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|---|---|
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# Our Patient Safety Incident Response Plan

## Introduction

This patient safety incident response plan sets out how Your Healthcare (YH) will seek to learn from patient safety incidents and take safety actions to reduce the risk of harm to patients. This is as part of its work to continually improve the safety of the care and treatment that the organisation provides.

This plan covers a period of approximately 18 months from the 1st April 2026 but will remain flexible as YH continues to monitor and develop its approach to managing patient safety incidents under the new patient safety management requirements. It will actively consider and involve those affected by incidents and include their views in the developing plan.

All YH services are covered by this plan, including NHS commissioned health and social care services and local authority commissioned health services (including Health Visiting and School Health).

## Aim

The plan aims to support YH to continue to improve the way it undertakes investigations into patient safety incidents. This is in order to reduce the risk of future incidents within the organisation to, As Low As is Reasonably Practicable (ALARP). This acknowledges the finite resource and human capacity its membership and partners work with. It will do this by:

- Ensuring the level of investigation is appropriate to the incident and will provide the swiftest learning and patient safety risk reduction without excessive and unworkable resource engagement
- Using a system-based approach to conducting investigations
- Considering the context within which incidents took place, when seeking to establish their cause
- Considering human factors
- Actively seeking to involve service users in its investigations which also aligns with the aims of its Patient and Public Involvement and Engagement Strategy (PPIE).

## Scope

This plan applies to all YH members delivering frontline and infrastructure services including, where relevant and required, locums, agency, bank staff, contractors and students (under the supervision of qualified YH members).

## Our Services

Your Healthcare is a Community Interest Company committed to providing high quality, safe, effective community health and social care services which are centred around the patient and service users' needs.

Services provided by Your Healthcare include:

| Service Area | Services |
|---|---|
| **Community Adult Health Services** | Inpatient rehabilitation, community nursing, a range of therapies, urgent care and response and specialist services such as wound care, urology and colorectal care, dietetics, podiatry and sexual health. |
| **Community Adult Social Care Services** | Reablement and a Shared Lives service. |
| **Children and Family Services** | School Health, Health Visiting, Speech and Language Therapy and young people's sexual health and relationship services. |
| **Neurodevelopmental Services** | Learning Disability Nursing, Speech and Language Therapy and Behavioural Anlaysis services and specialist provisions for attention deficit hyperactivity disorder (ADHD) and Autistic Spectrum Disorder (ASD). |

## Our Patient Safety Incident profile

To identify and agree the patient safety issues most pertinent to YH when the plan initially went live in April 2024:

- Staff members were consulted via an online questionnaire
- Patient Safety Partners who represent YH patients were engaged
- The commissioners of Your Healthcare Services were engaged
- Incident and complaint data from 2021- 2023 was reviewed
- Serious incidents reported to the SWL CCG/ SWL ICB from 2018-2023 were reviewed
- The YH Freedom to Speak Up Guardian (FTSU)was engaged with, in 2023
- The SWL ICB Patient Safety Team, was engaged with from January – December 2023

We planned to review and establish the continuing relevance of our initial plan, which was planned to run from April 2024 to September 2025, before October 2025. However, this required extension to March 2026 due to the capacity to review new data.

We reviewed incident and complaint data generated between 2023 and 2025 and liaised with our Patient Safety Partner. In future reviews we will also be able to review information reported on the incident reporting website Datix as part of the national Learn from Patient Safety Event Service question set. LFPSE went live at YH in April 2025 and as part of its assessment, it asks staff about the things they think went wrong when incidents occurred. This data will provide good insights into YH members' key patient safety concerns.

### Understanding patient safety incident response activity

Through a review of incidents reported on the YH incident reporting system, Datix, and other data sources, it was possible to establish the number of investigations that had taken place, within the national priority categories listed below.

### Patient Safety Incidents reported by Your Healthcare

A detailed breakdown of YH reported patient safety incidents, by type, can be found in **Appendix A.**

| Response type | Category | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|
| National priorities requiring investigation | Never Events - meeting criteria set out in the Never Events Framework (2018) | 0 | 0 | 0 | 0 |

| Response type | Category | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|
| | Incidents resulting in patient's death | 0 | 0 | 0 | 0 |
| | Deaths reviewed as having been hastened due to problems in care - criteria set out in Learning from Deaths guidance | 0 | 0 | 0 | 0 |
| | Incidents referred for independent investigation e.g. Child deaths referred to CDOP, Maternity and neonatal incidents meeting HSIB criteria | 0 | 0 | 0 | 0 |
| Local Incident investigation | Coroner or Medical Examiner initiated Patient Safety Incident Investigations | 0 | 0 | 0 | 0 |
| | Serious Incidents reported on StEIS | 4 | 1 | 1 | **0*** |
| | Adult Safeguarding incidents raised against us by ourselves or others and in which we participated in investigating | 9 | 8 | 10 | 4 |
| | Children's Safeguarding, Serious Case Review investigations which we participated in | 1 | 0 | 0 | 0 |

| Response type | Category | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|
| Patient safety reviews | Deaths of persons with learning disabilities / autism referred to LeDeR-external review | 15 | 7 | - | -** |
| | Inpatient death Mortality Reviews (PRISM) | 3 | 1 | 1 | 0 |
| | Internal Root Cause Analysis investigations into Patient Safety Incidents which have potential for learning | 11 | 8 | 4 | **N/A*** |
| | Incidents in which Learning Response completed | **N/A*** | **N/A*** | 8 | 11 |
| | All Patient Safety Incidents requiring investigation at a Team/Service level (reported and managed on Datix) | 938 | 1068 | 1219 | 1238 |

***** Note – From 1 April 2024, YH adopted the YH Patient Safety Incident Response Policy and Plan. This was in line with the requirements of the NHS Patient Safety Framework. As a result, YH no longer responded to patient safety incidents by reporting to StEIS. YH also stopped using Root Cause Analysis tools. Instead, YH began using Learning Response Tools, such as After-Action Reviews and Swarm Huddles.

8 incidents reported in 2023/2024, prior to the launch of the PSIRP were investigated using After Action Review (AAR) as part of a pilot.

****** YH LeDeR notifications are no longer captured in the organisation's incident reporting system because multiple providers submitting the same case leads to duplication and reduces the value of the data. Notifications to the LeDeR programme, however, run and managed by the SWICB, continue, although it has been proposed by the SWLICB that further to wider NHS England changes,

this may also change. YH supports these reviews through attendance at the steering groups and by providing clinical records for review, when they are requested as being required.

**Categories of incidents requiring notification to SWL CCG/ICB:**

Following the launch of the YH Patient Safety Policy and Plan in April 2024, YH no longer categorised incidents as SI's. After this date, YH was only required to report nationally mandated incidents requiring Patient Safety Incident Investigations (PSII's), to the ICB. There have been no nationally mandated submissions required since April 2024.

| Type of Incident | 2018/ 19 | 2019/ 20 | 2020/ 21 | 2021/ 22 | 2022/ 23 | 2023/ 24 | 2024/ 25 |
|---|---|---|---|---|---|---|---|
| Abuse/alleged abuse of adult patient by staff | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Pressure ulcer meeting SI criteria | 4 | 3 | 4 | 3 | 1 | 1 | 0 |
| Slips/trips/falls meeting SI criteria | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| Confidential information leak/information governance breach meeting SI criteria | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sub-optimal care of the deteriorating patient meeting SI criteria | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Medication incident meeting SI criteria | 0 | 0 | 0 | 1 | 0 | 0 | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **TOTAL** | **6** | **5** | **5** | **4** | **1** | **1** | **0** |

Below are the incidents, by category, where an internal RCA, or from April 2024, a Learning Response was conducted with the majority falling within one of the YH defined priority areas related to skin integrity.

