NHS
James Paget University Hospitals
NHS Foundation Trust

Patient Safety Incident Response Plan

Effective date: 1st September 2023

Estimated review date: 1st March 2025

Interim review: 22nd October 2024 to reflect:

- **change in terminology from 'BAU' to 'Level 4 – Local Review Required'**
- **recent update to ensuring inclusivity section (pg24)**

Endorsed by:

Integrated Care Board 10.08.23 - Hospital Management Board 22.08.23 – Board of Directors 27.10.23

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FOREWORD

Unlike previous frameworks, the Patient Safety Incident Response Framework (PSIRF) is not a tweak or adaptation of what came before. PSIRF is a whole system change to how we think and respond when an incident happens to prevent recurrence. Previous frameworks have described when and how to investigate a serious incident, PSIRF focuses on learning and improvement.

With PSIRF, we are responsible for the entire process, including what to investigate and how. There are no set timescales or external organisations to approve what we do. There are a set of principles that we will work to, but outside of that, it is up to us, which of course can be very scary.

When asked, "Why do we investigate incidents?" the common response is to learn, but what does that mean? Often, we mean 'learning' as understanding what has happened, but it should be much more than that. How often is the answer to what did we do about an incident "We investigated it"? How much has demonstrably changed/improved in 20 years using these methods?

Over the past 12 months, The James Paget University Foundation Trust (hereafter referred to as JPUH) has focused on improving our approach to patient safety incidents, with many examples of learning and involvement; this includes our engagement with key individuals, patients, their loved ones, and our staff to prepare for the transition from the Serious Incident Framework (SIF) to PSIRF. Within this period JPUH have been following a phased implementation approach, which includes our safety culture, with communication supported by education and training.

Essential to this has been fostering a patient safety culture in which people feel safe to talk. Education and training has included psychological safety training with an opportunity to create a group to support the safety culture. We will consider our use of language to support the 'no blame' culture, the reference to a *learning response* rather than an investigation and utilising a *reflection* rather than a statement.

Having conversations with people relating to a patient safety incident can be difficult and we will continue to explore how we can equip and support our colleagues to best hear the voice of those involved. In doing so, we will support our core ambition of working in partnership with patients and their loved ones to enhance safety. In addition, to recognise and support our staff too, when care does not go to plan.

It is important to recognise that there are good reasons to carry out a learning response. Sharing findings, having a conversation with those involved, validating the decisions made in caring for patients and facilitating psychological closure for those involved are all core objectives of a learning response. The challenge for us is to develop an approach to learning responses that facilitates thematic insights to inform ongoing improvement. Our approach must acknowledge the importance of our safety culture and what it feels like to be involved in a patient safety incident.

We recognise that changing culture is complex and we are passionate about being an organisation that lives and breathes a safety culture in which people feel safe to speak. PSIRF is a core component in continuing this journey, ensuring we create a psychologically safe culture, where people are confident to talk about patient safety events and to simply express their opinion.

September 1st, 2023, is only the beginning of our transition we will continue to learn as we progress.

We may not get it all right at the beginning, but we will monitor the impact and effectiveness of implementing PSIRF; we will talk, respond, and adapt as and when our approach is not achieving what we set out to achieve.

OUR INTRODUCTION TO OUR PATIENT SAFETY INCIDENT RESPONSE PLAN

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework. This document is the Patient Safety Incident Response Plan (PSIRP). It describes what we have achieved at JPUH to prepare for "go live" with PSIRF, and what comes next.

The Serious Incident Framework provided structure and guidance on how to identify report and investigate an incident resulting in severe harm or death. 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 through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer "investigations," but to do them better. Better means taking the time to conduct systems-based learning responses using the System Engineering Initiative for Patient Safety (SEIPS) framework by people that have been trained to do them. This plan and associate policies and guidelines will describe how it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation. Carrying out learning responses for the right reasons can and does identify learning. Removal of the serious incident process does not mean, "do nothing", it means respond in the right way depending on the type of incidents and associated factors.

A risk to successfully implementing PSIRF is continuing to investigate (learn) and review incidents as we did before, but simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from the other patient safety insights. PSIRF recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents. Part of which the fostering of a psychologically safe culture is shown in our leaders, our trust-wide strategy, and our reporting systems. We have developed our understanding and insights over the past 12 months, including regular discussions and engagement through our committees and groups.

Most recently, in July 2023, the Patient Safety & Quality Committee and the Patient Safety & Effectiveness Committee received the PSIRP for noting and comments both supported the thematic analysis and patient safety priorities that informs our patient safety priorities for PSIRF. This plan provides the headlines and description of how PSIRF will be apply in principle.

This patient safety incident response plan sets out how the JPUH intends to respond to patient safety incidents over a period of 12 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

The plan is underpinned by our trust policies on incident reporting and investigation available to all staff via our organisation's intranet (available to staff only).

* The JPUH is developing a specific PSIRF policy in 2023/24 to provide further clarity for staff on pathways for escalation, methods of review, safety action development, safety improvement plans, and monitoring improvement. This patient safety incident response plan sets out how we intend to respond to patient safety incidents over a period of 12 months. A glossary of terms used can be found at Appendix B.

OUR SERVICES INCLUDING OUR SCOPE OF PSIRF AND ALIGNMENT TO OUR STRATEGIC AMBITIONS

James Paget University Hospitals NHS Foundation Trust provides care to 250,000 people living in Great Yarmouth and Waveney, from our main hospital site in Gorleston, the nearby Newberry Clinic and other outreach clinics in the local area. In addition, to a recently supported inpatient area within the Carlton Court Hospital, which is managed by the Norfolk and Suffolk NHS Foundation Trust, James Paget Hospital has occupied three bungalows, Foxglove, Fernwood and Sweetbriar, within the Hospital.

Our hospital provides a full range of general acute services plus a number of specialised services; including a hyperbaric chamber for ventilating and monitoring critically ill patients whilst they are receiving hyperbaric oxygen therapy. The Trust has approximately 500 inpatient beds. These are a mix of critical, intensive and high dependency care, general surgery and medicine, maternity, paediatrics and neonatal, and escalation beds. We employ over 4,000 staff, both part and full time, making us the largest employer in the local area.

We play a significant role in the fabric of the local community, not only as a much-loved NHS Trust committed to providing compassionate, high-quality care, but as an institution within our area. We are a respected clinical educator and trainer that nurtures and develops its staff, both from local and international populations. Our Trust is on a journey to developing a New Hospital on its current estate, which will provide modern health and care services to meet the needs of the communities it serves for the future.

Our Trust works with a range of local partners to ensure we meet the needs of our population holistically, beyond the clinical treatment and support our hospital staff provide.

We work closely with our fellow hospitals and NHS Trusts in Norfolk and Waveney, General Practitioners (GP) and clinical teams in Primary Care Networks, community and mental health services, local government, independent providers and voluntary, community and social enterprise organisations to meet the evolving needs of our patients. Much of this collaborative working takes place directly with patients in our care, delivered through longstanding, integrated services that support the needs of people with joint health and care needs. The James Paget is a member of the Norfolk and Waveney Integrated Care System, which brings together a wide range of partner organisations that work together to transform local services, with input from staff, patients, families and carers, with an overarching aim of helping people lead longer, healthier and happier lives.

Further information about our organisation can be found on the JPUH website

There are many ways to respond to an incident or event. This document covers responses conducted solely for the purpose of systems-based learning and improvement. There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, Human Resources matters, legal claims, or inquests. This plan explains the scope for systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which is explained later within this document.

THERE ARE FOUR STRATEGIC AIMS OF PSIRF UPON WHICH THE PLAN IS BASED.

These strategic aims are aligned to our Trust priorities and ambitions.

Trust Priorities & Ambitions	Caring for our patients	Supporting our people	Collaborating with our partners	Enhancing our performance
PSIRF Strategic Aims	Support the compassionate engagement and involvement of patients, and their families	To provide education to support the use of national learning response tools to uncover contributing	Organisations must work collaboratively, understanding their shared aims of the PSIRF	The goal of the PSIRF is to maximise improvement

DEFINING OUR PATIENT SAFETY INCIDENT PROFILE

The Patient Safety team has engaged with key stakeholders, both internal and external and undertaken a review of data from various sources to arrive at a safety profile. This process has involved identification and specification of the methods used to maximise learning and improvement. This has led to the development of the local focus for our incident responses listed on pages 13 – 14.

