# 1. Patient safety incident response plan

## Appendix 1 Improvement programmes

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| Community Transformation | Adult/older people's community mental health team transformation - DTV | To meet the requirements of the national transformation model and road map requirements to ensure the needs of those with a serious mental illness are met more effectively.<br>To continue to work as a key system partner to implement the required service, workforce, and cultural change to deliver improved outcomes. | March 2024 |
| | Older people's community mental health team transformation – NYYS | To support 'place based' provision of care across our care group geography in line with NHSE/ICS direction.<br>Support a system wide approach to rehabilitation and independence.<br>To align service structure with future investment proposals to develop a resilient and sustainable memory service across MHSOP | March 2024 |
| | Adult community mental health team transformation – NYYS | To improve the lived experience and life potential of those with enduring mental health.<br>Improve patient and carer experience through seamless care, making the most of system overhaul.<br>Work closer and appreciate the value of our partners to bring about shared benefits for patients and carers. | |
| Reducing Inpatient bed pressures | Inpatient transformation work aligned with community transformation workstreams. | To meet the requirements of the national transformation model and road map requirements to ensure the needs of those with a serious mental illness are met more effectively. | March 2024 |
| CITO | Cito Patient Record System | Delivery of clinical record<br><br>Reduction in time clinical colleagues spend inputting information into digital systems and improvement in data quality. | Q4 2023/24 |
| Patient Safety | InPhase Risk management System | To ensure TEWV compliance with the learning from patient safety events (LFPSE) national directive. To replace the current Datix system with InPhase to support this compliance | October 2023 |
| Harm Free Care | Reducing the use of restrictive interventions | To reduce the use of restrictive interventions by 50% by 31 March 2024. | March 2024 |
| | Safeguarding / parental/carer mental ill health impact on children (PAMIC) | To minimise the impact from parental/carer mental ill health and behaviour on children. | |

