Tees, Esk and Wear Valleys
NHS Foundation Trust

Patient safety incident response plan

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1. Introduction

1.1. The patient safety incident response framework (PSIRF) is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves us doing the same thing but calling it something different, it is a cultural and system shift in our thinking and response to patient safety incidents and how we work to minimise recurrence. PSIRF enables us to move away from investigating incidents to produce a report to meet specific criteria in a framework, instead, our focus will be patient safety incident responses that will support learning and improvement.

1.2. This patient safety incident response plan (PSIRP) sets out how Tees Esk, and Wear Valleys (TEWV) NHS Foundation Trust will seek to respond to and learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of care we provide over the next 12-18 months.

1.3. This plan is dynamic in that we will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur, including associated learning and the needs of those affected. The plan will also help us measurably improve the efficacy of all our local reviews, as well as patient safety incident investigations (PSIIs) as detailed below in the National and Local priorities sections.

1.4. The plan will be underpinned by a new Patient Safety Incident Response Framework PSRF Policy.

1.5. A glossary of terms used within this document can be found in **Appendix 4**

2. Our services

2.1. Tees, Esk, and Wear Valleys NHS foundation trust (TEWV) was formed in April 2006 and was authorised as a foundation trust on 1 July 2008. From education and prevention to crisis and specialist care our talented and compassionate teams work in partnership with our patients, communities, and partners to help the people of our region feel safe, listened to, understood, believed in, and cared for.

2.2. We provide mental health and learning disability services for the people of County Durham and Darlington, Teesside, North Yorkshire, York, and Selby. Based on April 2022 figures, the unweighted population we serve is 2,120,347.00. We currently have 705 in-patient beds based in 15 hospitals (July 2023). We employ over 7,500 staff who work across more than 90 sites.

2.3. The Trust is commissioned to provide the following services:

- Adult mental health (inpatient and community including mental health crisis, services for the deaf, Psychiatric Intensive Care Units, acute in-patients, Liaison Psychiatry based in acute Trusts, perinatal mental Health Services)
- Mental health services for older people in-patient and community – (including memory clinics)
- Adult learning disability (in-patient and community)
- Adult medium and low secure services (including mental health, learning disability and autism spectrum disorder)
- Rehabilitation services
- In-reach into prisons (North-West, North-East, Hull and Humber)
- North-East immigration removal centre
- Liaison and Diversion services

- Adult eating disorders (in-patient and community)
- Child and Adolescent mental health services for forensics, respite, and community services
- Talking Therapy Services

2.4. A full directory of the services we provide as well as contact details can be located on our **website**. We deliver our services through two Care Groups, which are supported by corporate services. These care groups are:

- Durham, Tees Valley, and Forensics (DTVF)
- North Yorkshire, York, and Selby (NYY&S)

2.5. The trust has a discreet team of experienced serious incident reviewers which sits within the patient safety team. This team is the engine room, working in conjunction with the Care Groups, for monitoring all patient safety events from no harm to catastrophic harm, providing assurance on the quality of incident reporting, correct categorisations, quality, and timeliness of early learning reviews as well as the identification of themes and monitoring of associated actions.

2.6. Everything we do in TEWV is guided by 'Our Journey to Change' and our trust values. Our Journey to Change, sets out where we want to be and how we will get there. It was shaped by Our Big Conversation which involved 2,500 colleagues, service users, families, carers, partners, and our local communities. We are committed to three big goals over the next 5 years, these are to co-create a great experience for our patients, carers, and families, to co-create a great experience for our colleagues and to be a great partner. We are also working hard to embed our values and make sure that everyone, in every role across the organisation demonstrates Respect, Compassion and Responsibility. Our Journey to Change inspires all actions and decisions we make at all levels, all the time! In keeping with Our Journey to Change, we have working towards our 3 goals by ensuring that people using our services, families and carers, staff and partners have been involved in defining our patient safety incident profile and patient safety improvement profile prior to transitioning to PSIRF in January 2024.

3. Defining our Patient Safety Incident Profile

3.1 TEWV has a continuous commitment to learning from patient safety events. We have developed our understanding and insights into patient safety over the last 3 years to help us understand the trusts priorities for 2023/2024. We have engaged with key stakeholders, both internal and external and undertaken a review of data from various sources to define our patient safety incident profile. These sources include findings from external reviews, internal serious incident reviews, structured judgement reviews, inquests, complaints, patient/carer experience, staff surveys, safeguarding reviews, our organisational learning group, our fundamental standards group, the National Confidential Inquiry Suicides Homicides (NCISH) annual report, the Ockenden and Kirkup reviews, media reports from Panaroma (Edenfield) and Dispatches, as well as learning identified through shared forums and collaboratives with other trusts within the North East region.

