



Patient Safety Incident Response Plan

2024-2026

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This document will be reviewed by the policy owner periodically for compliance with policies, standards and any other requirements. Printed copies may be out of date.			
Change History			
Version	Date	Summary of Change	Reviewer
1.0	04/11/2024	New Plan, aligning with Patient Safety Incident Response Framework	Head of Operations Governance & Assurance Manager

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Introduction

This patient safety response plan details how Step One Charity intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Our plan is based on the analysis of themes and trends from all incidents, complaints and concerns, learning and recommendations from Serious Incidents (conducted under the previous framework), mortality reviews, risks and risk registers and feedback from employees, commissioners and patients during the past 24 months.

This plan should be read in conjunction with Step One Patient Safety Incident Response Framework (PSIRF) Policy.

Our Services

Step One provides a range of health and social care services for adults who experience mental health problems and/or neurodiversity. The delivery of these services is split across 7 main sites across Devon, and further provision occurs within local community spaces and individuals own residences.

Most of the services that Step One provides are commissioned. Step One Charity commissioned services are as follows:

- Cypress Hospital – Intensive Inpatient Rehabilitation and Recovery
- Devon Mental Health Alliance (DMHA) Recovery Practitioner Service
- Supported Living
- Community Enabling

NHS England dictates that all providers holding an NHS Standard Contract must adopt PSIRF. Step One holds two NHS Standard Contracts – Cypress Hospital and the DMHA provision. The Supported Living and Community Enabling services Step One provides are commissioned via local authority social care funding. Step One will also be adopting PSIRF for these services to provide a consistent and safe approach to patient safety.

This means that we need to define the term ‘Patient’ due to this not being the common language used to describe individuals using our services.

‘A patient is any individual that Step One provides a service to that is commissioned through Health or Social Care Bodies (Cypress, DMHA, Supported Living and Community Enabling).’

Step One services that are not commissioned will not adopt PSIRF, but instead will manage incidents and near misses according to Step One's Incident Management Policy.

Defining our Patient Safety Incident Profile

Step One has systems and process in place to measure and track the effectiveness of the services we provide, as defined with in our Quality Assurance Framework Policy. Step One has a defined several internal sources that allow for monitoring and reporting on the quality of the services we provide.



To create robust and effective Patient Safety Incident Response Plan, we have analysed the available information that has been collected from these internal sources, as defined in the above diagram. We have looked at 24 months' worth of data to extract key themes to inform our Patient Safety Incident Response Plan (PSIRP).

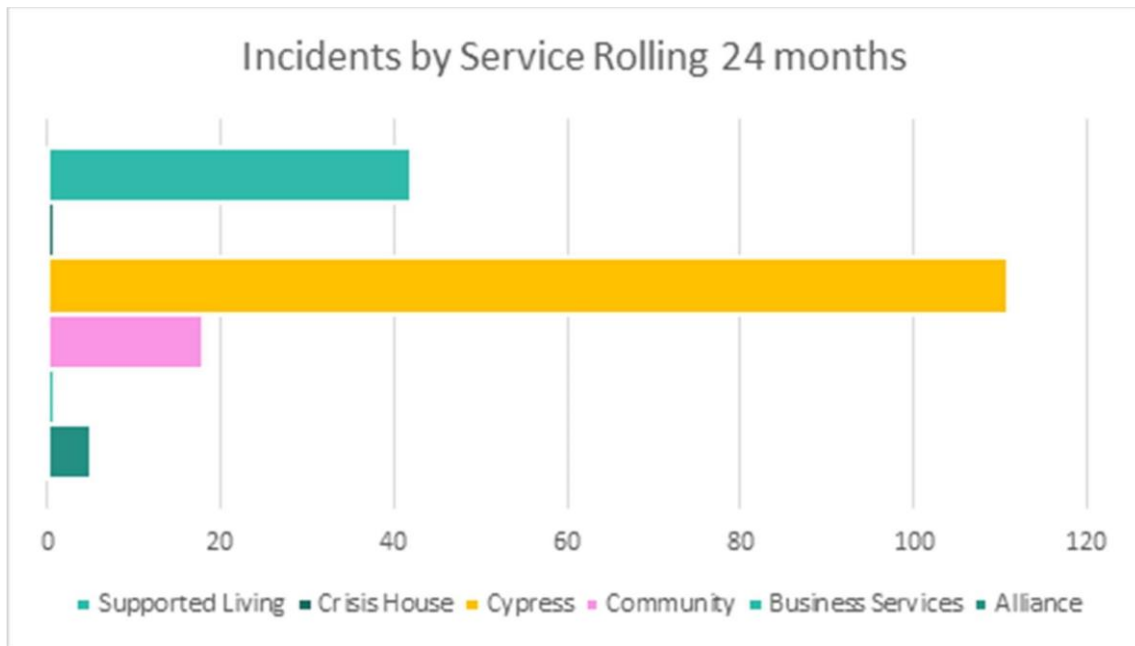
Step One also recognises that external quality monitoring and audits are important when reviewing our patient safety approaches. Step One defines external audits in our Quality Assurance Framework Policy as below.