**YH Internal RCA investigations and Learning Responses**

| Category | 2021/ 22 | 2022/ 23 | 2023/ 24 | 2024/ 25 |
|---|---|---|---|---|
| Abuse, Violence or Harassment | 1 | 0 | 0 | 0 |
| Access, Admission and Appointments | 1 | 0 | 1 | 0 |
| Accident (slips, trips & falls) | 0 | 1 | 2 | 0 |
| Confidentiality & Consent | 0 | 0 | 0 | 1 |
| Discharge & Transfer | 0 | 0 | 0 | 1 |
| Expected Service User Death | 0 | 1 | 0 | 0 |
| Medical Device/Equipment | 1 | 0 | 0 | 0 |
| Medication Incidents | 4 | 2 | 5 | 2 |
| Observations and Monitoring | 0 | 0 | 1 | 0 |
| Skin Integrity | 2 | 2 | 1 | 7 |
| Treatment Procedures | 1 | 2 | 0 | 0 |
| Unexpected Deterioration in Condition | 1 | 0 | 2 | 0 |
| **Grand Total** | **11** | **8** | **12** | **11** |

Information gathered from the complaints YH received, also supported an understanding of our patient safety profile.

**Complaints about YH Services**

To note, the table below contains themes from formal complaints raised regarding services provided by YH. For 2024/25, the figures include complaints categorised as 'formal' and from January 2025, complaints requiring 'a closer look'. This followed the adoption of the PHSO complaint handling standards which led to a change in how YH classifies complaints. Complaint levels have fallen to the lowest level in 4 years and due to the low numbers, no clear themes can be identified from this data.

| Complaint by subject | 2021/ 22 | 2022/ 23 | 2023/ 24 | 2024/ 25 |
|---|---|---|---|---|
| Access to treatment or drugs | 2 | 2 | 4 | 1 |

| | | | | |
|---|---|---|---|---|
| Admissions, discharge and transfers excluding delayed discharge due to absence of 14 care package | 0 | 1 | 1 | 0 |
| Appointments including delays and cancellations | 3 | 1 | 1 | 0 |
| Commissioning Services | 1 | 0 | 0 | 0 |
| Communications | 4 | 5 | 1 | 2 |
| End of Life Care | 1 | 0 | 1 | 0 |
| Facilities Services | 0 | 0 | 1 | 2 |
| Patient Care including Nutrition / Hydration | 0 | 3 | 5 | 1 |
| Prescribing errors | 1 | 0 | 0 | 0 |
| Privacy, dignity and wellbeing | 2 | 0 | 0 | 2 |
| Values & Behaviours (Staff) | 7 | 4 | 1 | 1 |
| Waiting Times | 3 | 0 | 0 | 2 |
| Other | 1 | 0 | 0 | 0 |
| **Total** | **25** | **16** | **15** | **11** |

## YH Priority Patient Safety Areas

Following the data review, YH has been able to redefine its current priority patient safety areas within the context of reducing risk to As Low as is Reasonably Practicable (ALARP), within the resource capacity of the organisation and its system partners.

Some areas identified e.g., discharge and transfer incidents, are already being addressed through existing mechanisms- e.g. the quarterly Cause for Concern meeting structure with Kingston Hospital Foundation Trust (KHFT).

| No. | Incident Type | Relevant Service Area(s) | Reason for inclusion |
|---|---|---|---|
| 1 | **Skin Integrity (Pressure Ulcers & Moisture damage)** | Community Adult Health Services | This constitutes the largest proportion of YH-reported incidents. It continues to provide opportunities for a new, systems-focused approach to learning. Applying human factors principles, such as understanding how staff interact with tasks, equipment, and their environment, supports deeper insight into why incidents occur and |

| No. | Incident Type | Relevant Service Area(s) | Reason for inclusion |
|---|---|---|---|
| | | | helps design safer, more resilient systems that can reduce recurrence. |
| **2** | **Medication Incidents** | Community Adult Health Services<br>Community Social Care Services<br>Neurodevelopmental Services | Although incident levels are proportionate to the population served, medication incidents continue to pose a high potential risk to patients. Focusing on this incident type through a system-based, human-factors approach, supported by the new NHS England » Being fair tool, reinforces a just, non-blame culture. This ensures investigations address system causes rather than individuals and supports more effective incident-reduction strategies. |
| **3** | **Inpatient falls** | Community Adult Health Services | An ageing population tends to correlate with increasing levels of frailty and this, alongside staffing stretch is likely to increase the risk of falls. Focussing on this type of incident using a system-based approach, including an examination of human factors through a just culture (non- blame) lens could support new approaches to incident reduction. |
| **4** | **New:**<br>**Infection prevention and control** | Community Adult Services (Inpatients) | Effective infection prevention and control remains a core NHS priority and is critical to maintaining patient safety within inpatient bedded units. An ageing population, increasing levels of frailty, rising antimicrobial resistance and fluctuating staffing capacity can increase vulnerability to healthcare-associated infections (HCAIs). In this context, maintaining robust IPC practices is essential to preventing avoidable harm, reducing acquisition and transmission risk, and sustaining safe, high-quality care environments. |

## Defining our patient safety improvement profile

To develop Your Healthcare's first Patient Safety Improvement Plan, launched in April 2024, we reviewed patient safety information from 2021–23. A working group comprising the Patient Safety Specialist, Quality and Risk Coordinator and Patient Safety Partners, analysed incident and complaint themes, RCA learning, Duty of Candour correspondences, and relevant audit and service review activity. National, regulatory and local priorities were also considered to form the initial patient safety improvement profile.

Key preparatory activity included:

- Engagement with PSPs to understand their experience of incident management and communication, with learning shared through governance committees.
- Joint work between the YH and ICB Patient Safety Specialists to ensure proportionate, data-led decision-making.
- Sharing emerging priorities with the Base and Board Leads through established governance routes.
- Reviewing relevant audits, QI activity and service-level learning in progress.

The resulting plan was developed with service leads and presented to the Base leadership team and then reviewed by South West London ICB before being signed off at the Integrated governance Committee and circulated to the organisation. Priorities were expected to evolve in line with new learning and capacity, with ongoing monitoring and support delivered through the Service Effectiveness team's quality function and specialist groups and committees such as the Pressure Ulcer Review Group and Frontline Effectiveness Committee.

Current Review and Update (2023–25)

For the 2023–25 cycle, a focused but proportionate refresh of the Patient Safety Improvement Plan was completed to ensure priorities reflect current risks, capacity and organisational learning. This included:

- A targeted review of updated patient safety data from 2023–25, including incident trends, complaints, harms and audit findings.
- Continued engagement with the YH Patient Safety Partner to reflect on progress and highlight areas requiring ongoing attention.

- Discussion with the Base leadership team to revisit previous priorities, confirm areas for continuation or adjustment and that ensure alignment with operational capacity.

- Consideration of updated NHSE, CQC and local patient safety expectations.

