement Work

We are driving forward to make Quality Improvement 'the way we always do things here' at the Trust so that we are continuously learning and improving to develop the care we provide.

The Trust established the Oxford Healthcare Improvement Centre to provide; training and support for quality improvement projects, enable collaboration, sharing of outcomes and horizon scanning for future projects. Our aim is that improvements to patient care are always co-produced with patients and their families. Further details about the Centre can be found here. The Patient Safety Team and Oxford Healthcare Improvement Centre work together to share learning to inform quality improvements.

Where we have identified a safety areas but have significant and relevant quality improvement work happening or planned, our efforts will be on testing and making the changes identified therefore the area is not separately identified as a local safety area in the incident response plan. The significant quality improvement projects for 2023 and 2024 with an impact on the safety of care are listed below.

National (both CQUIN[6] framework and national patient safety improvement programmes[7]);

- Assessment and documentation of pressure ulcer risk in community hospital wards
- Assessment, diagnosis and treatment of lower leg wounds in District Nursing
- Reducing use of prone restraint and length of seclusion episodes
- Reduce suicide and self-harm in inpatient mental health services, the healthcare workforce and non-mental health acute settings
- Reduce inpatient suicides or suicides within 14 days of discharge from a mental health ward
- Improve the sexual safety of patients and staff on inpatient mental health units

Local;

- Falls reduction
- Pressure Ulcer prevention and tissue viability management (see national work as well)
- Improving coordination and access to timely End of Life care
- Waiting times and waiting list management
- Recognising and responding to deteriorating patients/Sepsis
- Working with families by embedding the Triangle of Care
- Embed personalised care planning
- Improve the physical healthcare to people with a serious mental illness
- Medication management including the roll out of an electronic prescribing system
- Improving Quality, Reducing Agency use, focused on improving staff recruitment and retention.
- Managing challenging behaviour from patients towards staff (verbal and physical assaults)
- Autism and supporting reasonable adjustments

[6] Commissioning for Quality and Innovation (CQUIN), for more details see the NHS England website.

[7] More detail about the national patient safety improvement programmes can be found on the NHS England website

4. Our patient safety incident response plan

Below is our Patient Safety Incident Response Plan, this includes the NHS England national requirements (further details about the national requirements are available here) and the local safety areas/incidents identified in collaboration with key stakeholders. In addition we will continue to carry out an incident learning huddle or case record review for the majority of incidents resulting in moderate or greater harm to a patient or where we believe there is a potential for significant learning.

Learning Responses

Our incident learning responses will take a systems perspective to understand the different factors and how they interact so that we can identify learning that will inform improvements. We are using the methodology of Systems Engineering Initiative for Patient Safety (SEIPS) within our learning responses, further details can be found in this brief guide. SEIPs recognises the importance of exploring everyday work (how work is done in reality) and how people are routinely adjusting to match the ever changing conditions and demands of work.

We have identified a range of learning responses in the incident response plan to recognise there is no 'one size fits all' and the application of suitable learning methods needs to be based on the situation, incident type and what is already known about the safety area. The **Patient Safety Incident Response Approach** document describes each learning response. The number of learning responses by type of incident has not been specified in this plan as we will need to keep this under review to inform the allocation of time and resources. We will be taking a considered and proportionate approach, therefore will not always respond to a specific incident if we are familiar with the factors that need addressing so that we can focus on spreading the learning and making the changes to improve the safety of care.

We aim for learning responses to start as soon as possible after the incident is identified and expect most responses to be completed within 3 months although this will be flexible and we will work at the pace of those affected, particularly patients, families and staff. If a response requires the involvement of a number of partner organisations or we are carrying out a full in-depth patient safety incident investigation this may also take longer but we will still aim to complete this within 6 months. During all of the learning responses we recognise communication with those affected is crucial so we will provide routine updates on progress and any changes to the timescale.