3.2 We nurture the recovery journey of anyone in need of our help. In our Trust, everyone has a say in how they are supported and treated because we listen to every person in our care until they feel understood. Our patients, their families and carers work together with us towards better mental health and well-being.

3.3 TEWV commenced planning for PSIRF well in advance of the release of documents in August 2022. We consulted with PSIRF early adopters and continue to work closely with our neighbouring NHS Trust.

3.4 National standards related to PSIRF require a different approach to the oversight of patient safety events, with a focus on improved involvement of families, carers, and staff.

3.5 We have taken the following proactive actions to help us transition smoothly to PSIRF:

- In March 2020 we held a conference for families bereaved by suicide. This collaborative approach to incident investigation and associated learning provided us with feedback from families of their experience of being involved in an incident investigation by the Trust. This work enabled us to identify opportunities for improvement. Outcomes included the appointment of a Family Liaison Officer (FLO) and a further deep dive event. The deep dive event took place in July 2021 this resulted in further actions including mapping of the human experience of families and staff to the existing incident process to inform improvement work.

- In January 2021, the trust initiated key improvement work focusing on patient documentation, recognising that high quality documentation is an enabler of high-quality patient care. To monitor compliance with key standards, a Quality Assurance Schedule was developed. The Quality Assurance Schedule was implemented in the Trust from 01 April 2021 and uses 7 different assurance tools across in-patient and community services. Since inception, the tools have been developed to reflect and provide assurance that improvements are being made in relation to overarching themes identified from actionable learning relating to patient safety events.

- From May 2021 to December 2022 preparatory work was undertaken to ensure that effective procedures and processes were in place for identifying and reporting, correctly classifying, reviewing, and managing patient safety incidents, reviewing systems and processes to identify learning, identification of common themes, compliance with the duty of candour and the extent of family involvement following patient safety incidents. Outputs were shared with TEWV staff. Revised templates were devised to help with the transition to PSIRF capturing learning from moderate patient safety related incidents, compliance with the duty of candour and timely responses to early learning and themes. 80 people attended the event. Participants included bereaved families, all grades, and disciplines of clinical/medical/AHP staff, senior members of the board including the chief executive, director of nursing and quality, commissioners, provider collaboratives and representatives from NHSE.

3.6 In July 2022 we undertook a thematic review of 140 patient safety incidents from a 3-year-period across all services and specialities. This review included cases that had been investigated as either a serious incident or a structured case review under the mortality review process. In relation to cases investigated as a serious incident, seven overarching themes were identified. We triangulated this data with learning from mortality reviews, moderate harm incidents, external reviews, and complaints; the overarching themes applied to all learning identified. These themes were as follows:

- Risk assessment, risk management and contingency planning
- Safeguarding
- Medication Management
- Patient, carer, relative involvement
- Multi-agency involvement
- Care planning
- Record keeping

3.7 Each overarching theme was further analysed to help identify local priorities for patient safety and areas of learning (see local priorities)

4. Defining our patient safety improvement plan

4.1 In February 2021 an organisational learning group, chaired by the Director of Quality Governance was established to strengthen and embed the trusts arrangements in relation to responding effectively to learning from a range of sources.

4.2 In 2022 a Strategic Fundamental standards group, chaired by the Chief Nurse, was established. This provides an opportunity for both care groups and corporate services to consider trust-wide learning from patient safety events and how learning can be incorporated into clinical practice, policy, and procedures.

4.3 In October 2022, a listening and engagement exercise related to the Trust's Patient Safety Incident Management (PSIM) pathway was commissioned by the Director of Nursing and Governance and the Director of Quality Assurance. The aim was to identify gaps in the existing PSIM pathway prior to transitioning to PSIRF. Methods for the listening exercise included quantitative and qualitative approaches involving 91 staff, including 7 categories of staff groups, through 3 virtual meetings and 11 face to face focus groups. This was in addition to the provision of an online questionnaire for staff in selected areas who were unable to attend the listening exercise.

4.4 The following overarching issues were identified:

- A cumbersome IT infrastructure which required review to support changes to the PSIM pathway going forward.
- A de-skilled workforce due to centralised PSIM systems and processes.
- A lack of robust training to prepare staff for change.
- A lack of robust governance/response to escalated safety risks.
- A lack of communication and/or opportunities to learn from incidents due to insufficient resources.
- Improved engagement with families was required.