In this review, core NHS priorities, including frailty, a significant national focus area, were explicitly considered. Frailty has been identified as a key factor influencing one of YH's existing safety priorities, falls, due to the increased vulnerability, complexity and heightened harm profile of frail patients. The updated plan therefore reflects the need for strengthened multidisciplinary working, targeted risk mitigation and enhanced surveillance where frailty and falls intersect.

This streamlined review keeps the plan current, proportionate and aligned to the areas where improvement will have the greatest impact on patient safety, while incorporating relevant national priorities that directly shape local risk.

In deciding on YH's new Patient Safety Plan priorities, certain areas which feature significantly in reporting numbers have not been included because the underlying incident themes do not indicate issues that would benefit from targeted safety workstreams:

- Abuse, violence and harassment incidents largely reflect YH staff appropriately identifying and reporting concerns, rather than problems arising from YH practice.
- Communication-related incidents cover a broad and inconsistent range of factors, many outside YH's control, and do not present a clear theme which could produce clear and meaningful improvement activity plans.
- Patient deterioration incidents primarily relate to individuals admitted to the rehabilitation inpatient ward and correspond with rising patient acuity, an area where YH has limited ability to prevent deterioration.
- During 2024–25 it was established that the majority of incidents recorded as discharge and transfer issues at YH were misreported and were, in fact, access-related incidents attributable to external partners; this is supported by 2025–26 data where discharge incidents no longer present as a core trend, whereas access incidents do.

  NB: Discharge incidents are the responsibility of referring organisations and they are notified of these automatically, if appropriately set up on the system, through the Learning from Patient Safety Events Service(LFPSE)*. They can then take steps to manage the incidents and any themes and should report improvement action plans back to the reporting organisation through the

relevant reporting structures. Kingston and Richmond Foundation trust (KRFT) are the key organisation that discharge incidents emanate from at YH. The system wide Cause for Concern meeting structure and reporting into the joint Quality Governance Committee between YH and KRFT, provide appropriate opportunities for improvement activity reporting.

**LFSPE**

Learn from Patient Safety Events (LFPSE) is the NHS's national approach for capturing, analysing and learning from patient safety incidents. Incidents are reported locally through systems such as Datix, where reporters and incident handlers can select the organisation in which the incident occurred, ensuring events are attributed correctly. Relevant information is then shared with LFPSE, supporting both local improvement and national learning without duplicate reporting.

For these reasons and despite their contribution to overall incident volumes across 2023–25, these categories do not warrant inclusion as priority workstreams within the new Patient Safety Plan.

Our 2025–26 patient safety priorities were selected by triangulating our incident profile with national NHS patient safety direction and South West London ICS priorities. NHS England emphasises safer systems, system-based learning (PSIRF), and targeted reduction of high-harm categories (e.g., pressure ulcers, medicines safety, IPC), alongside strengthening frailty pathways; SW London's plans similarly prioritise frailty, prevention, and quality in community and inpatient care.

**Patient Safety Priorities (2025–26)**

- **Skin Integrity (Pressure Ulcers & Moisture Damage)**: High-volume, high-harm nationally; the National Wound Care Strategy sets a standardised, evidence-informed pathway to reduce variation and harm, aligning with NHSE's safer systems agenda and SWL's aging/frailty focus.

- **Medication Incidents**: Medicines safety is a core strand of the NHS Patient Safety Strategy; a just-culture, systems approach (PSIRF/Being fair) is endorsed nationally and aligns with SWL's focus on community care and long-term conditions where polypharmacy risks are prominent.

- **Inpatient Falls**: Directly linked to frailty, a major national programme area with an explicit push to manage complex needs in community/neighbourhood models; SWL's clinically-led strategy also highlights frailty as a core theme.

- **Infection Prevention & Control (IPC) in Inpatient Beds:** IPC is a core safety expectation within NHSE's safer systems focus; demographic pressures (ageing/frailty) and antimicrobial resistance (AMR) makes healthcare-associated infections (HCAIs) more likely to occur and harder to treat, because common germs no longer respond effectively to standard antibiotics. This aligns with SWL's emphasis on prevention and quality in community inpatient services.

**Improvement plans directly related to identified YH Priority areas**

Quality Improvement (QI) or Service Transformation (ST) projects currently underway or planned across the organisation between now and the 31st March 2025.

| Priority Area | Project Title | QI or ST? | Potential Impact on Patient Safety |
|---|---|---|---|
| **Skin Integrity** | **Harm Free Care Audit – (Cedars Inpatient) – *Tool currently under review and redesign** | QI | Monitoring the effectiveness of interventions that support improved tissue viability. this includes the initiation of shift change Safety Huddles, in order to improve outcomes for usually, already frail patients, who are at increased risk of pressure damage to their skin. This is in the knowledge that, without the QI initiative, infection, pain and more generalised health deterioration could occur for this patient cohort. |
| | **Pain management Audit** | QI | Now established, this audit is part of a regular YH audit cycle and reviews use of a pain management assessment tool by Community Nursing team staff, when completing initial, pressure area care and end of life appointments. This is in use to support the regular and standardised measurement of pain that is captured by a range of staff providing care to the same patient. This will support the establishment of patient pain level changes, that might indicate wound deterioration and/or a risk of further immobility and subsequent risk to the wound, without analgesic intervention. |
| | **Pressure Ulcer Review Group Effectiveness Audit *Tool currently under review and redesign** | QI | This is an annual audit which will continue, subject to some audit redesign based on learning from the initial audit round. It will include an annual audit of themes from PU AARs. This will consider any recurrent thematic systemic issues, informing new local and organisational approaches designed to have the greatest impact on patient outcomes. |

| Priority Area | Project Title | QI or ST? | Potential Impact on Patient Safety |
|---|---|---|---|
| **Medication Incidents** | **Reablement and Shared Lives MAR Chart (Audit)** | QI | Improving the accuracy of transcribed medicines data to support safe administration of medicines, reducing risks to patients through inaccurate transcribing and subsequent administration discrepancies. |
| | **Destruction and disposal of Controlled Drugs (CDs) (Audit)** | QI | To improve the consistency of managing CDs, held in patients' homes when no longer needed and to reduce the risk of CDS entering the open recreational drug market posing a risk- (through procurement) to the patient and the wider community. This audit tool has been updated to provide more granular detail, supporting quality improvement actions that may be required. |
| | **Insulin Pen storage and management (Audit)** | QI | Strengthening insulin-safety practices by monitoring the impact of quality improvements initiated to help reduce the risk associated with a previously identified small medicines-safety incident theme. This audit reviews clearer expiry labelling, regular stock rotation, safer needle use and is designed to support safer administration of insulin in the community. |
| **Inpatient Falls** | **Harm Free Care- Inpatients (Audit)** | QI | To introduce the delivery of the Harm Free Care audit monthly, in line with the NHS Safety Thermometer's monthly design to strengthen the reliability of harm-free care monitoring. This regular cycle will enable the earlier detection of risks, clearer tracking of safety trends, and more responsive improvement actions, supporting a sustained reduction in avoidable patient harm. |

