Birmingham and Solihull Mental Health
NHS Foundation Trust

# Patient safety incident response plan

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| | NAME | TITLE | DATE |
|---|---|---|---|
| **Author** | Samantha Munbodh | Head of Patient Safety | **December 2023** |
| **Authoriser** | Roisin Fallon-Williams | Chief Executive | **December 2023** |

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# 1.0 Introduction

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), which replaces the NHS Serious Incident Framework. This document is our Patient Safety Incident Response Plan (PSIRP). It sets out how BSMHFT intends to respond to safety incidents over the next 12 –18 months. This plan is not a permanent rule that cannot be changed. We remain flexible and consider the specific circumstance in which patient safety issues occurred and the needs of those affected.

This plan is underpinned by our existing Trust policy on reporting, management of incidents and the new Trust Patient Safety Incident Response (PSIRF) policy.

The Serious Incident Framework mandated when and how to investigate and provided structure and guidance on how to identify, report and investigate an incident. PSIRF is best considered as a learning and improvement framework with the emphasis placed on the system and culture that supports continuous improvement in patient safety.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better in a small number of areas of highest patient safety risk for us as organisation. 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 all works.

Carrying out investigations for the right reasons can and does identify new insight and learning. Removal of the serious incident process does not mean "do nothing", it means respond in a proportionate way depending on the type of incident and associated factors.

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

We have developed our understanding and insights about our patient safety profile over the past two years. In September 2023, this plan provides a description of how PSIRF will be applied at BSMHFT for the purpose of learning and improvement. There is not remit for preventability or cause of death with the learning responses.

# 2.0 Our services

BSMHFT provides comprehensive mental healthcare services for the residents of Birmingham and Solihull and to communities in the West Midlands and beyond. With more than 40 sites, we serve a culturally diverse population of 1.3 million, spread out over 172 square miles. We have a dedicated workforce of around 4,000 staff and a range of local and regional partnerships, making us one of the most complex and specialist mental health foundation trusts in the country. Our catchment population is ethnically diverse and characterised in places by high levels of deprivation, low earnings and unemployment. These factors create a higher requirement for access to health services and a greater need for innovative ways of engaging people from the most affected areas.

BSMHFT is governed by a Board of Directors, day to day running of the clinical and non-clinical services is delegated to Executive Directors, senior clinicians and managers.

The clinical services are grouped into service areas. Each service area is headed by an Associate Director and Clinical Director who is supported by a Head of Nursing and Allied Health Professional.

The four service areas are:

- Specialties and Demetia and Frailty
- Secure Care and Offender Health
- Acute and Urgent Care
- ICCR

Safety and governance are embedded within the organisation through the corporate and local services structure.

The Trust's Clinical Governance Committee has responsibility for the monitoring of the Trust's Governance (including patient safety) framework.

# 3.0 Defining our patient safety incident profile

A key part of developing the PSIRF Plan is understanding the key safety issues that lead to risks within BSMHFT, known as the Patient Safety Profile.

We reviewed our data and intelligence from various sources to understand the trusts profile and priorities for the year 2023/24.

Learning from early adopters that 2-3 years of data seemed to be about right to understand patient safety risks and issues; in January 2023 we identified the period 1st April 2020 to 31st March 2022 for our thematic data analysis which include serious incidents, prevention of future deaths, compliments and complaints, claims, freedom to speak up, mortality case note reviews, safeguarding, quality assurance activities, research for example the National Inquiry into suicides and safety in mental health 2023 annual report.

We were keen to involve our staff as key stakeholders in identifying our key patient safety risks and issues. Staff engagement sessions ran throughout the summer of 2023 and staff were asked to tell us about their main patient safety concerns.

The emphasis when analysing this information was to look for opportunities for improvement; areas where gaps in care and treatment and/or types of incidents remain a concern due to the impact on service users, families, carers. Where possible we have also considered what any elements of the data tell us about inequalities in patient safety. As part of our workshops, we have also considered any new and emergent risks relating to future service changes and changes in demand that the historical data does not reveal.