4.5 The following points were identified as key determinants for success:

- A visible, collaborative, executive team with strong leadership from both corporate and care groups to communicate the change programme.
- Programme management resources to support both national and local PSIM changes across the organisation.
- A clearly defined governance structure that would facilitate key implementation roles for a coordinated and effective change management process.
- A well-informed phased implementation plan that reflected the experience of staff closest to the safety issues, supported by ongoing progress updates.
- The engagement and involvement of a wide range of staff and roles to harness their expressed enthusiasm to drive change.
- A positive organisational culture that would support and incentivise staff autonomy to engage in continuous improvement.

4.6 Our Journey to Change set out a five-year strategy that included five areas of focus: Clinical, Quality, Cocreation, People and Infrastructure. As part of this journey, immediate priorities within the Clinical Journey and the Quality Journey were identified. As there were clear interdependencies between the priorities within both Journeys, taking into consideration the key determinant for success, it was agreed that these would be managed under one transformation group, the Advancing Our Clinical, Quality and Safety Journey to Change (AOCQSJ) sub-portfolio Board. The AOCQSJ currently oversees existing structures that are responsible for the delivery of the clinical, quality and safety priorities.

4.7 The Patient Safety Incident Management (PSIM) Board reports into the AOCQSJ. The purpose of the PSIM Programme Board is to be the primary decision-making body for the programme of work to transform patient safety incident management processes in TEWV. This includes the national transformation towards the requirement of the Patient Safety Incident Response Framework. The delivery of the transformation programme involves four projects that are coordinated by two Project Steering Groups, which report into the PSIM Board.

4.8 The four projects are as follows:

- PSIRF- to embed the PSIRF framework and develop a patient safety incident response plan and policy.
- LFPSE – (Learning From Patient Safety Incidents) to switch from NRLS (and later STEIS) to LFPSE and to have a full understanding of the functions within LFPSE and how this can be used to support on-going learning.
- Incident Reporting – to clear the backlog of patient safety incidents to enable a smoother transition to the new PSIRF.
- Risk Management/datix re-procurement – to have a LFPSE compliant risk management system that facilitates the new patient safety events and other risk processes that provides sustained monitoring and reporting.

4.9 The Programme Board has provided direction, resources and support to the Project Steering Groups which will escalate issues, risks, and decisions that they cannot deal with themselves. The two project steering groups are as follows:

- Risk Management System Group
- Policy and Process Group

4.10 Duty of Candour

4.10.1 Further to both internal identification of gaps and weaknesses, findings, and recommendations from external reviews by the Care Quality Commission (December 2021), Niche (March 2023) and AuditOne (April 2023), TEWV recognised there was significant improvement work required to ensure Duty of Candour is fulfilled. Duty of Candour is included in the scope of the Quality Journey. To support the improvement work TEWV commissioned NECS to complete a short Duty of Candour review project from January to April 2023.

4.10.2 The scope of the NECS review project was to:

- Review the Trusts current Duty of Candour policy against best practice and provide a revised draft policy.
- Collate a range of staff understanding and thoughts around the current Duty of Candour process in the Trust through focus group / key staff discussions.
- Analyse the key findings of an AuditOne Serious Incident Duty of Candour Audit.
- Produce a final report including key recommendations.

4.10.3 Recommendations included:

- To develop and implement a revised duty of candour policy.
- Governance and Compliance – to design and implement a robust duty of candour reporting process.
- Improve awareness and understanding.
- Training and development

4.10.4 The policy has been since been revised and further improvement work continues.

4.10.5 Further information about our improvement programmes for 2023/24 can be found in appendix 1.

4.11 Transition to PSIRF

4.11.1 Due to the incremental changes the Trust has made over the last two years we will be able to transition to PSIRF in January 2024. Prior to the transition, several processes have been reviewed and functional flowcharts created to align to other interdependent governance streams such as mortality reviews and the patient safety team processes. Several engagement workshops have been undertaken and webinars are planned to update staff members on how PSIRF will impact on their roles within clinical services. The PSIM group are working alongside comms to ensure that information about the transition is disseminated trust wide. This policy and process group continue to work with clinical services and an away day has already been held with matrons, practice development practitioners and Speciality Development Managers.

4.11.2 In terms of training, the substantive patient safety team, who will be carrying out the PSIIs, have either received bespoke training from a recognised training establishment or have attended the training provided by HSIB. New staff joining the PST will receive training compliant with PSIRF as soon as practicable. A budget has been determined for additional training for clinical staff who will be completing early learning reviews and other tools from the PSIRF toolkit.