| Priority Area | Project Title | QI or ST? | Potential Impact on Patient Safety |
|---|---|---|---|
| | **Reconditioning workstream (previously deconditioning)** | ST | The reconditioning QI project aims to strengthen patient safety by reducing the physical and cognitive decline associated with inactivity. Through the introduction of a standardised assessment, accessible self-support materials, and consistent messaging across YH services, it promotes early identification of at-risk patients and encourages daily movement and independence. This helps lower risks such as falls, pressure damage, reduced mobility, and delayed recovery, improving overall patient outcomes. |
| **Inpatient Falls** | **National Frailty Collaborative workstream Kingston/Richmond** | Service transformation | Involvement in the local and national frailty collaborative work which aims to strengthen patient safety by improving how frailty is identified, assessed, and managed across Kingston. As a core community provider within the Kingston & Richmond discovery site of the National Frailty Improvement Collaborative, YH is supporting earlier detection and frailty-attuned care in line with NHS England's model for shifting care closer to home. This aims to reduce avoidable deterioration and support safer care transitions. |
| **Infection prevention and control** | **Antimicrobial Stewardship (Audit)** | QI | The enhanced antimicrobial stewardship audit aims to strengthen patient safety by ensuring prescribing and stewardship practices align with updated national requirements. Recent changes, include the updated UK Antimicrobial Prescribing and Stewardship Competency Framework (2025), which reinforces safer, evidence-based antimicrobial use, and the new NHS England AMS digital standards (2025). These require better decision-support, diagnosis-linked prescribing and improved surveillance, increasing expectations on providers to minimise inappropriate antimicrobial use. |

| Priority Area | Project Title | QI or ST? | Potential Impact on Patient Safety |
|---|---|---|---|
| **Catheter Associated Urinary Catheter Infections** | **Indwelling Urinary Catheter Management (Audit)** | QI | Regular audit monitoring of compliance, together with QI actions introduced from previous audit cycles, aims to strengthen the safety and consistency of catheter care and reduce infection risk. Enhancing documentation standards, expanding long-term catheter-care training, and introducing clearer escalation pathways support earlier recognition of risk, fewer unplanned catheter changes, and prevention of avoidable complications such as CAUTI, blockage, and device-related pressure damage. By building on existing areas of good practice, this ongoing QI activity promotes safer, more proactive, and more reliable patient-centred care for people with indwelling catheters. |

A list of nationally, regionally, and locally driven improvement and service transformation programmes underway at YH, which support improvements in patient safety, beyond the identified priority areas, can be found in Appendix B.

# Our Patient Safety Incident Response Plan: Learning Responses

## Patient Safety Review

For the majority of patient safety incidents reported, it is likely that the safety issue or incident type is well understood. This is because previous incidents of this type have been thoroughly investigated, and national or local improvement plans, targeted at contributory factors, are being implemented and monitored for effectiveness.

Incident review will focus on optimising outcomes for service users, review of incidents of a similar type at a team level and monitoring and review at an organisational level. Learning will then inform existing local or national improvement plans.

## Learning to inform improvement

Where contributory factors are not well understood and there is minimal local improvement work underway, a learning response may be required, to fully understand the context and underlying factors that influenced the outcome. This can be achieved through the use of a range of nationally recognised methods:

- Multi-Disciplinary Team (MDT) Reviews
- After-Action Reviews
- Post- Fall Swarm Huddles

Where the incident is either, defined within a National priority group (see table on the following page) or, following review by the Patient Safety team, considered to be of greater significance, due to the outcome for the patient and/or the complexity of interactions with multiple elements of the organisational system, including with system partners then a:

- Patient Safety Incident Investigation (PSII)- which is a thorough and detailed investigatory process, will take place

These may be cross organisational investigations, and YH will actively participate, support and provide learning backwards and forwards between organisations when asked to do so and ensure the allocation of a lead of cross organisational investigations, seeking the support of the South West London Integrated Care Board (SWL ICB) when required to advance the work stream.

All PSIs for which a PSII is undertaken will require the compassionate engagement and involvement of those affected. These requirements are set out in the **YH Patient Safety Incident Response Policy**.

### Thematic reviews

YH may also undertake thematic reviews, which are useful for understanding common links or issues within a cluster of investigations, incidents or from patient safety data made available through other processes, such as complaints.

For any events which meet the criteria set out in Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 will require the Statutory Duty of Candour to be fulfilled.

## Enhancing the service user and YH member voice

Patient safety learning is being strengthened by more actively integrating the voices of service users and YH members, using structured insights captured through the Learn from Patient Safety Events (LFPSE) questions sets embedded in the Datix incident reporting system. This includes understanding the patient or service user perspective on what happened and why, for example, in inpatient falls at Cedars, capturing why a patient believes they fell, alongside the YH member view of contributory factors and what could have been done differently to reduced further patient risk. This approach aligns with YH's first published Patient and Public Involvement and Engagement (PPIE) plan in 25-26 which commits to involving service users more meaningfully and beyond standard NHS feedback mechanisms. This workstream is further strengthened through collaboration with partners and the active involvement of the YH Patient Safety Partner to ensure service user insight directly informs improvement actions.

# Our Patient Safety Incident Response Plan: National requirements

| | National Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|---|
| **1** | Never Events | All Patient Safety Incidents reported on Datix/LFPSE meeting the Never Events criteria. | Reviewed by Patient Safety Specialist who has access to all reported incidents in 'real time' and determines whether incident meets the criteria for reporting as a 'Never Event'. | PSII led by the organisation in which the event occurred. | No history of raising 'Never Event incidents' so not currently applicable. |
| **2a** | Inpatient deaths that meet the 'Learning from deaths' criteria | Unexpected deaths of inpatients on YH ward. | Reviewed by the impatient clinical lead and Patient Safety Specialist who has access to all reported incidents in 'real time on the incident reporting system. followed by a Mortality Review (PRISM) supported by the ward GP provision and the End of Life Lead, which assesses whether death was, more likely than not, due to problems in care, and whether care provided met all of the needs of the patient and their family. | If a Mortality Review finds that the death was more likely than not due to problems in care, then there will be a PSII led by the organisation in which the event occurred. | Improvement activity will be specific to the incidents of this type which occur on our single, inpatient rehabilitation ward. |

| | | | | | |
|---|---|---|---|---|---|
| **2b** | Community patient deaths that meet the 'Learning from deaths' criteria i.e. deaths thought more likely than not, to be due to problems in care | Unexpected deaths of patients open to YH community services, who die when regulated activity is taking place and where an action or omission occurred that may have contributed to the death.<br>And/or<br>Notification of the death of a patient open to YH services received from a Coroner or Medical Examiner. | Limited number of community deaths reported on Datix – these would be reviewed by Patient Safety Specialist who would, through review with other specialist professionals, determine if the death was due or potentially due, to actions or omissions in care delivery. These would also be, as required, reported on the CQC notification portal.<br>Deaths of community patients where YH is notified by a Coroner or Medical Examiner would be reviewed by the Patient Safety Specialist who would determine the response required, in terms of an investigation. In the case of a coronial request, this investigation would, if required, be completed alongside any specific coronial request – usually for statements from YH members. The report would then be sent to the coroner. | PSII led by the organisation in which the event occurred. | Improvement activity will be specific to incidents of this type, where it was assessed that there were acts or omissions in the delivery of care. |
| **3** | Maternal and neonatal incidents | Not applicable to YH provisions | Not applicable to YH provisions | Not applicable to YH provisions | Not applicable to YH provisions |

| | National Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|---|
| | meeting HSIB and MBRRACE-UK criteria | | | | |

