NHS
Oxford Health
NHS Foundation Trust

Patient Safety Incident Response Plan

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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 refreshed Patient Safety Incident Response Plan, 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.

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 influences, internal environment, tools/technology, tasks and persons; further details about this model 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 is 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[2] 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 Duty of candour policy for staff to follow and also training. We monitor the requirements through the incident

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

[2] 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.

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 in the next 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. The current incident response plan will be 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, including services such as district nursing, Special Care & Paediatric Dentistry, 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
- Community Health Services, Dentistry and Primary Care 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. This informed our first incident response plan from December 2023 and agreed to make only minor changes 12 months later when reviewed in early 2025.

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 was developed with stakeholders in 2023 and then drafts were extensively consulted on to help prioritise what safety areas we start on in year 1 and continue with until December 2026.

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 was for 12 months but this has evolved and each year to set out our next ambitions. The programme board meets monthly and is made up of senior clinical staff and leaders across the organisation as well as our patient safety partners[3] with lived experiences.

In the development of the original plan from December 2023 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 and quarterly reviews of progress with embedding 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[4])
- 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

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

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

- Themes and learning from quality improvement projects

Regular reports relating to the above safety areas are presented to our Trust Board of Directors and published including learning from patient safety incident reviews 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 enduring 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 netting and putting this in writing as part of consultations
- Missed or delayed diagnosis particularly related to wound care/identifying more complex injuries

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 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 regardless of whether a specific learning response is initiated, 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 a peer support approach to recognise and support when trauma is experienced, the approach is called Trauma Risk Injury Management (TRiM).

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 area 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 2024 and 2025 with an impact on the safety of care are listed below.

National (both CQUIN[5] framework and national patient safety improvement programmes[6]);

- Assessment and documentation of pressure ulcer risk in community hospital wards
- Assessment, diagnosis and treatment of lower leg wounds in District Nursing
- Mental health inpatient transformation programme
- Embedding the Patient and Carer Race Equality Framework, to address race inequalities in the delivery of healthcare
- National deteriorating patient workstream which aims to improve the reliability of recognition, response and communication, by adopting standardised tools such as NEWS2 (National Early Warning Score)
- The Medicines Safety Improvement Programme to reduce medication-related harm in health care

Local;

- Reducing restrictive practice including use of prone restraint and length of seclusion episodes
- Prevent and reduce suicides for patients open to our services
- Improve the sexual safety of patients and staff on inpatient mental health units
- Pressure Ulcer prevention work/District Nursing improvement plan
- 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 including embedding the national standards from the Triangle of Care where applicable
- 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
- Managing challenging behaviour from patients towards staff (verbal and physical assaults)

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

[6] 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 at NHS England » Patient safety incident response framework and supporting guidance) and the local safety areas/incidents identified in collaboration with key stakeholders. The outcome from every learning review in our response plan is scrutinised and signed off at a senior Trust-wide forum, the learning is shared widely and safety actions developed which are then monitored centrally. Learning themes are fed into and steer new quality improvement projects.

We will also 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 our commissioner.
	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 if there are significant new areas of learning progress to 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. Locally we will complete an incident learning huddle for all unexpected mental health inpatient deaths (not just patients under the Mental Health Act or Mental Capacity Act), followed by a Patient Safety Incident Investigation. The resuscitation team will be involved in the huddle and undertake a further review as needed. (incorporating 2024 local safety area 12) As relevant we link the findings to the national Real Time Surveillance System for inpatient deaths by suspected suicide and the Trust's suicide prevention strategy work.
	4	Mental health-related homicides	Mental Healthcare	Patient Safety Incident Investigation or Mental Health Homicide Review commissioned by NHS England
	5	Domestic abuse related death reviews (previously called domestic homicide reviews)	All	Case record review to identify immediate learning. This will feed into the multi-agency 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. In addition the Trust internally reviews the majority of deaths through an incident learning huddle or similar approach. Where problems in care are identified we may decide to undertake a further learning response to be decided based on the circumstances and how much is already known about the issue(s).
	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 led safeguarding adult review, Child Safeguarding Practice Review or any other review as required.

Category		Patient safety incident or event	Which services does this include?	Anticipated learning response method
	9	Deaths in custody related to health provision commissioned by the NHS and provided by OHFT	Mental Healthcare	Case record review or incident learning huddle to identify immediate learning. We will also participate/support any multi-agency review led by the Prison or Police authorities.
	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	Recognising and responding to a physically deteriorating patient (this includes responding to patients with suspected/confirmed Sepsis (New for 2025)	All	Incident learning huddle or equivalent for identified incidents. If similar areas for improvement are coming through, we won't repeat reviews and instead will focus on safety actions. Consider undertaking an annual thematic review. Link to NEWS2 and Sepsis quality improvement work.
	12	Unexpected death or serious incident for a mental health inpatient	Mental Healthcare	Patient Safety Incident investigation, unless initial review such as the incident learning huddle identified all areas for learning and there are no outstanding concerns/questions from family members.
	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. The theme of family engagement is added as an area to consider in all Patient Safety Incident Investigations and Incident Learning Huddles going forward in 2025 to ensure all learning and the impact of actions can be more effectively evidenced. Link to Carers, Friends and Family Strategy work plan and actions.
	14	Delays in accessing care/treatment (to include patients lost to follow up, significant harm whilst waiting to be seen or deferments of appointments, or difficulties with access to services due to a diagnosis or protracted characteristic)	All	Incident learning huddle or equivalent for identified incidents. If similar areas for improvement are coming through, we won't repeat reviews and instead will focus on safety actions. Consider use of thematic reviews or horizon scanning tool/workshops when clusters of incidents are identified.
	15	An incident of suspected suicide or serious self-harm where we identify issues in relation to risk formulation or safety planning	Mental Healthcare	Incident learning huddle or equivalent. If similar areas for improvement are coming through, we won't repeat reviews and instead will focus on

Category		Patient safety incident or event	Which services does this include?	Anticipated learning response method
				safety actions. Link to internal and external suicide prevention strategy work.
	16	An incident involving ineffective working between teams in OHFT	All	To be defined depending on incident(s). In 2024 this mostly involved the learning response of an incident learning huddles. Link to transformation work happening.
	17	Emergent Issues with significant learning	All	To be defined depending on incident(s). In 2024 the majority of emergent issues identified had a Thematic Review although we will always consider the most appropriate and proportionate response based on what is already known about the issue/concern.
	18	An issue where significant concerns have affected a patient's journey/transitions between different organisations	All	The organisations involved will agree the most appropriate approach to maximise learning. In 2024 the majority of learning responses included an incident learning huddle or Patient Safety Incident Investigation. Consider use of thematic reviews or horizon scanning tool/workshops when clusters of incidents are identified.