The patient safety risk process is a collaborative process. To define the JPUH patient safety risks and responses for 2023/24 the following stakeholders were involved:

- Staff – through the incidents reported on Ulysses/QSAFE incident system and arranged introduction to PSIRF workshops.
- Senior leaders across the divisions – through a series of stakeholder events
- Stakeholder Event which invited and included
  - Clinical leads,
  - Divisional representatives,
  - Healthwatch,
  - Patient Safety Partner,
  - Integrated Care Board, and local providers.

Key leads provided an oversight of Commissioners/Integrated Care Service (ICS) partner organisations – through partnership working with the ICS patient safety and quality leads

The JPUH patient safety risks were identified through the following data sources:

- Analysis of three years of incident data April 2020 to March 2023
- Detailed thematic analysis of incident data 2022/23

We have also considered the feedback and information provided by internal stakeholders and subject matter experts as part of our data collation process. Data and information (both qualitative and quantitative) have therefore been received from the following sources:

- Patient safety incident investigation reports both Root Cause Analysis and Concise reports
- Complaints/Patient Advice and Liaison Service feedback
- Freedom to Speak Up reports.
- Safeguarding reviews
- Claims and Litigation
- Mortality reviews and Structured Judgement Reviews
- Staff Survey results
- Inpatient Survey results
- Coroner's Inquest themes
- Divisional feedback including risks and 'gut feelings'.
- Output of stakeholder event discussions
- Themes from the Learning from deaths reviews,
- Pharmacy/Medicines Safety group review of frequently occurring medication incidents.

Where possible we have considered whether any elements of the data point towards 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.

SAFETY ISSUES HIGHLIGHTED BY THE DATA

All 21,000 incidents reported within the timeframe considered (2020 to 2023) were reviewed within categories. Following the revision, 13 emerging categories were highlighted as below.

Category	Descriptor
Falls	All incidents where a patient fell, tripped or slipped on Trust premises
Hospital Acquired Pressure Injuries	All pressure injuries sustained in Hospital.
Infection Prevention & Control	All incidents related to Infection Prevention & Control including hospital-acquired infections i.e. patients who have received a surgical site infection.
Medicine Management	All incidents whereby medicine management involved including anticoagulants, critical medications including insulin, controlled drugs, and patient controlled analgesia (PCA).
Deterioration in patient's health with consideration of both physical and psychological wellbeing.	All incidents whereby it was recognised that a patient un-expectantly deteriorated within our care, where there was omission of care or delay in mobility or escalation. Including patients waiting for diagnostics and treatment. This includes patients with a diagnosis of diabetes. Management of chest drains Postpartum Haemorrhage (PPH) >1500mls Post procedure/surgery complications
Hospital acquired thrombosis	All incidents whereby patients were diagnosed with a thrombosis both pulmonary and deep vein.
Blood Transfusion	All incidents that involved the transfusion of blood
Medical Devices/Equipment	All incidents that involved medical devices or equipment including those that was not available, not used correctly, faulty or missing.
Communication breakdown	Communication within teams/multiple specialities/multiple moves/transfer Handovers including delays in ambulance handovers.
Patient Flow – Discharge delay/Readmissions/Admissions/	All incidents involved within discharge/readmissions process. Including those patients awaiting transfer out of hospital units such as theatre recovery/Intensive Care Unit/ Emergency Department.
Pathways of surveillance/Admission delay/Appointment delay/Diagnostics/results	All incidents whereby patients have received a delay in care having an impact on their wellbeing, including missed or delayed diagnosis.
Mental Health Care including adolescents	All incidents whereby those patients receiving acute mental health care within the hospital.
Violence & Aggression	All incidents where violence and aggression has been witnessed or experienced by patients, staff and others.

SITUATIONAL ANALYSIS OF OUR PATIENT SAFETY ACTIVITY

Following the review of both qualitative and quantitative data for the above themes, it is evident that if we focus purely on numbers, both pressure injuries and falls sustained by patients in our care are our top incident types. It is recognised that there are both national and local improvement programmes in place to support the reduction in both harm levels and the reduction in number of incidents for both falls and pressure injuries.

We acknowledge that pressure injuries have increased by 100% in the past year within the Trust and therefore require a dedicated focus. Quality work-streams currently support staff to learn from both falls and pressure injuries within the Trust, it is recognised that the current quality work-streams may require further strengthening, with an emphasis on the multi professional approach. Both falls and pressure injuries have been allocated to a level three improvement response due to both local and national improvement programmes in place.

During the review of the data, we focused on the 21,000 incidents highlighting themes especially those themes that have increased each year, with a priority for those themes that had an overall increase in year three, from this data the deteriorating patient theme stood out from all other themes. Deteriorating patient not surprisingly is a theme seen over all three years, with a continued increase in the number of incidents reported by staff, in addition, to cases highlighted by the coroner, with the repeated cases seen due to mismanagement of chest drains, insulin, and anticoagulants, especially seen over the past year.

Our aim is to provide a safe environment for all of our patients that we care for, with recognition that we can all learn from the deteriorating patient cases, especially those where the clinical assessment was delayed or/and timely recognition of deterioration was not escalated appropriately. This learning can be far reaching across the Trust, as the deteriorating patient includes newborns, children, and adults.

As part of our patient safety improvement, we will focus on the deteriorating patient quality improvement work-stream. Ensuring that we have an executive responsible officer, a dedicated multi-professional leadership team who are responsible for the leadership of the improvements; this will include medical, nursing, operational, and allied health professional leads, supported by quality improvement leads, dedicated project management, data analysts, and administration support. The deteriorating patient quality improvement work stream will also include key members such as specialist support from areas such as pharmacy, diabetes and critical care outreach, who can provide a specialist advisory role; the improvement work-stream will contain improvement subgroups, to support the overall work-stream, this will include themes such as the management of chest drains, insulin and anticoagulants.

We will learn from our deteriorating patient improvement work-stream, taking that learning through to the other quality improvement work-streams.

DEFINING OUR PATIENT SAFETY IMPROVEMENT PLAN

Over a number of years, the Trust has developed its governance processes to ensure it gains insight from patient safety incidents and this feeds into quality improvement activity. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.

The quality Improvement work-streams will initially feed into a newly formed Patient Safety Improvement Group of which will report into the Hospital Management Group reporting into Patient Safety & Quality Committee this will provide assurance that quality improvement measures, including any safety improvement plans in use currently, or which require development and implementation in the future, continue to be of the highest standard. The Patient Safety Improvement Group will be responsible for the oversight of this quality improvement work including the robust use of quality improvement methodology.

Divisions are required to report to our Patient Safety Improvement Group in order to monitor and measure improvement activity across the organisation. This group will also provide assurance during the development of new safety improvement plans following reviews undertaken within PSIRF to ensure they have followed robust processes during development, fulfil specific, measurable, achievable, relevant, and time-bound (SMART) requirements, and are sufficient to allow the Trust to improve patient safety in the future.

We have drawn a listing of improvement work currently underway within the Trust. This can be found at Appendix C & D. Not all categories we have identified within our Trust incident profile have an impact on patient safety and therefore may not have an associated work-stream alongside.

We will focus on strengthening our current quality work-streams to provide an inclusive multi professional leadership team, of which will include specialist advisors, dedicated project management and administration support. It is imperative that the transition of PSIRF is recognised as a Trust transformational programme.

We plan to focus our efforts going forward on the development of safety improvement plans across our most significant incident types, either those within national priorities, or those we have identified locally. We will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: NATIONAL REQUIREMENTS

Given that the Trust has finite resources for patient safety incident response, we intend to use those resources to maximise improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

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, but the Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed.

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

From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 12 PSII reviews where national requirements have been met per annum.