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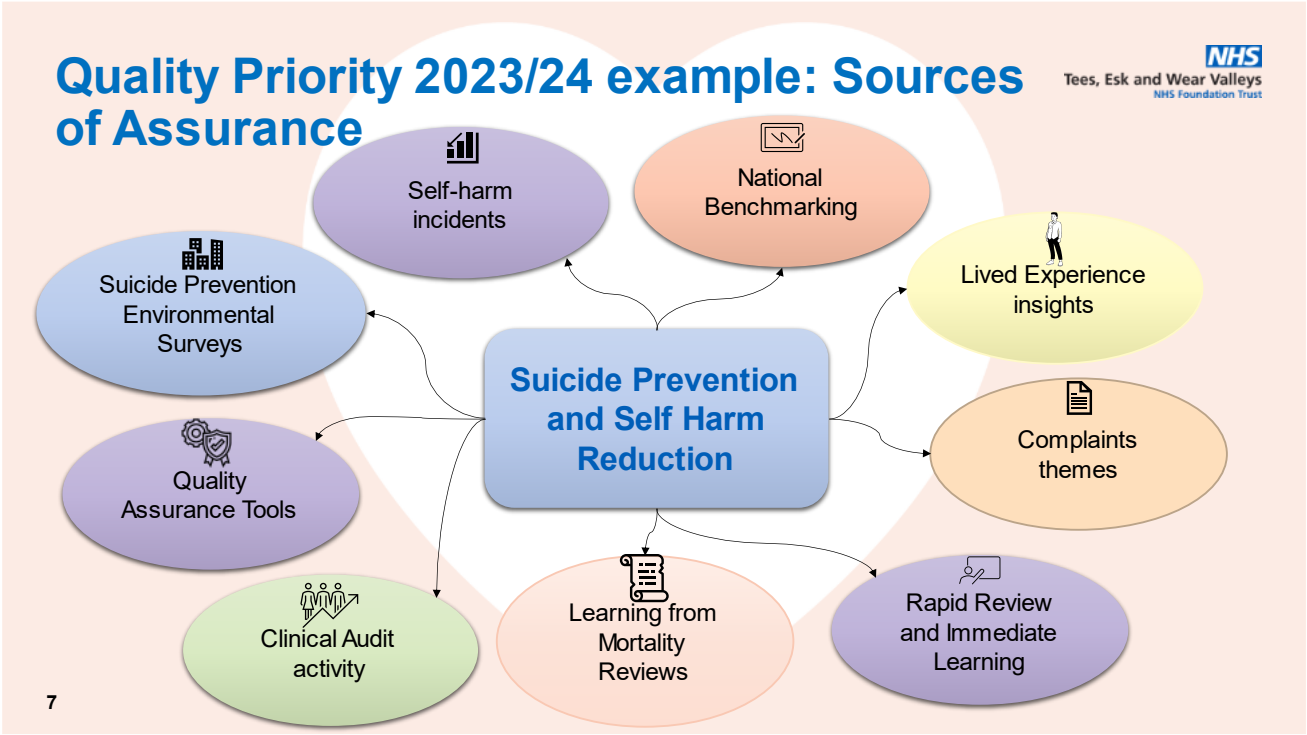
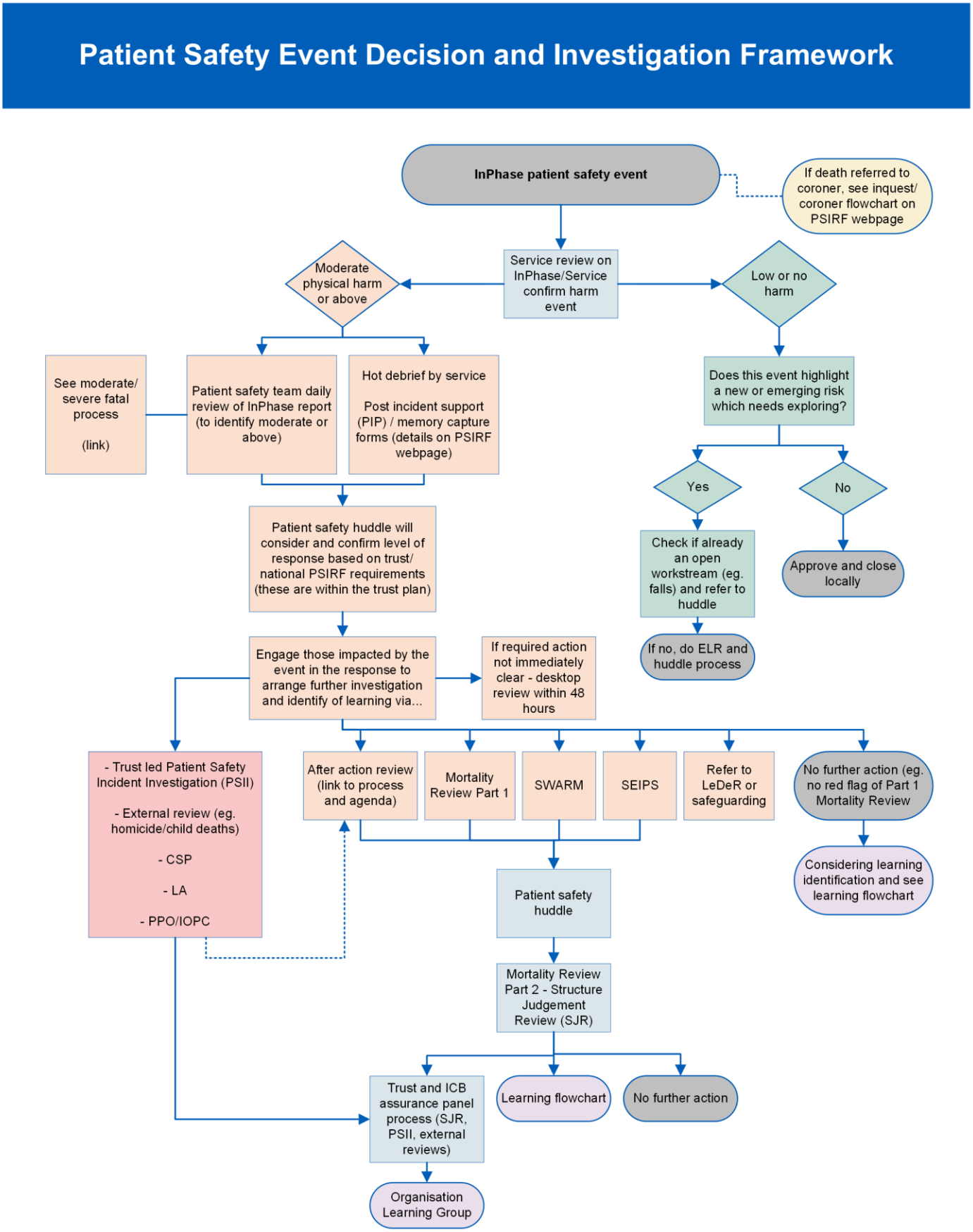
| | Reducing in sexual safety incidents | To reduce the number of sexual safety incidents to zero by 31 March 2024. | |
| | Reducing suicide/misadventure | target for the reduction of suicide/misadventure related incidents among people in the Trust's care is still being developed, although the ultimate ambition is zero suicide.<br>We are also considering a target of reducing staff sick days that are attributed to suicide related incidents. | |
| Personalised Care Planning | DIALOG+ full implementation through Cito | To manage the transition to DIALOG+ where all patients will have a Care Plan that is coproduced with them and their carers/family, that is managed via Cito.<br>This will mean that, patients will receive care that is formulated around their experiences and meets their needs.<br>This is central to the community mental health framework and refocus of CPA. It should improve patient satisfaction and reduce suicide rates. | October 2023 |
| Expand and develop lived experience posts | Expand and develop lived experience roles and leadership, including peer support workers and patient safety specialists | Target growth for peer support roles across TEWV - TBA at executive level (60 per year minimum across whole Trust.<br>• Peer relationships can facilitate personal recovery and wellbeing.<br>We should take steps to implement and support peer relationships, and diversity MDT workforce.<br>By growing this workforce, we can offer peer support across the whole range of places and services. | December 2023 onwards |
| Collecting and learning from patient and carer data | Improve and accurately capture patient experience data.<br>Undergo review and transform PALS and complaints pathways in line with cocreation principals | Capturing, reviewing, and learning from patient feedback is central to outstanding patient experience.<br>Good complaint handling provides a direct and positive connection between those who provide services and the people who use them.<br>Complaints offer a rich source of learning to help improve services for everyone. | January 2024 |
| Diversity and expand involvement | Embed and grow co-creation across the organisation and in the patient safety team. | Co-creation is one of our three goals. By co-creating we will create an open, compassionate culture that listens to patients and carers, and learns from their experience of quality patient care.<br>To facilitate increased co-creation some process and capacity development is needed, which this initiative focuses on. | October 2023 onwards |