The trust held meetings to agree priorities these included representation from corporate and clinical teams. Unfortunately, our EBE Safety Partners were not in role in time to develop our first PSIRP plan but will be involved in patient safety and in the development of future plans.

# 4.0 Our patient safety incident response plan: national requirements.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, which the Trust fully endorses as it fits with our aim to learn and improve within a just culture.

National guidance recommends that 3-6 investigations per priority are conducted per year. This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors. Attempting to do more than this will impede our ability to adopt a systems-base learning approach from thematic analysis and learning from excellence.

For clarity, all types of incidents that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods and are detailed in the table below.

| National priorities | | |
|---|---|---|
| **Patient safety incident type** | **Approach** | **Anticipated Improvement Route** |
| Incidents in screening programmes | Work with partners to ensure cases are referred to Public Health England (PHE) | Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy |
| Death of a person who has lived with a Learning Disability or autism | Refer for Learning Disabilities Mortality Review (LeDeR) liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required | |
| Safeguarding incidents in which:<br>Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence.<br>Adults over 18 years old are in receipt of care and support needs from their local authority.<br>The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence. | Refer to local authority safeguarding lead via BSMHFT named safeguarding lead<br><br>BSMHFT will contribute to domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and the local safeguarding adults boards | |
| Perpetrators of homicide (up to 6mths post discharge) | Identified by the police usually in partnership with the local community safety partnership with whom the overall responsibility lies for establishing review of the case. Where the CSP considers that the criteria for a domestic homicide review are met and establishment of a DHR panel, BSMHFT will contribute as required by the DHR panel. | |
| Death of patients in custody/prison/probation | Refer to Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) | |
| Patient Safety incidents meeting the Never Event criteria 2018 or its replacement | Patient Safety Incident Investigation | Create local organisational recommendation |
| 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 | | |
| Patient Safety incidents resulting in death where the death is thought more likely than not to be due to problems in care | | |

# 5.0 Our patient safety incident response plan: local focus

Apart from the national criteria for PSII above, the decision to carry out a patient safety incident investigation should be based on the following:

- the patient safety incident is linked to one of the Trust's Patient Safety Priorities that were agreed as part of the situational analysis.
- the patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.

Our Patient Safety Priorities:

| Priority | Approach | Local and system improvement route |
|---|---|---|
| Co morbidity with drug/alcohol – people in active treatment at BSMHFT | Patient Safety Incident Investigation (PSII) where agreed | Create local organisational actions in quality improvement strategy plus a system wide response to improving services for this cohort |
| Incidents resulting in harm or deaths by suspected suicide where care is fragmented/multiple contacts across the pathway | | |
| Incidents of evidence of disengagement, with 3 or more consecutive failed contacts prior to death by suspected suicide, | | |
| Harm or death of a service user with an emerging risk (increased calls crisis line, duty contacts, street triage contacts) and no evidence of risk management plan | | |
| Lack of family involvement, not hearing/taking on boarding warnings of concerns from family, resulting in harm | | |

For any incident not meeting the PSII criteria, or any other incident, we will use a specific patient safety review tool to enable a learning response. For lesser harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work.

| Patient safety incident type or issue | Planned response | Anticipated improvement route |
| --- | --- | --- |
| **Death** | Review by Mortality process and possible SJR/SJR plus (including family input) and Mortality MDT<br><br>Thematic review to be identified for particular service user groups<br><br>Review as PSII where index case or meets national priority criteria | Create local safety actions and feed these into the quality improvement strategy |
| **Service provision** | Review by operational managers in conjunction with service leads and cross system reporting as necessary<br><br>Continued monitoring through operational working groups<br><br>Continued monitoring of patient safety incident records to determine any emerging risks/issues<br><br>Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised | Inform ongoing improvement efforts |
| **Inappropriate behaviour** | Review by operational managers in conjunction with relevant subject matter experts<br><br>Continued monitoring through safety huddles, consider inclusion of EDI in huddle where appropriate<br><br>Continued monitoring of patient safety incident records to determine any emerging risks/issues<br>Risks/issues to be reviewed by toolkit if required where patient safety compromised | Inform on going improvement effort |