			Event	Approach	Improvement
Patient Safety Event Occurs	Patient Safety Incident Investigation	National Priorities	Maternity and neonatal incidents meeting HSIB and Special Healthcare Authority referral criteria	Work with partners to ensure cases are referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency/organisation as required.
			Child death	Refer for Child Death Overview Panel (CDOP) and liaise with panel as locally led PSII may be required	
			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: 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	Refer to local authority safeguarding lead via JPUH Safeguarding Team Safeguarding will contribute to domestic independent inquiries, joint targeted area	

			receipt of care and support needs from their local authority. The incident relates to Female Genital Mutilation, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.	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	
			Domestic homicide	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.	
			Incidents in screening programmes	Work with partners to ensure cases are referred to Public Health England (PHE)	
			Death of patients in custody/prison/probation	Refer to Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC)	
			Mental health-related homicides	Refer to the NHS England Regional Independent Investigation Team for consideration for an independent PSII, locally led PSII may be required	
			Patient Safety incidents meeting the Never Event criteria 2018 or its replacement	Patient Safety Incident Investigation	Create local organisational recommendations and actions and feed these into the quality improvement plan
			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		

OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL FOCUS

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety insights, based on the review of incidents, engagement meetings and workshops, we have determined that the Trust requires the main patient safety priorities of the deteriorating patient as local focus.

This draft plan has been shared for comment at the Hospital Management Group meeting on July 25th, 2023, returning with a final plan on the 22nd August 2023. Taken to Patient Safety & Quality Committee 15th September 2023 and endorsed by the Trust Board on October 27th 2023; the plan has been formally presented to the Integrated Care Board (ICB) August 10th, 2023.

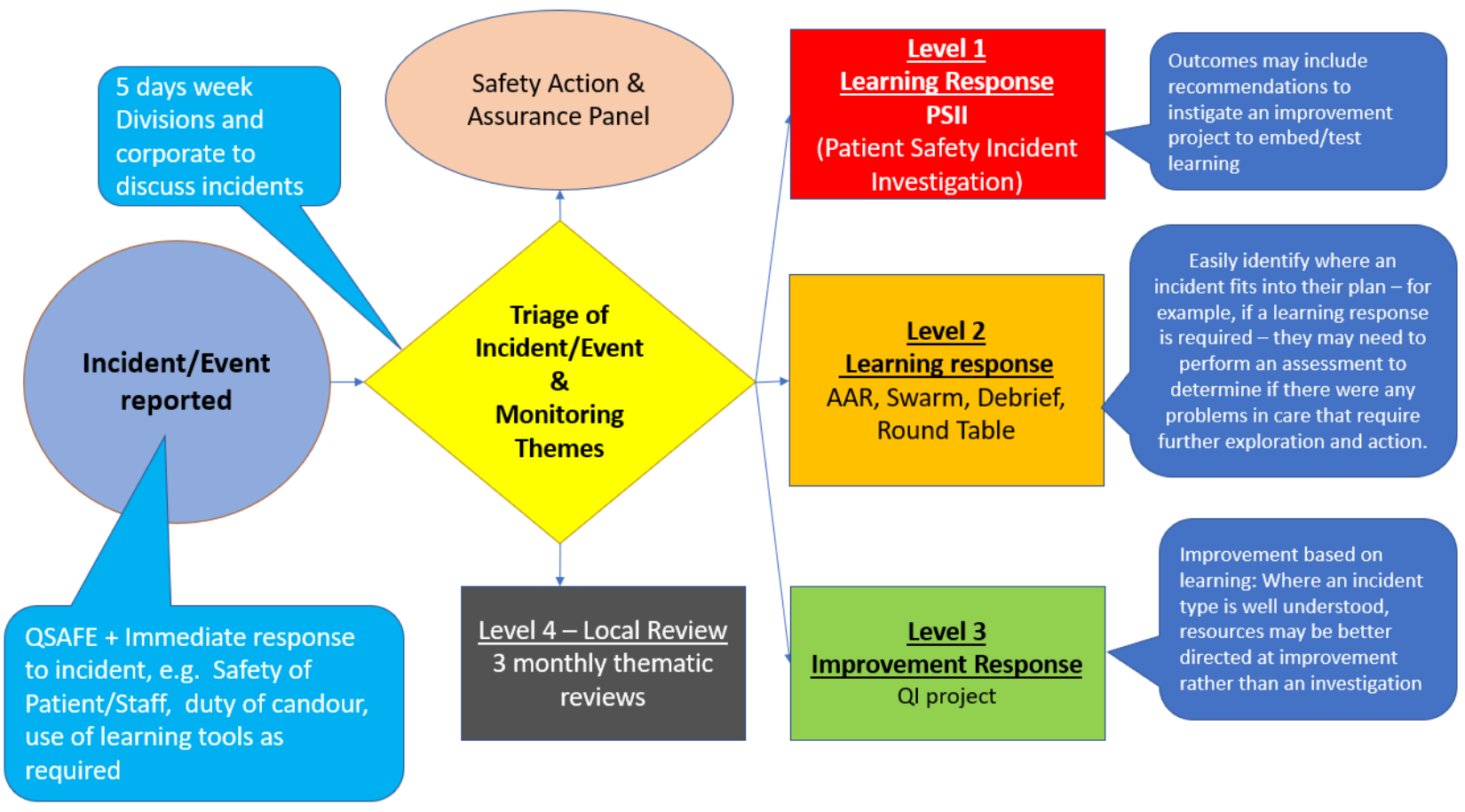
			Event	Approach	Improvement
Patient Safety Event Occurs	Patient Safety Incident Investigation	Trust priorities Level one learning response (Red cases)	Patient Safety Priority Index Case types meeting identified features a heading of: Deteriorating patient • Any patient that deteriorates whereby the clinical assessment was delayed or/and timely recognition of deterioration was not escalated appropriately. • Any patient that deteriorates due to insulin mismanagement. • Any patient that deteriorates due to anticoagulation mismanagement • Any emergent area of risk National Profile • Patient Safety incidents meeting the Never Event criteria 2018 or its replacement Patient Safety incidents resulting in death where the death is thought more likely than not to be due to problems in care	Patient Safety Incident Investigation where agreed	Create local organisational recommendations and actions and feed these into the Deteriorating Patient Quality Improvement Work-stream
	Learning Response	Local Level Two Learning Response Amber Cases	• Any adverse event with a chest drain involved. • All patients who have a postpartum haemorrhage of >1500ml • Any adverse event whereby a patient requires escalation of care due to a post-operative/treatment/procedure complication.	Divisionally led statutory duty of candour with an After Action Review (AAR) including a learning response timeline	

	Learning Response		• Error in prescribing or administration of critical medications or controlled drugs resulting in harm to the patient. • Communication breakdown involving patients who have more than one specialty involved in their care, resulting in a deterioration of the patient. • Any incident that requires further scoping following triage	Divisionally led statutory duty of candour and appropriate toolkit item such as an After Action Review (AAR)/ multidisciplinary team (MDT) case note review.	Inform thematic analysis of ongoing patient safety risks and use to build a case for a new improvement plan or inform ongoing improvement efforts.
	Learning Response		Patient Access/Discharge • Where a patient has been allocated to an inpatient area and concerns have been raised in relation to the speciality caring for them • Where a patient is readmitted within 24 hours of discharge due to concerns in care arrangements	Divisionally led statutory duty of candour and appropriate toolkit item such as an After Action Review (AAR)/ multidisciplinary team (MDT) case note review.	
	Improvement Response	Local Level Three	• Pressure Injuries (Work-stream) • Falls (Work-stream) • Hospital Acquired Thrombosis (Group) • Surgical Site Infection (Group) • Hydration & Nutrition (Work-stream) • Medicines Safety (Group) • Patient Access/Transfer/Discharge (Work-stream)	Divisionally Led AARs for all falls including other tools as required.	All monitored and reviewed by the relevant quality work-stream, group, feeding into the newly formed Patient Safety Improvement Group