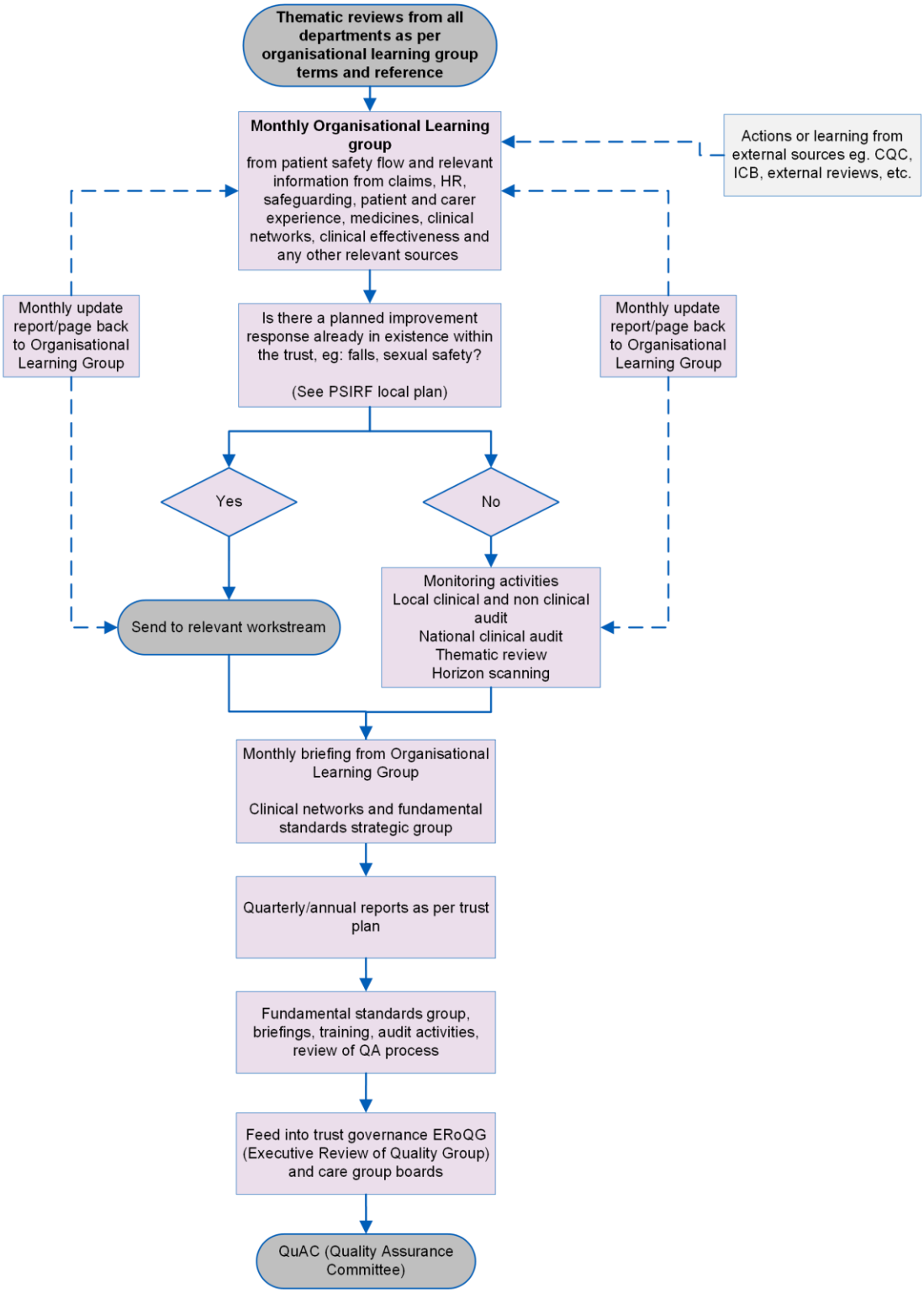
## Appendix 2 Quality Priority 2023/24 example: Source of Assurance