| | National Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|---|
| **4** | Child deaths | Deaths of children open to YH services at the time of death. | Where YH is aware of a child death, Kingston Child Death Overview Panel (CDOP) Coordinator is notified. | Refer to the South West London Child Death Overview Panel (SWL CDOP).<br><br>CDOP review will take place (in which YH may be asked to participate)<br><br>Serious child safeguarding cases, including any required Rapid Reviews or Local Child Safeguarding Practice Reviews (LCSPRs), will, if required, be directed by the Kingston & Richmond Safeguarding Children Partnership. | Improvement activity will primarily be directed by the requirements of the Child Death Review process (via the South West London Child Death Overview Panel), and any resulting safeguarding reviews, such as Rapid Reviews or Local Child Safeguarding Practice Reviews (LCSPRs), will apply only in the rare circumstances where care provision is assessed as having contributed to the death of the child. |

| | National Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|---|
| **5** | Deaths of people with a Learning Disability or autism | Known deaths of patients, open to YH services with an LD or Autism diagnosis, who die outside of the provision of direct care. | Deaths of patients with LD or an autism diagnosis, are identified by YH services. | Currently reported to LeDeR study for panel review.<br>The outcomes of the SW London panel review will inform decisions about whether a PSII is required.<br>This is subject to change due to LeDeR process revisions anticipated in 2026. | Through the LeDeR process.<br>This is subject to change due to LeDeR process revisions anticipated in 2026. |

| | | | | | |
|---|---|---|---|---|---|
| **6** | Safeguarding incidents | Incidents in which:<br><br>Children under 18 who are on a Child Protection plan, Child in Need plan or have other known vulnerabilities, including Children Looked After<br><br>Adults 18 and over who have additional needs, supported by the Local Authority<br><br>Incidents involving FGM, radicalisation (PREVENT), modern slavery & human trafficking or domestic abuse/ violence. | Children's safeguarding incidents and concerns are monitored, managed and reviewed through the Local Authority commissioned Multi-Agency Safeguarding Hub, and by the YH Safeguarding Children's team, who work in collaboration with each other.<br><br>Adult Safeguarding incidents are reported on Datix and reviewed by the Safeguarding Adults Team. | Referral to the Local Authority (LA) commissioned Child Safeguarding Team, and the LA provided, Adult Safeguarding Team.<br><br>Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.<br><br>PSII led by YH (or other response e.g., AAR or Post Falls SWARM Huddle) may be required alongside Adult and Child Safeguarding reviews where gaps in provision have led to poor outcomes for adult or child service users- but rarely. | Through existing Child and adult safeguarding structures. |

| | National Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|---|
| **7** | Incidents in screening programmes | Ad Hoc Cervical Screening provision by the Contraception and Sexual health Service. | Through review of those incidents reported on Datix, by the Patient Safety Specialist. | PSII where it is determined to be relevant to investigate at this level. | Improvement activity will be specific to the rare incidents of this type, where it is assessed that there were acts or omissions in the delivery of care. |
| **8** | Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies | Not applicable to YH provisions | Not applicable to YH provisions | Not applicable to YH provisions | Not applicable to YH provisions. |

| | National Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|---|
| **10** | Mental health related homicides | All patients | Mental health homicides are identified by the police. | MH Homicides are referred to NHS England's Regional Independent Investigation Team for consideration for an independent PSII.<br>Locally led PSII may be required, with mental health provider as lead and YH participation if requested as required | Directed by the NHS England team where relevant. |
| **11** | Domestic Homicide | All adult patients | A Domestic Homicide is identified by the police/ Community Safety Partnership - where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, DHR Panel established. | Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers of health services in relation to domestic homicide reviews. | Directed by the DHR panel. |

# Our patient safety incident response plan: local priorities

## Community Adult Health Services & Community Social Care Services & Neurodevelopmental Services

| Local Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|
| **Inpatient Deaths** | All Inpatient deaths where death is **NOT** thought to be due to problems in care or service delivery. | All inpatient deaths reported on Datix and Patient Safety Specialist alerted. | **Mortality review** using PRISM tool. | Improvement activity will be specific to the incidents of this type which occur on our single, inpatient rehabilitation ward. |
| **Community Deaths** | Selected community deaths where death is **NOT** thought to be due to problems in care or service delivery, but review of care required for assurance e.g. where death was referred to coroner or where there are queries by a Medical Examiner, GP etc. | Contact from Coroner or Medical Examiner. | **Mortality review** using PRISM tool<br><br>If PRISM reveals problems in care or service delivery then **PSII** led by YH, will be considered. | Improvement activity will be specific to the rare incidents of this type, where it was assessed that there were acts or omissions in the delivery of care.<br><br>In the case of any required PSIIs, recommendations will be provided to the organisation, via the Integrated Governance Committee, further to the PSIIs completion and, appropriate, systems- based Safety Action Plans will be designed, and then monitored, at the committee level. |

| Local Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|
| **Pressure Ulcers** | Pressure Ulcers acquired or worsened under YH care and assessed as Category 3, Category 4, Unstageable, or patients with multiple Category 2s **AND** a pattern or trend of skin integrity incidents that may be due to a common theme where contributory factors are not well understood and local improvement work is minimal. | All skin integrity incidents reported on Datix are reviewed by Tissue Viability Team who confirm their category at a weekly Pressure Ulcer Review Group (PURG) meeting. | **After Action Review** instigated by PURG, based on a local decision making tool and in collaboration with the Patient Safety Specialist, where this are unknowns and potential for learning not already met by other quality improvement measures.<br><br>**Annual Thematic Review of AARs-** completed by PURG.<br><br>If AARs or thematic review of AARs highlight problems in care or service delivery, that require a more in-depth investigation then a **PSII,** led by YH, will be considered, via the monthly Patient Safety Oversight Group | Learning from individual incident investigations or reviews, which then contribute to quarterly and annual themes that support SMART action plans, monitored on our internal systems.<br><br>In the case of any required PSIIS, recommendations will be provided to the organisation, via the Integrated Governance Committee, further to the PSIIs completion and, appropriate, systems-based Safety Action Plans, will be designed, and then monitored, at the committee level. |

| Local Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|
| **Medication** | A medication incident where a patient sustained moderate physical or psychological harm (or above) **AND** where contributory factors are not well understood and work already underway, is not addressing the emerging themes. | All Medication incidents reported on Datix are reviewed by Medicine Management Lead, Pharmacist and incident handler who confirms level of harm. | Incidents to be discussed at monthly Medicines Incident Review Group (MIRG) and an **After-Action Review** completed for each incident following the YH AAR process outlined above for Pressure ulcers and including, where required and relevant, a member of the MIRG.<br><br>If AARs or a thematic review of AARs, highlight problems in care or service delivery, that require a more in- depth investigation, then a **PSII,** led by YH, will be considered, via the monthly PSOG. | Learning from individual incident investigations or reviews, which then contribute to action plans, monitored via the Medicines Management Committee and on our internal systems.<br><br>In the case of any required PSIIs, recommendations will be provided to the organisation, via the Integrated Governance Committee, further to the PSII's completion, and appropriate, systems- based Safety Action Plans will be designed and then monitored, at the committee level. |