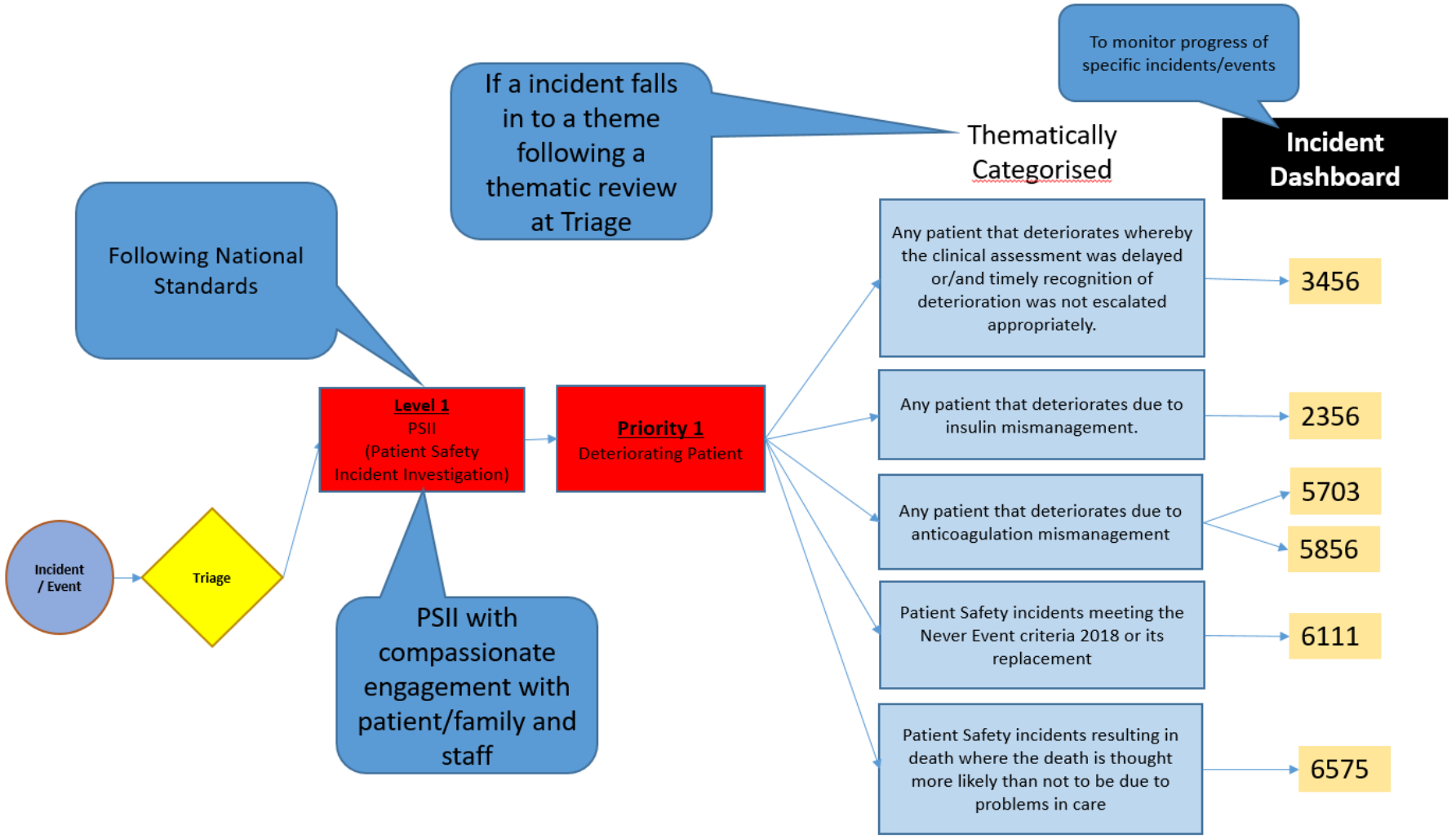
For any incident not meeting the PSII criteria, or any other incident, we will use a specific patient safety review tool to enable a learning response. For lower harm incidents we propose to manage these at a local level with ongoing thematic analysis supported by an inclusive daily clinical triage of the previous days' incidents (initially excluding weekends) via our existing Trust assurance processes which may lead to new or supplement existing improvement work. A three-monthly in person MDT thematic review will be held to support learning and provide assurance led by the corporate team for all no harm, minor harm incidents.

HOW WE WILL RESPOND TO PATIENT SAFETY INCIDENTS

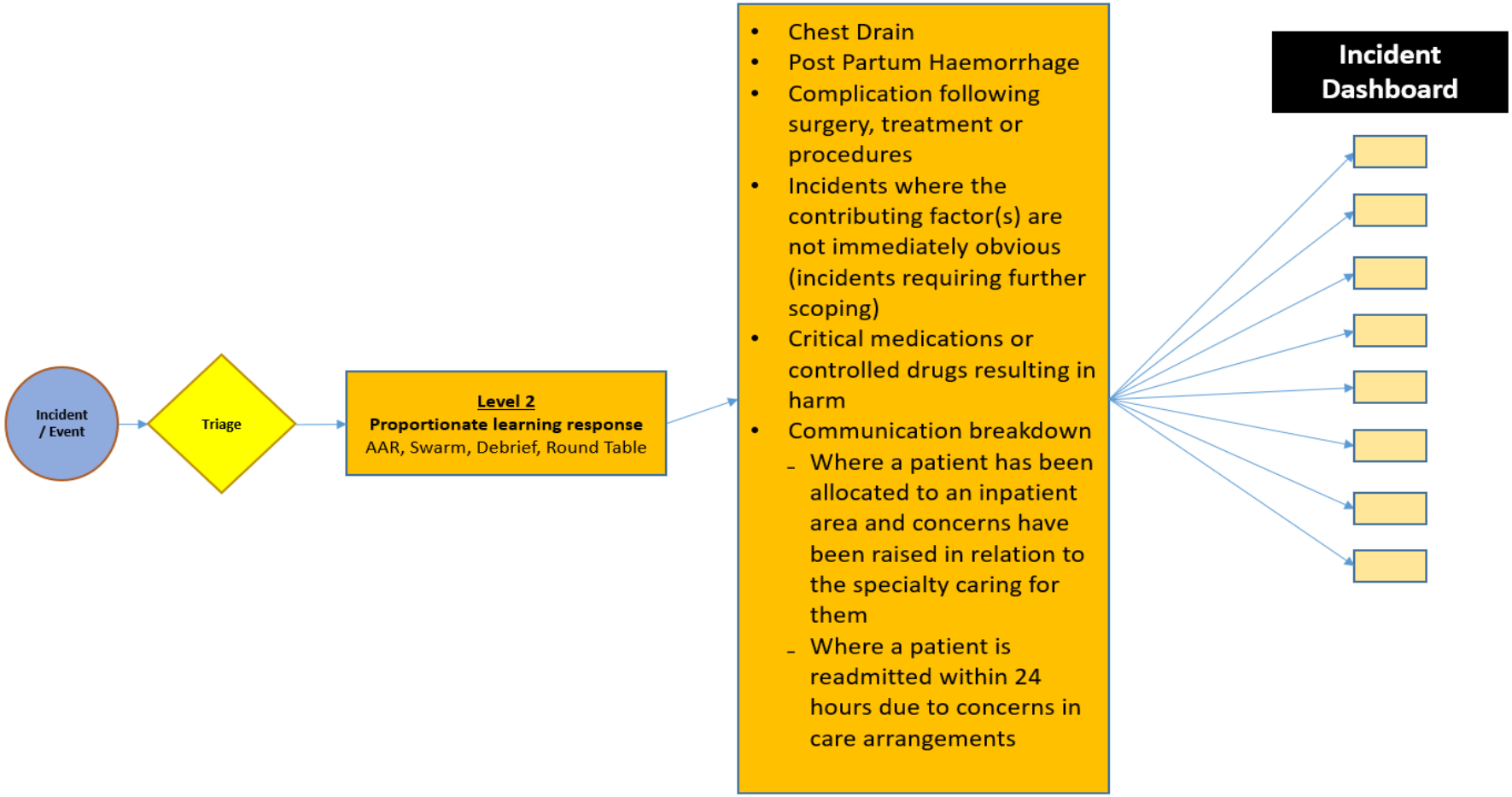
Deciding what to investigate through a Patient safety Incident Investigation (PSII) process will be a flexible approach, informed by the local and national priorities. Our objective is to facilitate an approach that involves decision making through a multi-professional approach to commission investigations and receive findings and recommendations.