4.11.3 From 1st October all PSIIs being commenced will be written on the PSIRF templates. Further discussions will be required with Coroners, as not all incidents will require a full comprehensive Patient Safety Incident Investigation and reports will be presented in a different format. There is a new PSIRF Policy, that will be in place for January 2024.The Trust has ensured that the National Patient Safety Strategy training levels 1 and 2 have been made essential for all staff.

5. Our patient safety incident response plan: national requirements

5.1 Given that the Trust has definable 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.

5.2 Some patient safety incidents, such as Never Events and deaths thought to be 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.

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

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

Patient safety event	Type of Investigation										Who by					Improvement work/ Existing workstreams
See Glossary for terms	PSII	ELR /AAR	External	SJR	LeDeR	Refer to safeguarding	Organisation	PPO/IOPC	CSP	LA	Patient Safety team	Service	NHSE Commission MH homicide review	Safeguarding	DHR Panel	
Deaths of patients detained under the MHA (1983) or where the MCA (2005) applies	✓	✓	✓								✓		✓			ELR/AAR – MDT involvement in services – policy and process group have already started this at an event on ELR/AAR reviewed by policy and process group – development work to continue. Policy and process group meet every month – chaired by Associate Director of Patient Safety
Suicide, self-harm, or assault resulting in the death or long-term severe injury of a person in state care or detained under the MHA	✓	✓									✓	✓				As above
Deaths of Persons with mental illness whose care required case record review as per the Royal College of Psychiatrists' mortality review guidance which have been determined to be more likely than not due to problems in care	✓			✓							✓	✓				

Patient safety event	Type of Investigation										Who by					Improvement work/ Existing workstreams
See Glossary for terms	**PSII**	**ELR /AAR**	**External**	**SJR**	**LeDeR**	**Refer to safeguarding**	**Organisation**	**PPO/IOPC**	**CSP**	**LA**	**Patient Safety team**	**Service**	**NHSE Commission MH homicide review**	**Safeguarding**	**DHR Panel**	
Incidents meeting the Never Events Criteria 2018 (or its replacement)	✓	✓									✓					Environmental risk group
Mental health-related homicide	✓		✓										✓	✓		New process now in place. Homicide reviews are commissioned externally and feed into Organisational learning group
Child Deaths	✓										✓					
Deaths of persons with learning disabilities					✓											Mortality review process now part of PSIRF process.

Patient safety event	Type of Investigation										Who by					Improvement work/ Existing workstreams
See Glossary for terms	PSII	ELR /AAR	External	SJR	LeDeR	Refer to safeguarding	Organisation	PPO/IOPC	CSP	LA	Patient Safety team	Service	NHSE Commission MH homicide review	Safeguarding	DHR Panel	
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 receipt of care and support needs from their local authority the incident relates to FGM, Prevent, modern slavery and human trafficking or domestic abuse/violence		✓								✓				✓		Safeguarding team and meetings internally and external SAB boards.
Incidents in NHS screening programmes							✓									These are incident specific
Deaths in custody (e.g., police custody, in prison, etc) where health provision is delivered by the NHS	✓							✓								Prison specific reviews (PSII's) as well as external clinical reviews and PPO
Domestic homicide									✓							External homicide reviews.

6. Our patient safety incident response plan: local focus

6.1 These themes will have ongoing review, in order to remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights (see appendix 2):

- TEWV is implementing quarterly MDT thematic reviews of serious incident actions. (First meeting was 04/11/23) This meeting consists of Medical Director, Chief Nurse, Director of Therapies, Deputy Chief Nurse, Associate Director of Patient Safety, Associate Director of Quality Governance, Compliance and Quality Data. Complaints and HR. The meeting reviews and establishes thematic information and allocates to specific workstreams or identifies new systemic actionable learning. The ongoing feedback and learning will then be aligned to QA processes, audit etc as identified.
- All workstreams that are identified are monitored through the Organisational Learning Group, Quality Governance, Compliance and Quality Data team and learning is disseminated through the trust 'fundamental Standards group'. As well as all other forums of information sharing, monitoring and scrutiny.

6.2 All moderate and above incidents will be reviewed by the patient safety team huddle in order to ensure oversight and support identification of tools to be used, organisational learning and accurate site level monitoring of incidents. For any incident not meeting the PSII criteria, or any other incident, we will use a specific patient safety review tool to enable a learning response. For lesser harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work. InPhase will allow incidents to be reported thematically and this will be run on a monthly basis through patient safety huddle. Appendix 3 demonstrates the patient safety processes and how learning will be implemented.