| Local Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|
| **Medication** | A medication incident where a high-risk medication was involved e.g., insulin **AND** where contributory factors are not well understood and work already underway is not addressing the emerging themes. | All Medication incidents reported on Datix are reviewed by Medicine Management Lead, Pharmacist and incident handler who confirms if high-risk medication involved. | Incidents to be discussed at monthly Medicines Incident Review Group (MIRG) and an **After-Action Review** completed for each incident following the YH AAR process and including, where required and relevant, a member of the MIRG.<br><br>If AARs or a thematic review of AARs, highlight problems in care or service delivery, that require a more in- depth investigation, then a **PSII,** led by YH, will be considered, via the monthly PSOG. | Learning from individual incident, investigations or reviews, which then contribute to action plans, monitored via the Medicines Management Committee and on our internal systems.<br><br>In the case of any required PSIIs, recommendations will be provided to the organisation, via the Integrated Governance Committee, further to the PSII's completion, and appropriate, systems- based Safety Action Plans will be designed and then monitored, at the committee level. |

| Local Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|
| **Medication** | A series of medication near miss events where there is potential for harm and where there may be a common theme/pattern **AND** where contributory factors are not well understood and work already underway is not addressing the emerging themes. | All Medication incidents reported on Datix are reviewed by Medicine Management Lead who will identify pattern/trends | Incidents to be discussed at monthly Medicines Incident Review Group (MIRG) and an **After-Action Review** completed for each incident following the YH AAR process and including, where required and relevant, a member of the MIRG.<br><br>If AARs or a thematic review of AARs, highlight problems in care or service delivery, that require a more in- depth investigation, then a **PSII,** led by YH, will be considered, via the monthly PSOG. | Learning from incident investigations or reviews, which then contribute to action plans, monitored via the Medicines Management Committee and on our internal systems.<br><br>In the case of any required PSIIs, recommendations will be provided to the organisation, via the Integrated Governance Committee, further to the PSII's completion, and appropriate, systems- based Safety Action Plans will be designed and then monitored, at the committee level. |

| Local Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|
| **Inpatient falls** | Any incident in which an inpatient has a fall and sustains severe or catastrophic physical harm. | All patient safety incidents are reported on Datix and reviewed by the Patient Safety Specialist (PSS) | **YH led PSII** (the use of a Post Fall SWARM huddle should always be considered if sufficient for the purpose of learning) | Recommendations from a PSII will be provided to the organisation, via the Integrated Governance Committee, further to the PSII's completion, and appropriate, systems- based Safety Action Plans will be designed and then monitored, at the committee level. If another form of learning is used such as a Post Falls SWARM Huddle, then learning and any associated action plans must be shared through the relevant Governance committees and actions monitored. |

| Local Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|
| **Safeguarding** | Any incident that meets the safeguarding adults' threshold where an investigation is required and is not covered by the criteria above. | All safeguarding incidents reviewed by Adult Safeguarding Team | The type of response required is determined in collaboration with the Patient Safety Specialist and the Local Authority Safeguarding Lead, with an appropriate lead identified<br>• **PSII**<br>• **After Action Review**<br>• **Post Fall SWARM huddle**<br>• **MDT review** | Learning from individual incident investigations or reviews, which then contribute to action plans, which will be shared with the Local Authority patient/ service user and/or their family, and will be monitored via the Joint Safeguarding and Integrated Governance Committee and on our internal systems.<br>In the case of any required PSIIs, recommendations will be provided to the organisation, via the Integrated Governance Committee, noted at the Joint Safeguarding Committee and further to the PSII's completion, appropriate, systems- based Safety Action Plans will be designed and then monitored, at the committee level. The Local Authority and patient/ service user and/ or their family and carers will be updated throughout. |

| Local Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|
| **IPC** | IPC incidents or near-misses with potential for patient harm, where recurring patterns are emerging (e.g., repeated aseptic lapses, environmental hygiene issues, or clusters of HCAIs), and where contributory factors remain unclear despite existing improvement efforts. | All patient safety incidents are reported on Datix and reviewed by the Patient Safety Specialist (PSS) and IPC Lead | **After Action Review** instigated by PSS in collaboration with relevant specialists and or leads, as required | Learning from individual incident, investigations or reviews, which then contribute to action plans, monitored via the Frontline Effectiveness Committee and on our internal systems. |

| Local Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|
| **Other Patient Safety Incidents** | Any patient safety incident(s) that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the specific criteria above **AND** where contributory factors are not well understood and work already underway is not addressing the emerging themes. | All patient safety incidents are reported on Datix and reviewed by the Patient Safety Specialist (PSS) | Type of response to be determined by PSS from the following, in consultation with relevant specialists and or leads as required:<br>• **PSII**<br>• **After Action Review**<br>• **Thematic Review**<br>• **MDT review** | Learning from incident investigations or reviews, which then contribute to action plans, monitored via the relevant committee and on our internal systems.<br>In the case of any required PSIIs, recommendations will be provided to the organisation, via the Integrated Governance Committee, further to the PSII's completion, and appropriate, systems- based Safety Action Plans will be designed and then monitored, at the committee level. |

## Children & Family Services

| Local Priority | Scope | How identified | Response | Anticipated improvement route |
|---|---|---|---|---|
| **Other Patient Safety Incidents** | Any patient safety incident(s) that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the specific criteria above **AND** where contributory factors are not well understood and work already underway is not addressing the emerging themes. | All patient safety incidents are reported on Datix and reviewed by the Patient Safety Specialist (PSS) | Type of response to be determined by the PSS in collaboration with relevant specialists and or leads, as required: from following:<br>• **PSII**<br>• **After Action Review**<br>• **Thematic Review**<br>• **MDT review** | Learning from incident investigations or reviews, which then contribute to action plans, monitored via the relevant committee and on our internal systems.<br>In the case of any required PSIIs, recommendations will be provided to the organisation, via the Integrated Governance Committee, further to the PSII's completion, and appropriate, systems- based Safety Action Plans will be designed and then monitored, at the committee level. |

## Patient Safety Plan review

Within 18 months YH will ensure a review of its Patient Safety Plan but will be advised by the South West London Integrated Care Board if this review period can be extended.

## Appendix A – Thematic Review of Incidents

Below are all YH reported patient safety incidents, divided by theme:

**All YH Patient Safety Incidents by category:**

| Category | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|
| Abuse, Violence or Harassment* | 67 | 83 | 57 | 85 |
| Access, Admission and Appointments | 24 | 35 | 29 | 39 |
| **Accident** | **60** | **74** | **112** | **122** |
| Clinical Assessment and Diagnosis | 11 | 16 | 22 | 16 |
| Communications** | 40 | 73 | 65 | 52 |
| Confidentiality and Consent | 18 | 11 | 25 | 27 |
| Discharge and transfer*** | 86 | 75 | 86 | 112 |
| Estates/Facilities and Environment | 8 | 15 | 10 | 6 |
| Expected Service User Death | 3 | 17 | 11 | 4 |
| **Infection Control** | **24** | **32** | **29** | **25** |
| Information Technology | 4 | 21 | 14 | 8 |
| Medical Device/Equipment | 15 | 23 | 18 | 20 |
| **Medication Incidents** | **117** | **119** | **119** | **133** |
| Observations and Monitoring | 12 | 22 | 18 | 12 |
| Security | 6 | 7 | 10 | 11 |
| Sharps Injury (Needlestick) | 1 | 1 | 0 | 0 |
| **Skin Integrity** | **385** | **492** | **512** | **474** |
| Treatment Procedures | 7 | 17 | 12 | 21 |
| Unexpected Deterioration in Condition**** | 17 | 41 | 50 | 64 |
| Unexplained Injury | 5 | 6 | 17 | 4 |
| Workforce/HR | 6 | 3 | 3 | 3 |
| **Grand Total** | **916** | **1183** | **1219** | **1238** |

*Abuse, violence and harassment incidents relate, in the main, to the identification of these issues by YH staff and as such although the figure is high this is not an area that requires a Patient Safety Plan workstream.