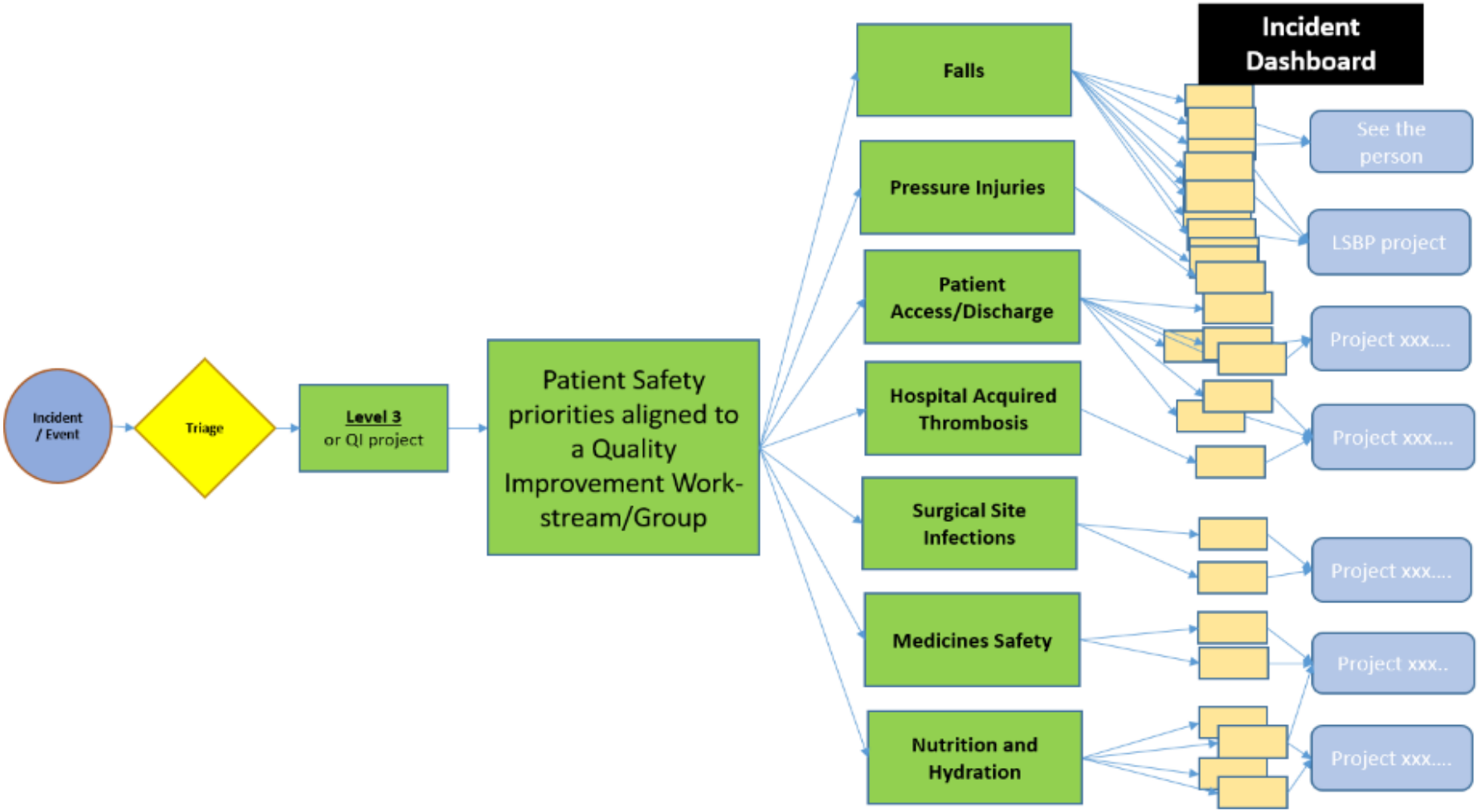
Level 1 – Priority 1 Incidents



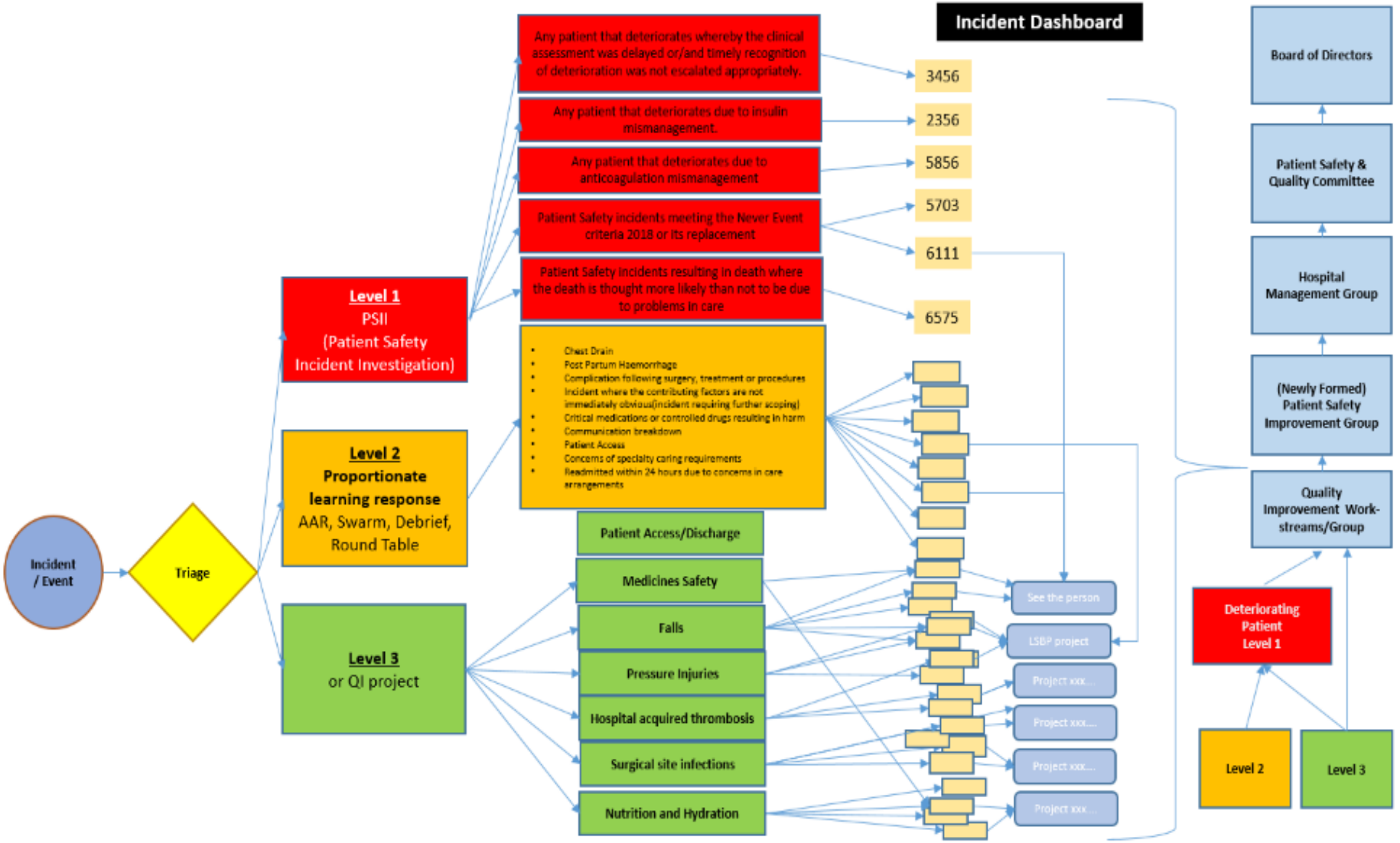
Level 2 – Learning Response



Level 3 – Improvement Response



The Patient Safety Incident Response



At the onset, we will use existing structures to support the process of decision making, although we acknowledge that the structures will require strengthening.