Category		Patient safety incident or event	Which services does this include?	Anticipated learning response method
National (NHS England)	1	Incidents meeting the Never Events criteria (nationally defined further details at - NHS England » Never events)	All	Patient Safety Incident Investigation or alternative as agreed with the Integrated Care Board.
	2	Deaths thought more likely than not due to problems in care (meeting the learning from deaths criteria)	All	Mortality review process to be followed including an initial screening of the care provided, an incident learning huddle or mortality review report and then as required a Patient Safety Incident Investigation.
	3	Unexpected deaths of people under the Mental Health Act (1983) or the Mental Capacity Act (2005) where problems in care identified	All	Patient Safety Incident Investigation.
	4	Mental health-related homicides	Mental Healthcare	Patient Safety Incident Investigation or Mental Health Homicide Review commissioned by NHS England (wording amended in September 2024)
	5	Domestic homicides	All	Case record review to identify immediate learning. This will feed into the multi-agency Domestic Homicide Review commissioned by the community safety partnership.
	6	Deaths of people with a learning disability or diagnosed with autism where problems in care identified	All	All deaths are automatically reviewed through the multi-agency LeDeR (People with a Learning Disability and autistic people) process. Where problems in care are identified we will undertake a response to be decided based on the circumstances and how much is already known about the issue. (wording amended in September 2024)
	7	Child deaths (all deaths for children aged 0-17)	All	Case record review, usually completed by the Safeguarding Team or clinical team. This will feed into the multi-agency child death overview panel review coordinated by the Local Authority.
	8	Safeguarding incidents meeting national criteria	All	Case record review to identify immediate learning. This will feed into the wider Local Authority review.
	9	Deaths in custody related to health provision commissioned by the NHS and provided by OHFT	Mental Healthcare	Case record review to identify immediate learning. We will also participate in any multi-agency review.
	10	Blood transfusions resulting in serious adverse reactions, a serious adverse event or significant near miss (PSIRF-and-impact-on-haemovigilance-in-England)	Physical Healthcare	Patient Safety Incident Investigation.
Local	11	Pressure ulcers developed whilst under our care – inpatient and community services (defined nationally as developed in service)	Physical Healthcare	Annual thematic review or horizon scanning tool/workshop of category 2 ulcers developed in service. All category 3 and 4 ulcers, deep tissue and unstageable ulcer incidents developed in service will continue to be reviewed and key themes taken to the Pressure Ulcer Prevention Group. Reviews will include the use of incident learning huddles. Any concerns about the care provided will be identified and areas for improvement reviewed against current actions.

Category		Patient safety incident or event	Which services does this include?	Anticipated learning response method
Local				The focus is on implementing and monitoring the impact of safety actions in progress and identifying any new emerging areas. Link to national Quality Improvement work in District Nursing and Community Hospitals.
	12	Unexpected death or serious incident for a mental health inpatient	Mental Healthcare	Patient Safety Incident Investigation. Link to national Quality Improvement work and the Trust's suicide prevention strategy work.
	13	Incident which identified learning around involving families e.g. consent/confidentiality, involvement in care/safety planning and sharing information	Mental Healthcare	Clinical team to complete self-assessment/audit against national Carers Trust 'Triangle of Care' to include input from carers/families. Information about the Triangle of Care is available here. If assessment has been completed already in last 6 months, focus on family and staff feedback and review impact of actions being taken. Link to Carers, Friends and Family Strategy work plan and actions.
	14	Delays in accessing care/treatment for example due to a wait where moderate or greater harm occurred, and Issues with accessing care/treatment for example due to a diagnosis or condition	All	Extended learning huddle for identified incidents. If similar areas for improvement are coming through, we won't repeat reviews and instead will focus on safety actions. Annual thematic review or horizon scanning tool/workshop for Podiatry services. Outcome to inform the Oxfordshire Podiatry service working group involving OHFT and Oxford University Hospitals NHS FT. Annual thematic review for community mental health services. Feed learning into caseload reviews and suicide prevention workstream in relation to neurodiverse conditions.
	15	An incident of suspected suicide or serious self-harm where we identify issues in relation to risk formulation or safety planning	Mental Healthcare	Extended learning huddle or Appreciative Inquiry Approach. If similar areas for improvement are coming through, we won't repeat reviews and instead will focus on safety actions. Link to internal and external suicide prevention strategy work.
	16	An incident involving ineffective working between teams in OHFT (wording amended in September 2024)	All	To be defined depending on incident(s). Link to transformation work happening – Community Mental Health Framework, Podiatry and District Nursing.
	17	Emergent Issues with significant learning	All	To be defined depending on incident(s).
	18	An issue where significant concerns have affected a patient's journey between different organisations	All	Cross-organisational Patient Safety Incident Investigation (up to 5 a year).