**Communication covers a range of issues, in an out of YH member's control and without a clear theme to explore will not be a focus.

*** It was established in 2024-25 that the absolute majority of incidents raised as Discharge and transfer incidents, which would be attributable to YH, were being

misreported and were actually Access Incidents which would be attributable to others. This is borne out by 2025-26 data where Discharge incidents are no longer featuring as a core incident area.

******** The deterioration of patients is almost entirely related to those patients admitted to the Rehabilitation inpatient ward managed by YH. The patient deterioration levels appear to align with the increased acuity of patients the setting has been admitting over the last few years which they have minimal ability to influence.

**YH Attributable Medication incidents**

| Sub-Category | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|
| Administration or other type error involving staff/ patient/ another person | 50 | 56 | 52 | 56 |
| Dispensing error made by pharmacist | 0 | 0 | 0 | 0 |
| Prescribing Error made by GP/Doctor/Consultant/another | 2 | 3 | 5 | 11 |
| **Grand Total** | **52** | **59** | **57** | **67** |

# Appendix B – Quality Improvement (QI) and Service Transformation (ST) Programmes

**Nationally Driven Improvement and Service Transformation Programmes**

| Project Title | QI or ST? | Potential Impact on Patient Safety |
|---|---|---|
| **Anti-microbial Audits (IPC)** | QI | Reduction in over supply of antibiotics, leading to antibiotic resistance in the general population |
| **Respiratory Function and Motor Neurone Disease Audit (CNRT)** | QI | To increase the use of required assessments to a national level which support an understanding of respiratory function changes that require intervention to prevent a risk to life. |
| **Sentinel SSNAP National Audit (CNRT)** | QI | To improve outcomes for people who have suffered a stroke by monitoring their involvement with services for specific reasons and within specific time frames to improve their access |
| **UK Parkinson Transforming Care audit (CNRT)** | Q1 | To improve the quality and experience of Parkinson's care for all service users and their families. |

| Project Title | QI or ST? | Potential Impact on Patient Safety |
|---|---|---|
| **Routine Enquiry 2019- Domestic Abuse - Health Visiting (HV)** | QI | To improve the quality, regularity and skill of practitioners asking questions about the safety of people who are parents/carers, in order to enact supportive and safeguarding measures when risks exist within the home |
| **UNICEF Baby Friendly Initiative (HV)** | QI | Improving uptake of breastfeeding to support lower infection risks, bonding and cognitive outcomes. |
| **CQUIN-13 Malnutrition Screening- (inpatient beds Cedars)** | QI | To improve nutritional outcomes for patients |
| **EPACT2- National prescribing audit** | QI | To ensure prescribing activity is appropriate and cost effective |

### Regionally driven improvement and service transformation programmes

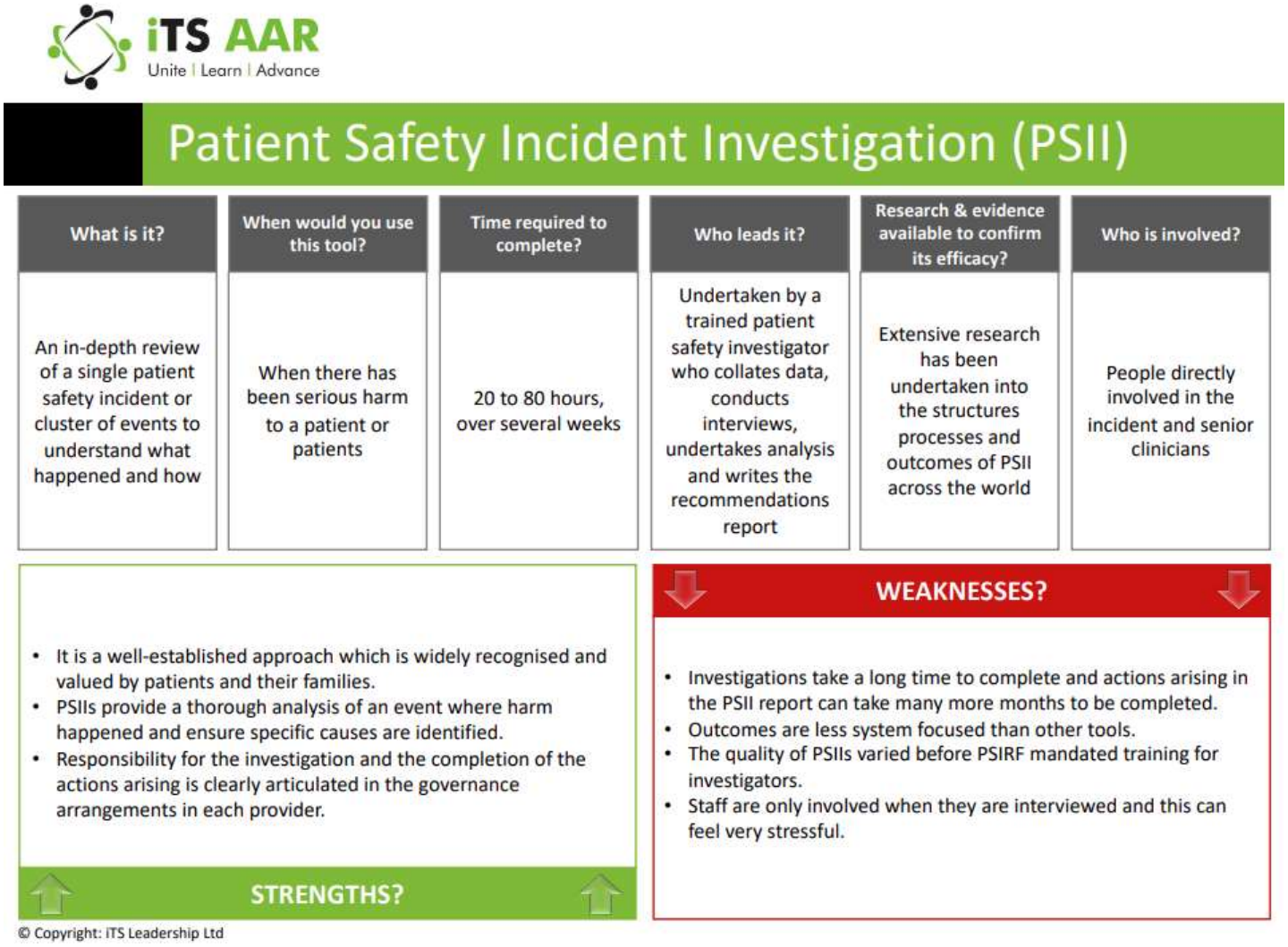
| Name | QI or ST? | Potential Impact on Patient Safety |
|---|---|---|
| **High impact interventions audits in relevant clinical services, including inpatients** | QI | Identifying variations in practice early, reducing avoidable harm, and ensuring consistent delivery of evidence-based care, including robust Infection Prevention and Control (IPC) measures that minimise the risk of healthcare-associated infections. |
| **Maternal Early Childhood Sustained Health Visiting Programme- (MECSH) Visiting Programme – for targeted families with increased and specific vulnerabilities** | ST | To improve a range of outcomes for children born into families where there are more vulnerabilities – to support them to remain safe and to achieve optimal outcomes in life. |