There is an established Monday to Friday daily review of incidents; this daily review will become more inclusive for both clinicians and non-clinicians with inclusion of Divisions early in the process, with an aim to progress to seven days a week. The main aim of the triage will be to filter incidents into our responses as per Level 1, 2 and 3, there is also an opportunity to identify incidents that may require further exploring, or a theme is evolving. In addition, the review of submitted harm caused for incidents stated as moderate/severe harm as statutory Duty of Candour requirements will need to be followed.

Any incident that does not fit into the above levels will be categorised as Level 4 – local review and actioned at a local level. These incidents will also be reviewed thematically every quarter to ensure no learning is lost.

National guidance recommends that 3-6 PSII investigations be conducted per priority per year. When combined with patient safety incident investigations from the national priorities this will likely result in 18-20 investigations per year. National guidance suggests that trained investigators (those who have undertaken national training) conduct 9-10 per year equivalent of a full-time employee. Therefore, as a Trust, two full time investigators are required to meet national expectations, there is currently a restructuring programme taking place to enable the shortfall.

Patient Safety incidents that MUST be investigated under PSIRF:

Any incident that fits the Never Event criteria	Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.	National priorities for investigations (at the time of developing this plan, there are none apart from those already listed above; any new priorities will be included as they emerge).

Patient safety incidents are events where a patient has or could have experienced physical and/or psychological harm or hurt because of healthcare activity. An incident indicates that something is wrong with our systems and processes whether actual harm occurred or not. Therefore, it is important to look at all incidents regardless of harm.

As we transition into PSIRF, the Divisional governance teams will work collaboratively to support the responses required. In PSIRF the approach of greater than or equal to severe harm will no longer apply, the national and our local patient safety priorities will guide us.

The process will be described in detail in associated policies, particularly in new policies that describe Patient Safety Incident Responses and involving patients and staff in discussions about incidents, learning, and improvement.

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 Level 1 priorities
- 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.

Incidents that meet the statutory Duty of Candour thresholds. There is no legal duty to investigate a patient safety incident. Once an incident that meets the statutory Duty of Candour threshold has been identified, the legal duty as described in Care Quality Commission (CQC) Regulation 20 says we must;

Step 1: The person/people involved (including family where appropriate) that a safety incident has taken place.	**Step 2:** Apologise for what has happened.	**Step 3:** Provide a true account of what happened, explaining whatever you know at that point.
Step 4: Explain what else you are going to do to understand events. For example, review the facts and develop a brief timeline of events.	**Step 5:** Follow up by providing this information and the apology in writing, and providing an update. For example, talking to them about what happened and what we have learned.	**Step 6:** Keep a secure written record of all meetings and communications.

Patient safety incidents that have resulted in moderate/severe harm. These incidents would likely have been classed as a serious incident under the Serious Incident Framework. It is crucial that these incidents are not routinely investigated using the PSII process, otherwise we will be recreating the Serious Incident Framework.

The routine response to an incident that results in moderate/severe harm and meets the criteria will be to follow the statutory Duty of Candour requirements and undertake a Patient Safety Review. This will provide insights to thematic learning and provide information about the events to share with those involve

PATIENT SAFETY INCIDENT INVESTIGATIONS

Patient safety investigations are conducted to identify the circumstances and systemic, interconnected causal factors that result in patient safety incidents.

Investigations analyse the system in which we work by collecting and analysing evidence to identify systems-based contributory factors. We will no longer search for a single root cause as per the previous Root Cause Analysis (RCA) previously conducted, we will look at the different events that occurred leading up to the incident and analyse the possible causes. This supports us in looking at the system and not the people as individuals who work in it, supporting our just culture.

Safety recommendations are created from this evidence-based analysis, to target systems based improvement.

The Trust will conduct PSII using the Systems Engineering Initiative for Patient Safety (SEIPS) Model to explore care system interactions and outcomes. This approach includes a detailed investigation of the tools and technology used, tasks undertaken and the factors that influence the patient and staff involved. It also explores the internal and external factors affecting systems and processes and how the work has been organised.

During 2022, the Patient Safety Incident Investigator has completed Level 3 award (bronze) in safety investigation as provided by Healthcare Services Investigation Branch (HSIB).

This training includes the SEIPS Model, additional training has been received, including all the training as recommended by HSIB, this includes:

- A systems approach to learning from Patient Safety incidents - Oversight Training
- A systems approach to learning from Patient Safety incidents PSIRF methodology
- Involving patients, families and staff in patient safety incidents
- Investigative Interviewing
- Strategic Decision Makers - James Paget University Hospital
- After Action Review (AAR) training
- Psychological Safety training

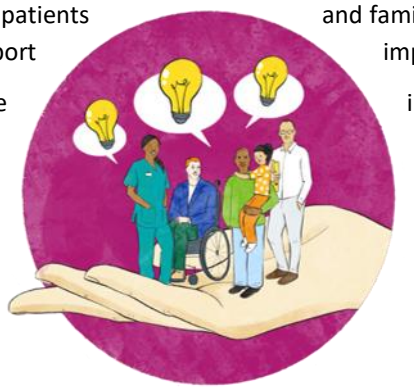
During 2023:

- 30 staff attended three days formal PSIRF training as commissioned by NHS England and Improvement (NHSE/I) this includes involving patients, families, and staff in patient safety incidents these staff are recognised to support as engagement leads with patients and families.
- 22 executive and senior leaders attended Strategic Decision Makers oversight training
- 8 staff attended Psychological Safety train-the-trainer training to support a Psychological Safety Group
- 36 staff have attended After Action Review (AAR) conductor training. AAR is an important patient safety review methodology that the Trust will be using to review incidents at a local level. AAR is a structured, facilitated discussion of an event, whereby individuals involved in the event gain an understanding of why the outcome differed from that expected and identify the personal learning to assist improvement. AAR generates insight from the various perspectives of the multidisciplinary team (MDT) and can be used to discuss both positive outcomes as well as incidents. A further eight staff will undergo AAR conductor train-the-trainer sessions supporting the rollout across the Trust.
- ELearning Patient Safety 1 & 2 available to staff to access.

2024: 100 additional After Action Review conductors will be trained by in-house trainers

PATIENTS, FAMILIES AND CARERS FOLLOWING INCIDENTS

We recognise the significant impact patient safety incidents can have on patients, their families, and carers. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.



We recognise that we have improvements to make to support patients and families; early learning demonstrates that we need to be timelier with our responses when care does not go to plan.

We need to acknowledge events that have an impact on families and staff these events may not be recognised as incidents but may cause hurt to both families and staff.

<u>There are nine engagement principles that we will follow to support involvement:</u>

Apologies are meaningful	The approach is individualised	Timing is sensitive
Guidance and clarity provided	Those affected are heard	Approach is collaborative and open
Subjectivity is accepted	Treated with respect and compassion	Strive for equity

APPENDIX A - CREATING THE RIGHT FOUNDATIONS FOR OUR STAFF AND PATIENTS

It is imperative that our staff are equipped to support compassionate engagement with colleagues, patients, their families, and carers.