External audits – external sources of assurance are sought where practical including CQC visits, H&S inspections, Commissioner reviews, accreditations, etc. Step One will engage positively with all external assurers. Recommendations from external assurers are recorded in a central filing system and tracked through to completion.

When creating our PSIRP we have reviewed external reports and audits from the following sources; CQC, Contract Review Meetings, RQR and Serious Incident Reviews.

Defining our Patient Safety Improvement Profile

To define our Patient Safety Improvement Profile, Step One has conducted analysis from the previous 24 months as described above. This analysis was completed via the Patient Safety Management Group to identify the key service improvement focuses over the next 18 months. Analysis has shown several overarching themes that apply to all services within Step One that are adopting PSIRF. These core themes require organisational wide improvement to ensure consistency to patient safety mechanisms in place. Continuing analysis highlights the need for a breakdown of themes across different services.



When accessing our incident data, it is important to recognise the difference between the number of incidents reported per service. For example, compared to other services, the Alliance reporting rate is very low – only 4 incidents reported over 2 years. We have identified that there is a need to improve and streamline our incident reporting processes and increase our reporting culture to fully capture incident and near miss data. This has led to the creation of the Core Improvement theme of Incident Reporting Processes.

Incident Type	DMHA	Business Services	Community	Cypress	Supported Living	Crisis House	Total
Abuse to person	1		3	2	6		12
Access				2	1		3
Accident			4	11	5		20
AWOL				8	1		9
Damage to Property				1			1
Environment			1	6	3		10
Information		1		7			8

Medical Emergency	3		4	3			10
Medication management				45	4	1	50
Self-harm			3	7	10		20
Violence & aggression			2	18	5		25
Total	4	1	17	110	35	1	168

The most common incident type over the past 24 months has been Medication Management, and 90% of these have occurred at Cypress. This has led to the creation of the Cypress Improvement theme of Medication Management. A more detailed dive into the incident data shows that several incidents are due to errors made by pharmacies, and so requires improved feedback systems with these external partners.

For Community Services, the top two most common incidents were accidents and medical emergencies. Of the 8 incidents reported in these categories, 50% involved an existing physical health condition. This has led to the creation of the Community Services Improvement theme of Physical Health.

The above data also contains near misses, although these are not currently separated out from actual incidents. Near misses provide valuable opportunities for learning and will be monitored and reported separately going forward. Although accidents was also a relatively common incident type, the data does not split out workplace accidents involving colleagues and other accidents involving patients. Further analysis of the data shows that 30% of the accidents reported were workplace accidents and were not related to patient safety. This has led to the creation of the Core Improvement theme of Incident Reporting Processes.

We also considered complaints data when defining our patient safety profile. The table below shows that there are 4 complaint types which have been upheld or partially upheld over the past 24 months. These are:

- Communication
- Confidentiality
- Dissatisfaction with service
- Staff conduct

This creates the opportunity for patient safety to be improved through better feedback and experience measures to address concerns earlier on. This has led to the creation of the Core Improvement theme of Feedback/Experience Measures.