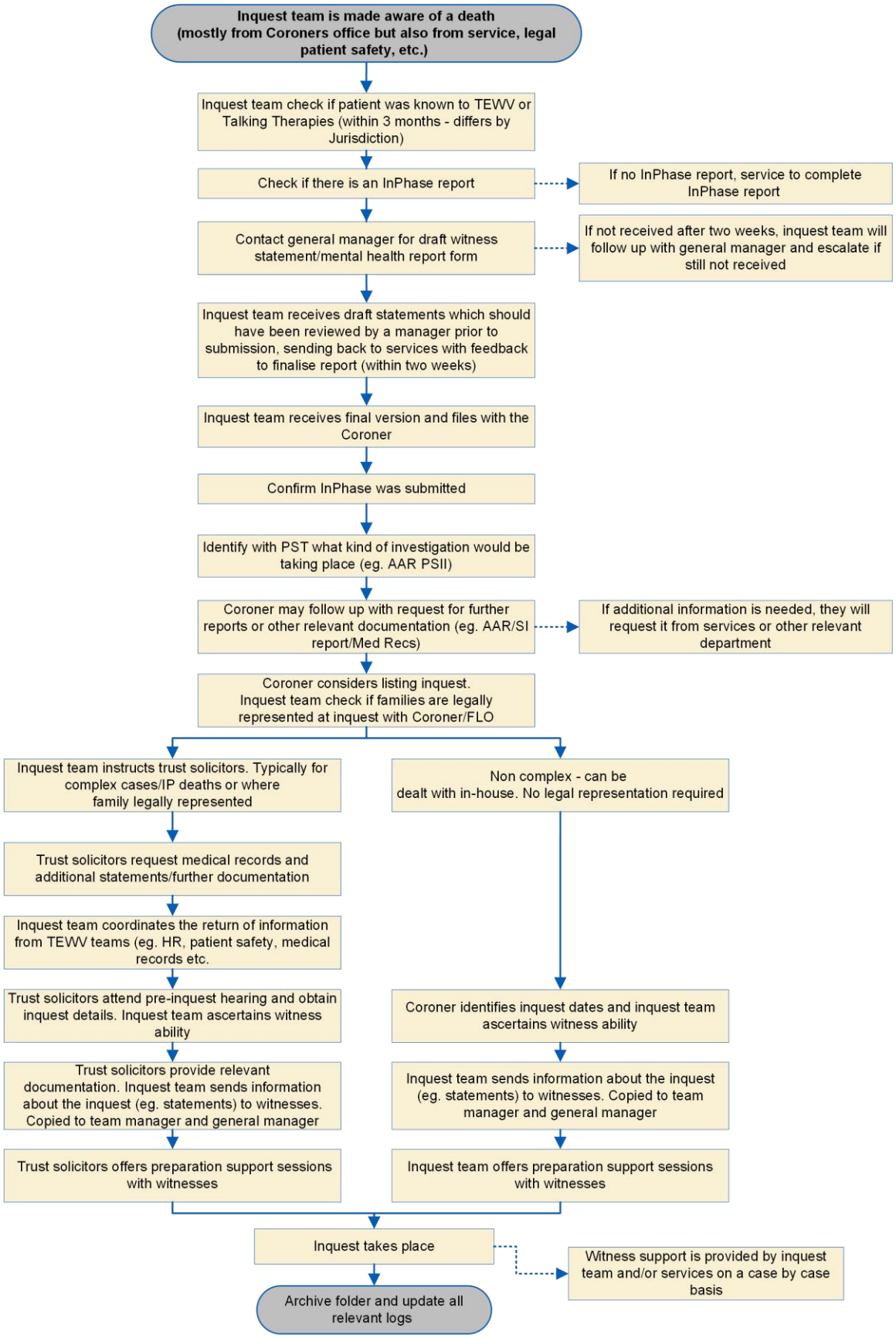
## Appendix 3 PSIRF Flowcharts



# Patient Safety Event Learning Process



# Inquest Team Coroners Process



## Appendix 4 Glossary of Terms

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| **PSIRF**<br>Patient Safety Incident Response Framework | This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk. |
| **PSIRP**<br>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 divisions and specialist risk leads supported by analysis of local data. |
| **PSII**<br>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. |
| AAR<br>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. |
| SJR<br>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. |
| 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. |
| 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. |
| 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.<br><br>**S = Specific**<br>A goal should not be too broad but target a specific area for improvement.<br><br>**M = Measurable**<br>A goal should include some indicator of how progress can be shown to have been made.<br><br>**A= Achievable**<br>A goal should be able to be achieved within the available resources including any potential development needed.<br><br>**R = Relevant**<br>A goal should be relevant to the nature of the issue for improvement.<br><br>**T = Time-related**<br>A goal should specify when a result should be achieved, or targets might slip |