As a Trust, we recognise the foundations:

- **Leadership** – The Trust promotes the development of compassionate and effective leadership supported by dedicated leadership courses.
- **Training and competencies** – Focused training has been provided to support staff; this includes, psychological safety, oversight, PSIRF principles, systems approach to learning from incidents, involving patients, families and staff in patient safety incidents and After Action Review (AAR) training.
- **Support Systems** – Patients, family and staff may require signposting to support when care does not go to plan. A dedicated pathway for patients and families when harm has been caused has been initiated and supported by the Integrated Care Board. There are numerous systems in place to support our staff when care doesn't go to plan, such as a culture that supports 'no blame', an organisational and wellbeing team who will listen and signpost as required, Professional Nurse and Professional Midwifery Advocacy roles, Freedom to Speak Up Guardian support roles, and learning tools that support the personal learning such as after-action review opportunities. Sage and Thyme communication training offered to staff, this training provides the framework to support both patients and staff who may appear distressed.
- **Ensuring Inclusivity** – Engagement and involvement must take into account individual needs, as a Trust we recognise this within our priorities and ambitions. In addition, we recognise the need to reduce health inequalities and to ensure equitable inclusion for all. Our experience of recent (2024) highlights an example of ensuring those loved ones of patients who are detained within His Majesty's Prison Service receive the same communication as for all loved ones. This process of supporting the contacting of detained loved ones will be assisted by the Trust's legal team.
- **Information Resources** – For staff, patients and families affected by a patient safety incident will receive clear information about the purpose of a learning response and what to expect from the process.
- **Processes for seeking and action on feedback** – We will offer opportunities for feedback from our staff, patients and families in relation to engagement following a patient safety incident and their involvement within that response.
- **Processes for managing dissatisfaction** – When expectations are not met by our staff, patients, or families, we will actively listen to provide meaningful, truthful and clear expectations as to why this was not possible.

INVOLVEMENT AND SUPPORT FOR STAFF FOLLOWING INCIDENTS

"But errors are consequences: the leakage that occurs around the edges when you put pressure on a system without taking other factors into account." Sidney Dekker

Patient safety incidents are 'unintended or unexpected events which could have, or did, lead to harm to patients' (NHS, 2017). The patient is the person most directly harmed following an incident, but harm can also occur to others. These include the patient's family, healthcare staff who have cared for the patient, those who investigate the incident, and the organisation where the patient was treated. Staff may experience emotional distress or wellbeing issues as a result of patient safety incidents. They may also sustain moral injury, which is 'the psychological distress which results from actions, or the lack of them, which violate someone's moral or ethical code' (NHS Leadership Academy, 2020).

We are on a journey at the Trust to build a just and restorative culture to ensure that it is a safe and fair place to work, where all staff are encouraged to share their voice whatever their role, to be valued and listened to.

To create a learning culture, whereby staff are encouraged to be empowered, therefore helping us to continually learn, inspire change, innovate and improve.

When an incident is reported:

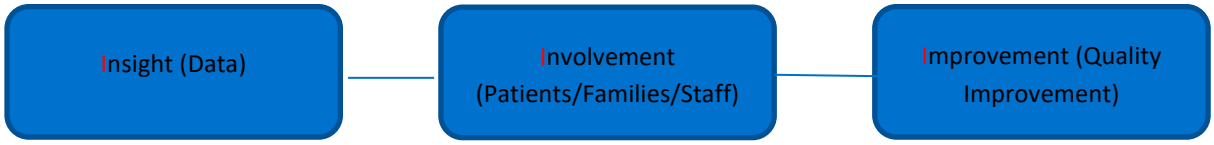
- We will initially respond to all those affected by the incident, ensuring no further hurt or harm is endured.
- We will encourage their perception of events, their insights, their learning.
- We will ensure their voice is heard.
- We will provide a safe environment to discuss and share events that may have led up to the incident.
- We will explore the system in which they work and listen openly without judgement.
- We will ensure staff are enabled to access support both internally and externally.
- We will follow up on our staff and check on their wellbeing.
- We recognise that many staff will be involved with a patient safety incident at some point in their careers and recognise that this can be a traumatic experience; we have a range of psychological wellbeing support for all staff. This includes but not limited to local support from line managers and leaders, the people and culture team, organisational development and wellbeing, Schwartz rounds[1], counselling services, in house legal team to support coroner's inquest attendance, Professional Nurse and Midwifery Advocates.
- We will provide alternative ways to respond to incidents by utilising learning response tools such as after action reviews, a swarm huddle, Multidisciplinary case note review, a hot debrief (as per glossary of terms Appendix A).
- We will change our language to support staff; we will reduce the need for the term 'statements' but use alternatives such as 'reflections'. We will reduce the need for the term 'investigation' although recognise nationally the level one response alludes to patient safety incident investigation, however we will utilise the term 'learning response' rather than investigation for level 2.

MECHANISMS TO SUPPORT EVALUATE AND MONITOR IMPROVEMENTS FOLLOWING PATIENT SAFETY LEARNING RESPONSES.

We will take learning through established work-streams or groups, we recognise these will require strengthening to support the framework required. Findings from investigations and learning responses will be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and investigations. Therefore, safety recommendations will be shared at the newly formed Patient Safety Improvement Group of which agreed plans will feed into the Patient Safety and Quality Committee.

It is recognised that learning takes place with those involved directly with an incident, therefore innovation occurs within that team, it must be acknowledged that their own innovation may not always be transferrable, as ownership may be defined to that learning team, transferable innovation will occur, however we are mindful that it may become diluted.

We will utilise the 3 I's from the National Patient Safety Strategy (2019) to support our ongoing PSIRF programme.



Reports to the relevant groups/committees will include aggregated data on:

- Patient safety incident reporting
- Findings from patient safety incidents
- Audit and review findings
- Progress against PSIRP
- Results from monitoring of improvement and transformation plans
- From an implementation and efficacy point of view
- Results of any surveys and/or feedback from patients/families/carers on their experiences of the organisations response to patient safety incidents

ROLES AND RESPONSIBILITIES

BOARD OF DIRECTORS

The Board of Directors has overall responsibility for patient safety within the Trust.

PATIENT SAFETY AND QUALITY COMMITTEE

The purpose of the Patient Safety and Quality Committee (PSQC) is to support the Board of Directors (Board) by obtaining objective assurance that:

- There are robust processes in place for the effective management of Patient Safety and Quality governance across the Trust that support the organisation to deliver its strategic objectives relating to the provision of high quality care;
- The structures in place to support the governance of Patient Safety and Quality operate effectively and action is taken to address areas of concern

HOSPITAL MANAGEMENT GROUP

The purpose of the Hospital Management Group is:

- Implement the strategic direction set by the Board of Directors within agreed parameters, setting organisational and operational objectives, and maintaining and overseeing associated plans
- Ensure that there is appropriate integration, connection, and liaison between clinical and corporate functions and between strategic and operational matters, both within the Trust and across the ICS
- Support individual directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information, mutual support, resolution of issues and agreement on management priorities
- Make management decisions on issues within the remit of the HMG
- Manage risk that may jeopardise the Trust's ability to deliver its objectives

PATIENT SAFETY IMPROVEMENT GROUP (TO BE FORMED)

The purpose of the Patient Safety Improvement Group is:

- To create an environment open to continuous and sustainable improvement
- Promote a positive safety culture, encouraging staff to gain insight and share learning from good and poor practice.
- Support quality improvement (QI) methodology, ensuring change is consistently measured and evaluated
- Grow QI capability across the Trust so we can continue to improve.

APPENDIX B – GLOSSARY OF TERMS

PSIRF - 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 - 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 co-production approach with the divisions and specialist risk leads supported by analysis of local data.

PSII - 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 effectively and sustainably address those system factors and help deliver safer care for our patients.

Learning response - Any response to a patient safety incident that incorporates a system-based approach to capturing learning to inform safety actions for improvement. This may be a patient safety incident investigation, but other methods can be used such as multidisciplinary team debriefs, huddles and after-action reviews. A final report should be produced for all individual Patient Safety Incident Investigations (PSII)

SEIPS - Systems Engineering Initiative for Patient Safety replaces the contributory factors classification framework. This is made up of six factors or elements that when considered together cover all elements of a 'system.' All the national PSIRF tools are based on SEIPS.

Engagement - Engagement is everything an organisation does to communicate with and involve people affected by a patient safety incident in a learning response. This may include the Duty of Candour notification or discussion, and actively engaging patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened. Compassionate engagement describes an approach that prioritises and respects the needs of people who have been affected by a patient safety incident

Engagement Leads – is anyone who leads on engaging with and involving those affected by a patient safety incident. This may be a person leading a learning response or a family liaison officer (or similar).

Those affected - include staff and families in the broadest sense; that is: the person or patient (the individual) to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred.

Multidisciplinary team (MDT) review - An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.

AAR – 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 - 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.