Our patient safety incident response plan: local focus

Patient safety Priority	Type of Investigation	Who by															Improvement work required OR within existing work-steams
	PSII	Locally led PSIII	ELR	External Review	SJR	LeDeR	Refer to	Organisational	PPO/IOPC	CSP	LA	Patient Safety team	Service	NHSE Commission MH homicide review	Safeguarding	DHR Panel	
Sexual Safety			✓										✓				Sexual safety meetings that feed into Executive Review of Quality Group i.e., number of incidents – emerging themes
Reducing incidents of Suicide and Self-harm			✓										✓				Preventing suicide and self-harm group chaired by medical Director and suicide prevention leads. This will also feed into wider ICB suicide prevention networks.
Safeguarding including PAMIC and think family.			✓										✓				Reports to Exec review of quality and QuAC.
Physical Health			✓										✓				Physical health meeting and sub groups – reports to Exec review of quality
Reducing Restrictive Interventions			x										x				Positive and Safe Group – reports to Exec review of quality and Quac.
Dual Diagnosis			x								x						Public health – working group and Physical health group
Safe transfers			x														Inpatient review group
Medication Management													x				Drugs and therapeutic's meetings
Falls			x										x				Falls group that works to the physical health group.
Autism			x			x							x				SDM's and Organisational learning group.

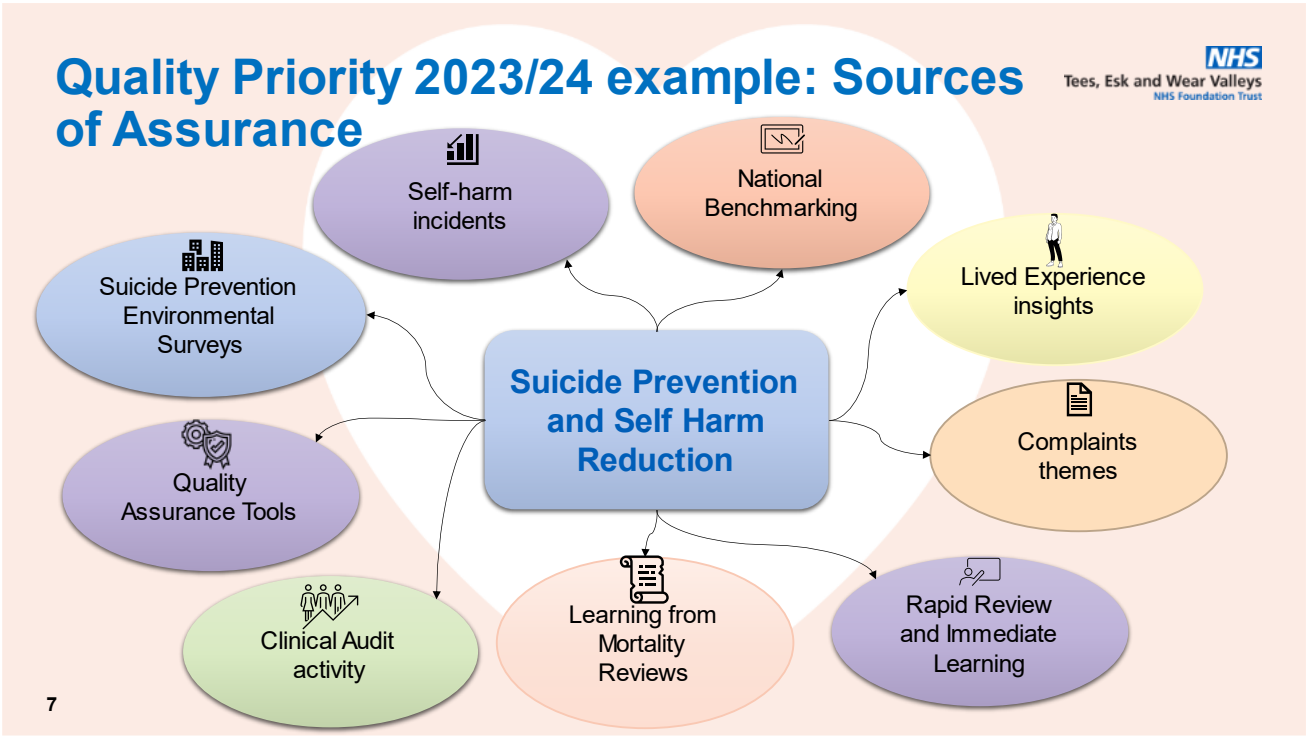
6.3 PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. From the work we have undertaken in defining our Quality Journey and patient safety incident profile TEWV have identified these **10** patient safety priorities as local focus. The priorities identified reflect the various services we provide and the population we serve. This will allow us to apply a systems-based approach to learning from all incidents relating to these priorities, exploring multiple interacting contributory factors within established resources.