Subject	Upheld	Partially upheld	Not upheld	N/A	Total
Communication	1	1	1		3
Confidentiality	1				1
Damage to property			1		1

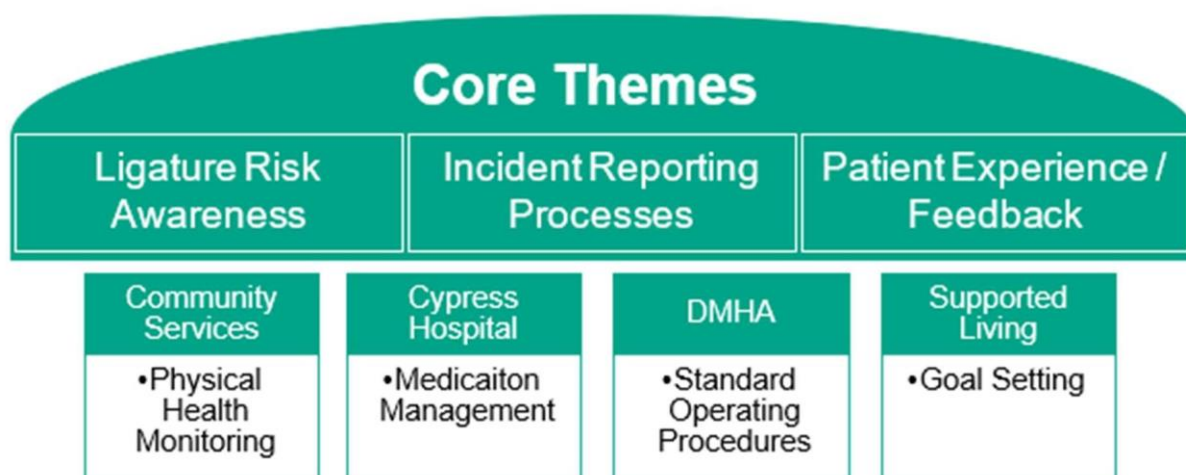
Discharged from waiting list			1		1
Dissatisfaction with service		1	1		2
Incident management			1		1
Staff conduct	1	2			3
Various			1		1
Internal dispute with residents				3	3
Total	3	4	6	3	16

There have been 3 serious incident investigations in the past 24 months. All 3 were unexpected deaths of current or former patients, one from Cypress and two from the Devon Mental Health Alliance. The death of a former Cypress patient was by hanging. Combining this with a recent near miss incident from supported living has led to the identification of the Core Improvement theme of Ligature Risk Awareness.

Following internal investigations of the two Alliance service user deaths, it was identified that clarity was required around the agreed processes to follow. This was also agreed during a Rapid Quality Review, which identified improvement actions for both Step One and Devon Mental Health Alliance. This has led to the identification of the Alliance Improvement theme of Standard Operating Procedures.

Analysis of feedback received during social care reviews and actions arising from a Step One internal audit show that individuals spend more time than anticipated in placements. This creates the opportunity to improve the processes we have in place to support individuals through our services, with a view to maximising their independence. This has led to the identification of the Supported Living Improvement theme of Goal Setting.

The below diagram shows Step One's Core and service specific improvement themes for the next 18-month period. This plan will be reviewed ahead of the start of the financial year 2026 to create an updated plan for the following 12 months. This process will continue in 12 monthly cycles moving forward. It is important to note that this is not a rigid plan that cannot be altered and amended if required. This allows for flexibility to consider improvements as required, for example if a new patient safety issue emerges from an ongoing review or is newly reported.



Step One's Patient Safety Improvement Plan will be monitored through the Patient Safety Management Group and through individual service level governance and assurance monthly meetings. Both these forums report to the Operational Governance and Assurance Committee, with board oversight of the patient safety being achieved through the Quality Improvement and Assurance Committee. This oversight process is reflected within Step One's Governance Structure Diagram.

It is important to recognise that Step One is a partner organisation of the Devon Mental Health Alliance. The Alliance has created internal governance structures to monitor quality and improvement of the services it is providing. Step One will be flexible with its approach and will engage with the Alliance governance process when patient safety concerns arise within this service. It is also important to recognise, that where possible, all Alliance partners providing similar services should be aligning their ways of working for consistency and transparency. This means that when a patient safety improvement response is required, it should be recommended through Alliance governance structures to ensure that consistent approach.