Hot Debrief - Debriefing is a process of communication that takes place between a team following a clinical case. Debriefing facilitates discussion of individual and team level performance and identifies points of excellence as well as potential errors made. This helps to develop plans to improve subsequent performance. Hot debriefing is a form of debriefing which should occur 'there and then' following a clinical event.

Swarm Huddle - The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.

Thematic Review - A thematic review may be useful for understanding common links, themes or issues within a cluster of investigations, incidents or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety.

Never Event - Patient safety incidents that are considered 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.

2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)

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

S- Specific – a goal should not be too broad but target a specific area for improvement

M- Measurable – a goal should include some indicator of how progress can be shown to have been made

A- Achievable – a goal should be able to be achieved within the available resources including any potential development needed

R- Relevant – a goal should be relevant to the nature of the issue for improvement

T- Time-related – a goal should specify when a result should be achieved or targets might slip

APPENDIX C - JPUH PATIENT/STAFF SAFETY IMPROVEMENT PROGRAMMES TO SUPPORT PRIORITIES

Priority	Theme	Reports into	Existing Work streams Projects 2023/2024	Comments
Red Level 1	**Deteriorating Patient**			
Level 1	Sepsis	Sepsis Group	ICS QI Project (Scoping) – Reducing the no. Of patient being discharged with catheters	
Level 1	NEWS2	Newly formed Deteriorating Patient Quality Improvement Work-stream	CQUIN07 NEWS2	
Level 2	Diabetic Ketoacidosis	Diabetes Governance		
Level 2	Post-Partum Haemorrhage > 1500 mls	Maternity Governance Committee – monthly	Maternity Incident Review & Escalation forum (weekly)	
Level 2	Complications from post-operation/procedure/treatment	Newly formed Deteriorating Patient Quality Improvement Work-stream	CQUIN02 Supporting patients to drink, eat and mobilise (DrEaMing) after surgery	
Level 2	Communication breakdown involving patients who have more than one specialty involved in their care.	Newly Formed Quality Improvement Work-stream		

Priority	Theme	Reports into	Existing Work streams Projects 2023/2024	Comments
Level 2	Chest Drain Management	Respiratory Governance Safer Invasive Procedure Group	Standardising 3 Acutes Theatre Check Lists	
	Medicines Management			
Level 1	Insulin Management	Medicines Management Committee		
Level 1	Anticoagulation Management	Medicines Management Committee		
Level 2	Critical Medications	Medicines Management Committee		
Level 2	Controlled Drugs	Medicines Management Committee	QI: EezyCD measuring rulers for liquid CDs QI: POCDs sealed in clear tamper-proof bags QI: Nursing staff involvement with completion of quarterly CD audits via new Tendable audit QI: Methadone dispensing within pharmacy for named inpatients	
	Patient Access/Discharge.			
Level 2	• Where a patient has been allocated to an inpatient area and concerns have been raised in relation to the speciality caring for them • Where a patient is readmitted within 24 hours of discharge due to concerns in care arrangements	Newly Formed Quality Improvement Work-stream	CQUIN04 Compliance with timed diagnostic pathways for cancer services	

Priority	Theme	Reports into	Existing Work streams Projects 2023/2024	Comments
Level 3	Falls	Quality Improvement Work-stream	Ward 12 QI project LSBP Sticker Ward 12 QI Project LSBP Training Ward 6&7 QI Project (scoping) -Fall, Continence and Enhanced supervision	
Level 3	Pressure Injuries	Quality Improvement Work-stream	CQUIN12 Pressure Ulcers	
Level 3	Hydration & Nutrition	Quality Improvement Work-stream		
Level 3	Infection Prevention & Control			
Level 3	Surgical Site Infections	Surgical Governance		
Level 3	Hospital Acquired Thrombosis	Hospital Acquired Thrombosis Committee		

APPENDIX D JPUH PATIENT/STAFF SAFETY IMPROVEMENT PROGRAMMES TO SUPPORT KEY THEMES

Category	Descriptor	Reports into	Existing Work streams Projects 2023/2024	Comments
Falls	All incidents where a patient fell, tripped or slipped on Trust premises	Patient Safety		

Category	Descriptor	Reports into	Existing Work streams Projects 2023/2024	Comments
Hospital Acquired Pressure Injuries	All pressure injuries sustained in hospital	Patient Safety		
Infection Prevention & Control	All incidents related to Infection Prevention & Control including hospital-acquired infections e.g. patients who have sustained a surgical site infection.	Patient Safety		
Medicine Management	All incidents whereby medicine management involved including anticoagulants, critical medications including insulin, controlled drugs, and patient controlled analgesia (PCA).	Medicines Management Committee		
Deterioration in patient's health with consideration of both physical and psychological wellbeing.	All incidents whereby it was recognised that a patient un-expectantly deteriorated within our care, where there was omission of care or delay in mobility or escalation. Including patients waiting for diagnostics and treatment. This includes: • patients with a diagnosis of diabetes. Management of chest drains • Post-Partum Haemorrhage (PPH) >1500ml • Post procedure/surgery complications	Maternity Governance Committee – monthly	Maternity Incident Review & Escalation forum (weekly)	
Hospital Acquired Thrombosis	All incidents whereby patients were diagnosed with a thrombosis, either both pulmonary and deep vein	Hospital Acquired Thrombosis Group		

Category	Descriptor	Reports into	Existing Work streams Projects 2023/2024	Comments
Blood Transfusion	All incidents that involved the transfusion of blood	Hospital Transfusion Committee	The Hospital Transfusion Team have identified several QI projects and brought them to the attention of the committee, but they need engagement and involvement from Matrons and Consultants. Introduced safe processes that, if followed, would reduce misidentification of patients when taking blood to almost zero. Suggested and supported the introduction of an anaemia pathway for surgical patients to meet NICE quality standard 138(1) and reduce potential unnecessary transfusion by using iron to correct iron deficiency anaemia. Introduced electronic blood tracking system to improve patient safety. Monitoring of Transfusion Practice and addressing issues as and when they arise – currently trying to improve appropriate use of FFP and cryoprecipitate through individual education when error is identified.	

Category	Descriptor	Reports into	Existing Work streams Projects 2023/2024	Comments
Medical Devices/Equipment	All incidents that involved medical devices or equipment including those that was not available, not used correctly, faulty or missing.	Medical Devices Group	Under £5K equipment replacement, to replace lost equipment and obsolete devices, ensuring device availability. • Airbeds • T34 Palliative care syringe drivers • Laerdal emergency suction units • Obs machines • Cardiac monitors • 24hr ECG recorders	
Communication breakdown	Communication within teams/multiple specialities/multiple moves/transfer Handovers including delays in ambulance handovers.	Newly Formed Quality Improvement Work-stream	Ward 12 QI Project - Improving clinical staff conversation and documentation in the correspondence with next-of-kin (NOK)	
Patient Flow – Discharge delay/Readmissions/ Admissions	All incidents involved within discharge/readmissions process. Including those patients awaiting transfer out of hospital units such as theatre recovery/Intensive Care Unit/ Emergency Department.	Newly Formed Quality Improvement Work-stream		
Pathways of surveillance/Admission delay/Appointment delay/Diagnostics/results	All incidents whereby patients have received a delay in care having an impact on their wellbeing, including missed or delayed diagnosis.	TBC	Pre-operative QI project - Improve the identification and management of anaemia and iron deficiency in patients awaiting elective major colorectal and gynaecological surgery.	

Category	Descriptor	Reports into	Existing Work streams Projects 2023/2024	Comments
Mental Health Care including adolescents	All incidents whereby those patients receiving acute mental health care within the hospital.	TBC	Ward 10 QI project- reducing length of stay for children and young people with eating disorders Mental Health Safety Improvement Programme (MHSIP)	
Violence & Aggression	All incidents where violence and aggression has been witnessed or experienced by patients, staff and others	Health & Safety Committee	NHS Violence prevention and reduction standard Scale up reduction of incidence of restrictive practice in I/P MH and LD services Local improvement work-stream - reducing restrictive practice.	

NHS
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NHS Foundation Trust