Appendix 1 Improvement programmes

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

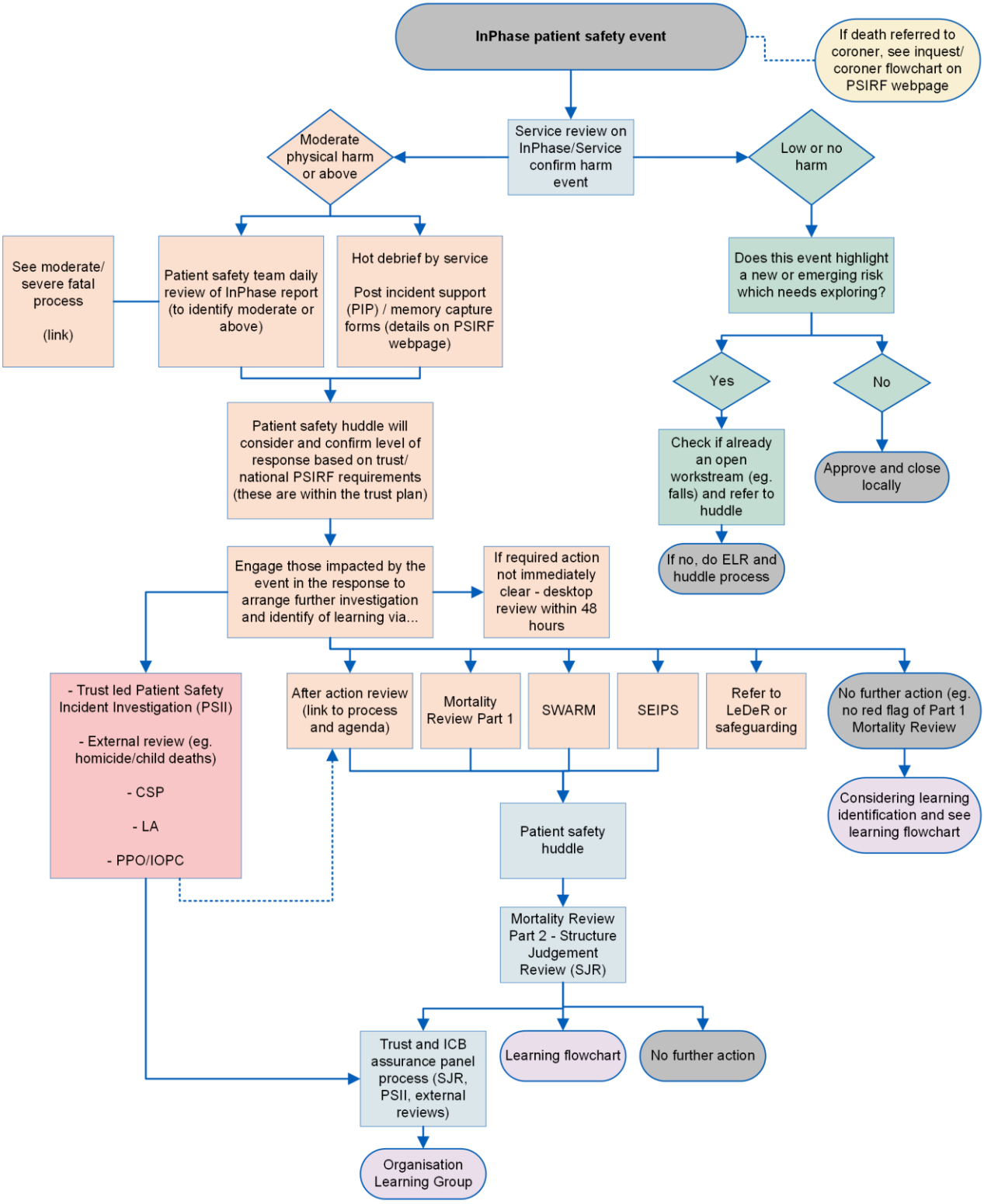
		We are also considering a target of reducing staff sick days that are attributed to suicide related incidents.	
Personalised Care Planning	DIALOG+ full implementation through Cito	To manage the transition to DIALOG+ where all patients will have a Care Plan that is coproduced with them and their carers/family,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