Our Patient Safety Incident Response Plan: National Requirements

Step One will use its resources appropriately to maximise improvement of patient safety within our services. NHS England has set out requirements for certain patient safety incidents, such as deaths or Never Events. Step One supports this National approach and Incidents such as Never Events or deaths will always require a Patient Safety Incident Investigation (PSII) for learning and improvement.

The below table defines the approach that Step One will take when responding to specific Patient Safety Incidents.

Patient safety incident type	Required response	Anticipated improvement route
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Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Patient Safety Incident Investigation	Create local organisational recommendations and actions and feed these into the quality improvement strategy
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Patient Safety Incident Investigation	Create local organisational recommendations and actions and feed these into the quality improvement strategy
Incidents meeting the Never Events criteria 2018, or its replacement.	Patient Safety Incident Investigation	Create local organisational recommendations and actions and feed these into the quality improvement strategy
Mental health-related homicides	Referred to the NHS England Regional	Respond to external recommendations as

	Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	required and feed actions into the quality improvement strategy
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII	Respond to external recommendations as required and feed actions into the quality improvement strategy
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Respond to external recommendations as required and feed actions into the quality improvement strategy

<p>Deaths of persons with learning disabilities</p>	<p>Refer for Learning Disability Mortality Review (LeDeR)</p> <p>Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this</p>	<p>Respond to external recommendations as required and feed actions into the quality improvement strategy</p>
<p>Safeguarding incidents in which:</p> <ul style="list-style-type: none"> • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence 	<p>Refer to local authority safeguarding lead</p> <p>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 boards</p>	<p>Respond to external recommendations as required and feed actions into the quality improvement strategy</p>
<p>Incidents in NHS screening programmes</p>	<p>Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes</p>	<p>Respond to external recommendations as required and feed actions into the quality improvement strategy</p>
<p>Deaths in custody (e.g. police custody, in prison, etc) where health provision is delivered by the NHS</p>	<p>Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations</p> <p>Healthcare organisations must fully support these investigations where required to do so</p>	<p>Respond to external recommendations as required and feed actions into the quality improvement strategy</p>

Domestic homicide	<p>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</p> <p>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</p> <p>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</p>	Respond to external recommendations as required and feed actions into the quality improvement strategy
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Step One has identified 6 colleagues to undertake investigator training and they will undertake a PSIRF leadership role to support the review of incidents and to undertake an investigation response when agreed. When a PSII is required, this will be lead and conducted by an investigator that is not directly responsible for the provision of the service within which the incident occurred. The lead will conduct the investigation with the Governance and Assurance Manager supporting, and oversight from the Head of Operations. Appendix 1 is the Patient Safety Incident Investigation Report form that will be completed by the PSII. This report should be completed using the guidance and information contained within NHS England PSII Report Template.

Our Patient Safety Incident Response Plan: Local Focus

Step One has identified 3 core themes and an individual service specific theme that will be the local focus of our Patient Safety Improvement Plan. The below table reflects Step One's planned approach to responding to our locally identified Patient Safety Improvement themes.

Patient safety incident type	Planned Response	Improvement Routes
Core		

Ligature Risk Awareness	<p>SOP for ligature awareness training to be created.</p> <p>Training to be developed in line with SOC policies.</p> <p>All SOC patient facing staff to be trained.</p> <p>Clearly defined expectations around ligature risk for different services</p>	<p>Clear approach to ligature awareness training across SOC services.</p> <p>All employees fully ligature awareness trained in line with SOC policy.</p>
Incident Reporting Processes	<p>Redefine SOC Incident Management approach outside of Patient Safety Incidents.</p> <p>Review of Incident Management Policy.</p> <p>Improve process for employees to report incidents.</p> <p>Redefine incident classification approach. Encourage increased reporting of near miss incidents.</p>	<p>Introduce more effective incident reporting method.</p> <p>Increased incident data to analyse and form learning responses from.</p>
Patient Experience/Feedback	<p>Introducing PROMs across all services.</p> <p>Alignment of patient experience and feedback</p>	<p>Improved feedback response rates.</p> <p>Increased data available for analysis and forming learning responses.</p>