| Patient safety incident type or issue | Planned response | Anticipated improvement route |
|---|---|---|
| **Violence and aggression** | Review by operational managers in conjunction with Health and Safety or relevant subject matter experts<br><br>Continued monitoring through safety huddles, EDI to be considered as part of huddle for racially abusive incidents<br><br>For Secure Services ensure reporting according to set requirements<br><br>Continued monitoring of patient safety incident records to determine any emerging risks/issues<br><br>Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised | Inform ongoing improvement efforts |
| **Medication** | Review by operational managers in conjunction with Medicines Management and cross system reporting as necessary<br>Continued monitoring through medicines safety meetings and safety huddles<br><br>Continued monitoring of patient safety incident records to determine any emerging risks/issues<br><br>Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised<br><br>Review as PSII where index case | |
| **Missing patient/Abscond/AWOL** | Review by operational managers in conjunction with relevant subject matter experts<br>Continued monitoring through safety huddles<br>For Secure Services ensure reporting according to set requirements<br>Continued monitoring of patient safety incident records to determine any emerging risks/issues<br>Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised<br><br>Consideration for PSII where felt appropriate | inform ongoing improvement efforts |
| **Access / admission/ transfer / discharge** | Review by operational managers in conjunction with service leads and cross system reporting as necessary<br><br>Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised | Inform on going improvement |

| Patient safety incident type or issue | Planned response | Anticipated improvement route |
|---|---|---|
| **Sexual incidents** | Review by operational managers in conjunction with relevant subject matter experts<br><br>Continued monitoring through  safety huddles and Sexual Safety group<br><br>For Secure Services ensure reporting according to set requirements<br><br>Continued monitoring of patient safety incident records to determine any emerging risks/issues<br><br>Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised | |
| **Infection control** | Review by operational managers in conjunction with Infection Control and Prevention team and cross system reporting as necessary<br><br>Continued monitoring through safety huddles<br><br>Continue post infection reviews for outbreaks<br><br>Continue nationally required external reporting for specific infection groups<br><br>Continued monitoring of patient safety incident records to determine any emerging risks/issues<br>Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised | |

| Patient safety incident type or issue | Planned response | Anticipated improvement route |
|---|---|---|
| **Patient care and treatment** | Review by operational managers in conjunction with relevant subject matter experts and cross system reporting as necessary<br>Continued monitoring through safety huddles<br><br>Restrictive interventions – harm has occurred, excessive force, overuse or lack of rationale, ethnicity or gender bias is suspected (see Use of Force Act 2019) to be reviewed by toolkit item<br><br><br>For Secure Services ensure reporting according to set requirements<br><br>Continued monitoring of patient safety incident records to determine any emerging risks/issues<br><br>Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised | create local safety actions and feed these into the quality improvement strategy<br>Review as PSII where index case |
| **Self harm** | Review by operational managers in conjunction with subject matter experts<br>Continued monitoring through safety huddles<br>For Secure Services ensure reporting according to set requirements<br>Continued monitoring of patient safety incident records to determine any emerging risks/trends<br>Thematic analysis<br>Risks/issues to be reviewed by toolkit item, if required, where patient safety compromised<br>Escalate for review to PSII where required | create local safety actions and feed these into the quality improvement strategy |
| **Slips, Trips and Falls** | Review by operational managers in conjunction with relevant subject matter experts<br>Continued monitoring through Divisional/Trust safety huddles and Falls Harm free group | create local safety actions and feed these into the quality improvement strategy |