Appendix 2

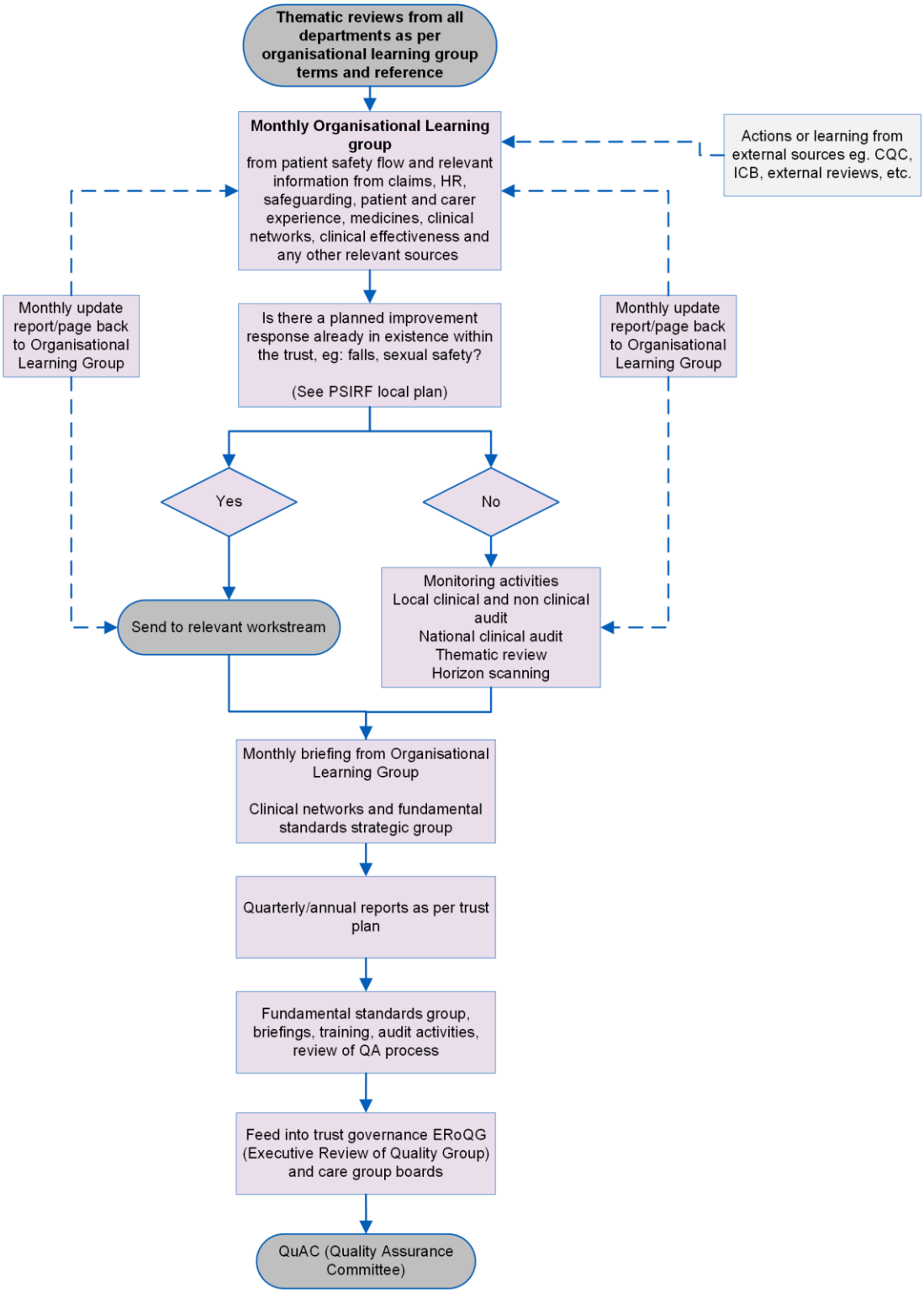

Quality Priority 2023/24 example: Sources of Assurance
Tees, Esk and Wear Valleys NHS Foundation Trust
Self-harm incidents
National Benchmarking
Suicide Prevention Environmental Surveys
Lived Experience insights
Suicide Prevention and Self Harm Reduction
Quality Assurance Tools
Complaints themes
Clinical Audit activity
Learning from Mortality Reviews
Rapid Review and Immediate Learning
7