	<p>measure across SOC services.</p> <p>Define approach for gaining feedback from harder to reach areas of our services.</p> <p>Improved training for employees around application of measures.</p>	
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Cypress

Medication Management	<p>Redefine clerking in medication approach.</p> <p>Introduce additional controls around medication stock checks.</p> <p>Improve feedback route for identified external incidents.</p>	Reduction in Medication related incidents.
Community Services		
Physical Health Monitoring	<p>Improve physical health monitoring.</p> <p>Introduce PROMs to track physical health needs of patients.</p> <p>Increase awareness information and resources available to individuals.</p> <p>More in-depth support planning around individuals specific physical health needs.</p> <p>Improve early identification of when individuals require more specialist physical health services.</p>	<p>Develop an increased awareness for individuals on the impact their physical health has on their mental health and wellbeing.</p> <p>Reduction in physical health related incidents.</p>
Supported Living		
Goal Setting	<p>Imbed GBO as an approach to track and monitor goals of individuals.</p> <p>Give individuals more ownership of their goals and how they want to achieve them.</p>	More frequent move on rates through Supported Living pathway due to increased independence.
	<p>Increase proactive approach to move on, enabling individuals to strive for greater independence.</p> <p>Evidence effectiveness of services to commissioners and external partners.</p>	

Devon Mental Health Alliance

Standard Operating Procedures	Create SOPs for Recovery Practitioner activity. Align SOPs across other Alliance RP service providers. Improved messaging to external partners around service offer.	More consistent approach to service delivery. Reduction in waiting list times.
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Patient safety incidents, their outcome and any subsequent learning will always be used to improve the planning to manage incidents. Step One will be flexible to this and adapt our approach if required.

The process Step One will follow when accessing the required level of response to patient safety incidents is contained within the PSIFR policy. Safety plans developed will be reviewed through the Patient Safety Management Group. All Patient Safety Incident Investigation Reports will be reported to the Board of Trustees, via the Quality Assurance and Improvement Committee. It is important to recognise that incidents relating to ongoing improvement themes may occur. In this scenario, it is important to still be open and transparent in line with Step One's Being Open & Duty of Candour Policy.

Appendix 1

Patient Safety Incident Investigation (PSII) Report

Incident ID Number:	
Date Incident Occurred	
Report Completed By:	
Date Report Completed Report:	
Approved By:	
Date Approved:	

Distribution List

The below table details who this report will be shared with outside of Step One. All PSII reports will be distributed to the Board of Trustees via the Quality Assurance and Improvement Committee.

Name	Position

About Patient Safety Incident Investigations

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving health and social care systems; they do not look to blame individuals. Other organisations and investigation types consider issues

such as criminality, culpability or cause of death. Including blame or trying to determine whether an incident was preventable within an investigation designed for learning can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to provide a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSII's examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care patients receive.

PSII's begin as soon as possible after the incident and are normally completed within three months. This timeframe may be extended with the agreement of those affected, including patients, families, carers and colleagues.

If a PSII finds significant risks that require immediate action to improve patient safety, this action will be taken as soon as possible. Some safety actions for system improvement may not follow until later, according to a safety improvement plan that is based on the findings from several investigations or other learning responses.

The investigation team follow the Step One Being Open & Duty of Candour Policy in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident. Investigators encourage human resources teams to follow the Just Culture guide in the minority of cases when colleagues may be referred to them. PSII's are led by a senior lead investigator who is trained to conduct investigations for learning. The investigators follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

Acknowledgement

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Summary of Key Findings

Summary of Areas for Improvement and Safety Actions

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Background and Context

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Investigation Team

Role	Initials	Job Title, Department
Investigation Oversight		
Investigation Lead		
Investigation Support		

Summary of Investigation Process

Terms of Reference

Information Gathering

Findings

Summary of Findings, Areas for Improvement and Safety Actions

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References

Policy Name	Patient Safety Incident	Response	Owner	HoO
Version	1.0		Signature	ERForeman
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