Appendix 3 - PSIRF Flowcharts

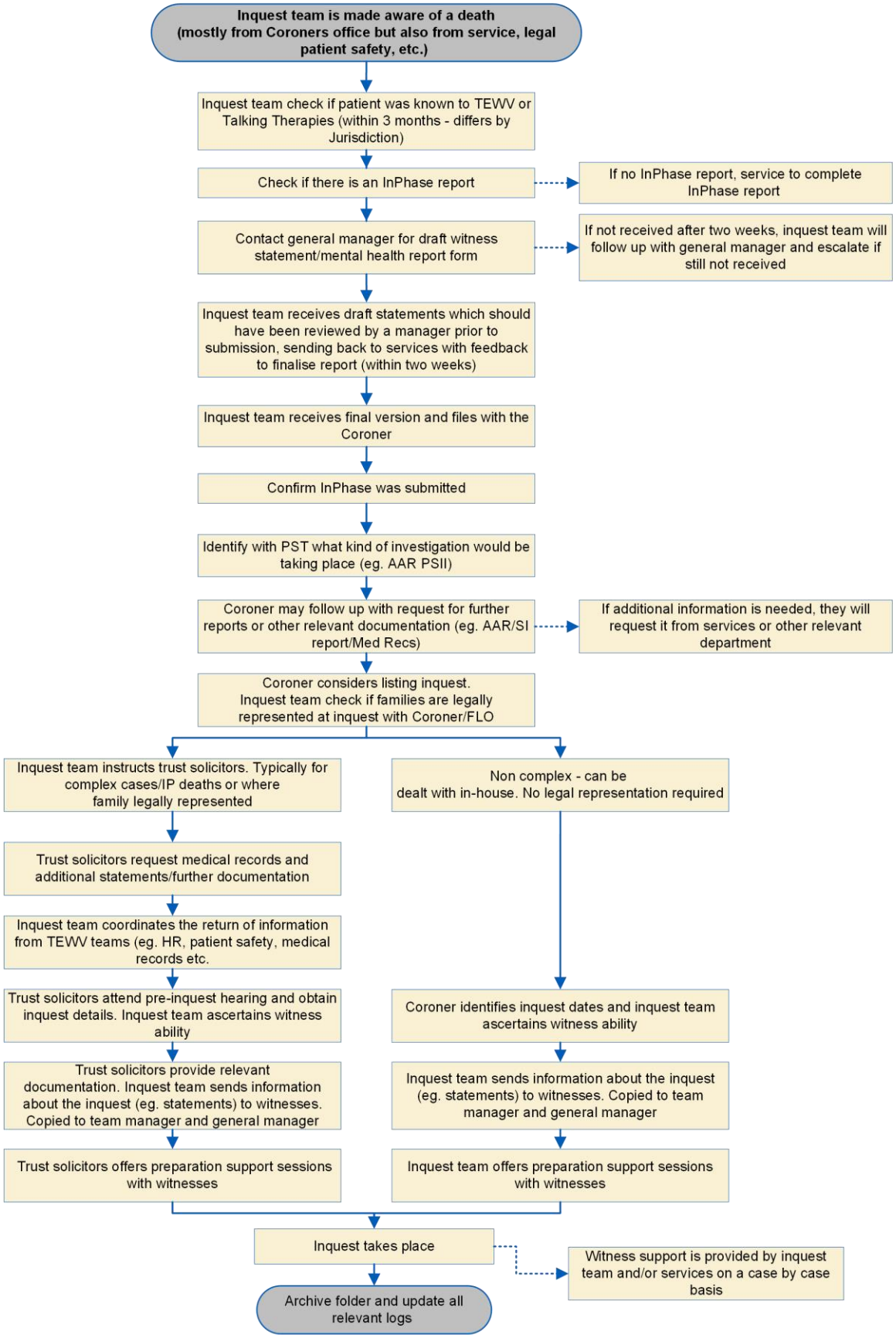
Patient Safety Event Decision and Investigation Framework



Patient Safety Event Learning Process



Inquest Team Coroners Process



Appendix 4 - 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 coproduction 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 address those system factors and help deliver safer care for our patients effectively and sustainably.
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.
SWARM	Used within Healthcare in the UK and US, a SWARM approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis and to support those immediately involved.
Never Event	Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
SMART	SMART criteria are used to guide how objectives or goals are set to make sure that they achieve what they intend to achieve. SMART is taken from the first letter of a set of 5 criteria or rules to help for the goal setting as follows. **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