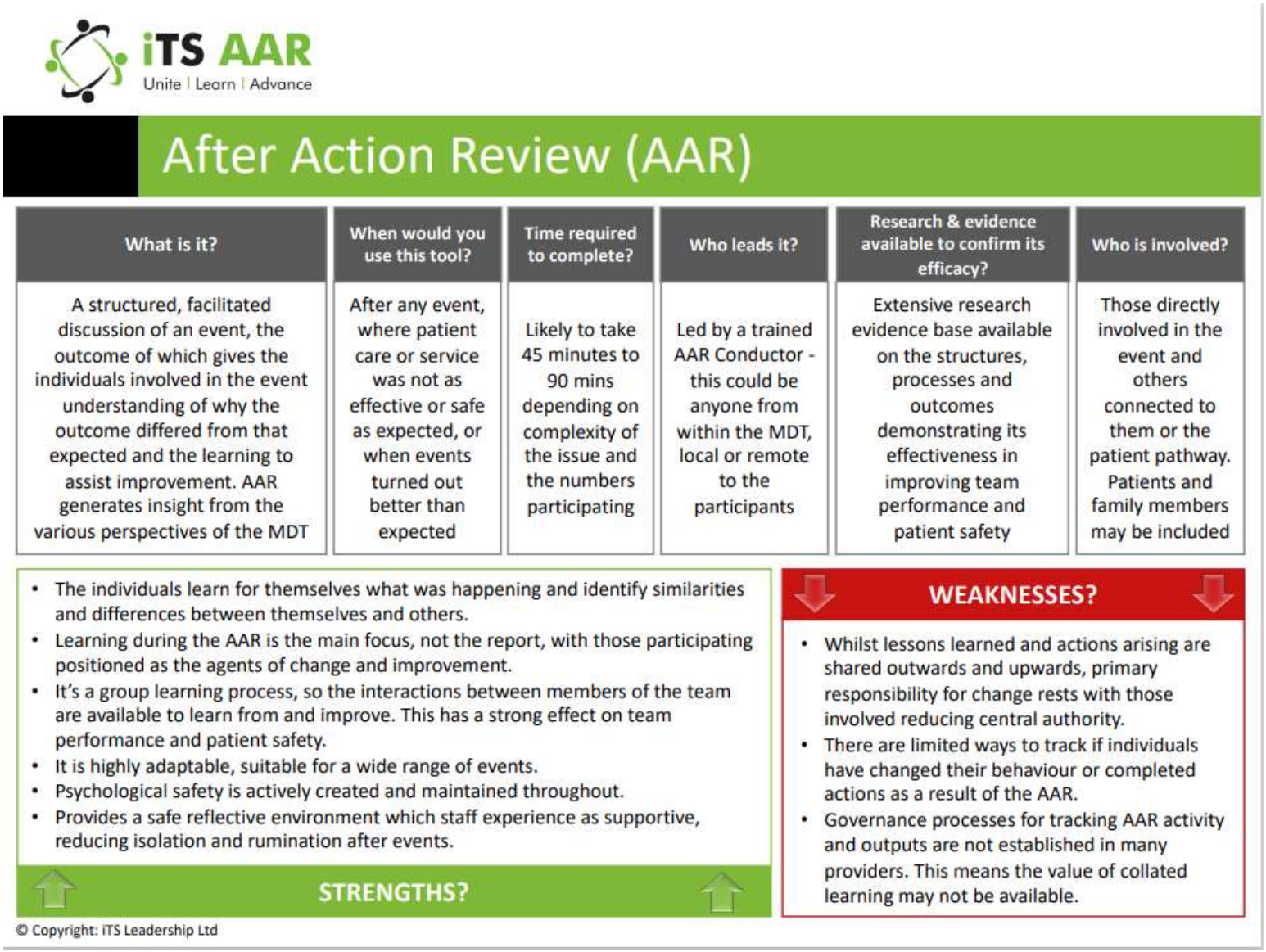
### Locally driven Improvement and Service Transformation Programmes

| Name | QI or ST? | Potential Impact on Patient Safety |
|---|---|---|
| **NEWS2 Audit inpatient and community** | QI | Consistent response to the deteriorating patient advancing their escalation into an acute hospital setting to improve their outcomes. |
| **Neurodevelopmental (NdS)service Nursing Referrals (Nds)** | QI | Improving quality of referrals to the service to ensure the needs of this service group with learning difficulties and Autism and ADHD are better served, improving their chance of better health outcomes |
| **Epilepsy Care plans for Kingston and Richmond Neurodevelopmental Clients (NdS)** | QI | Improving the use of Care plans for service users with Epilepsy to ensure adequate management of their condition and reducing the risk of poor management and escalation to the acute setting. |
| **Project 2020- Neurodevelopmental Nursing service (NdS)** | ST | The provision of a system which support residential and care staff to support service users with learning disabilities to access all of the preventative health care appointments that will benefit their health outcomes- and put in place as a consequence of learning from LeDeR. |

| Name | QI or ST? | Potential Impact on Patient Safety |
|---|---|---|
| **Harm free care (Patient Safety Thermometer)- Inpatient Unit** | QI | A range of measures monitored on the unit and designed to reduce harm to patients through quality assessment, safety risk reduction and anticipatory actions. |
| **Evaluating the use of Therapeutic Outcome Measures in Community Neuro Rehabilitation team to identify domains of change across people accessing the service. (CNRT)** | QI | To have a clear metric across the MDT to evaluate change. |
| **Improving uptake of Cervical Screening opportunistically for those not taking up the GP offer within the Contraceptive and Sexual Health Service (CASH)** | QI | Reducing the risk of developing cervical cancer by providing a screening offer as standard practice for patients identified as missed to GP offer, and accessing sexual health services. |

## Appendix C-Guide to Learning Response Tools




iTS AAR
Unite | Learn | Advance
After Action Review (AAR)
What is it?
A structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT
When would you use this tool?
After any event, where patient care or service was not as effective or safe as expected, or when events turned out better than expected
Time required to complete?
Likely to take 45 minutes to 90 mins depending on complexity of the issue and the numbers participating
Who leads it?
Led by a trained AAR Conductor - this could be anyone from within the MDT, local or remote to the participants
Research & evidence available to confirm its efficacy?
Extensive research evidence base available on the structures, processes and outcomes demonstrating its effectiveness in improving team performance and patient safety
Who is involved?
Those directly involved in the event and others connected to them or the patient pathway. Patients and family members may be included
• The individuals learn for themselves what was happening and identify similarities and differences between themselves and others.
• Learning during the AAR is the main focus, not the report, with those participating positioned as the agents of change and improvement.
• It's a group learning process, so the interactions between members of the team are available to learn from and improve. This has a strong effect on team performance and patient safety.
• It is highly adaptable, suitable for a wide range of events.
• Psychological safety is actively created and maintained throughout.
• Provides a safe reflective environment which staff experience as supportive, reducing isolation and rumination after events.
STRENGTHS?
WEAKNESSES?
• Whilst lessons learned and actions arising are shared outwards and upwards, primary responsibility for change rests with those involved reducing central authority.
• There are limited ways to track if individuals have changed their behaviour or completed actions as a result of the AAR.
• Governance processes for tracking AAR activity and outputs are not established in many providers. This means the value of collated learning may not be available.
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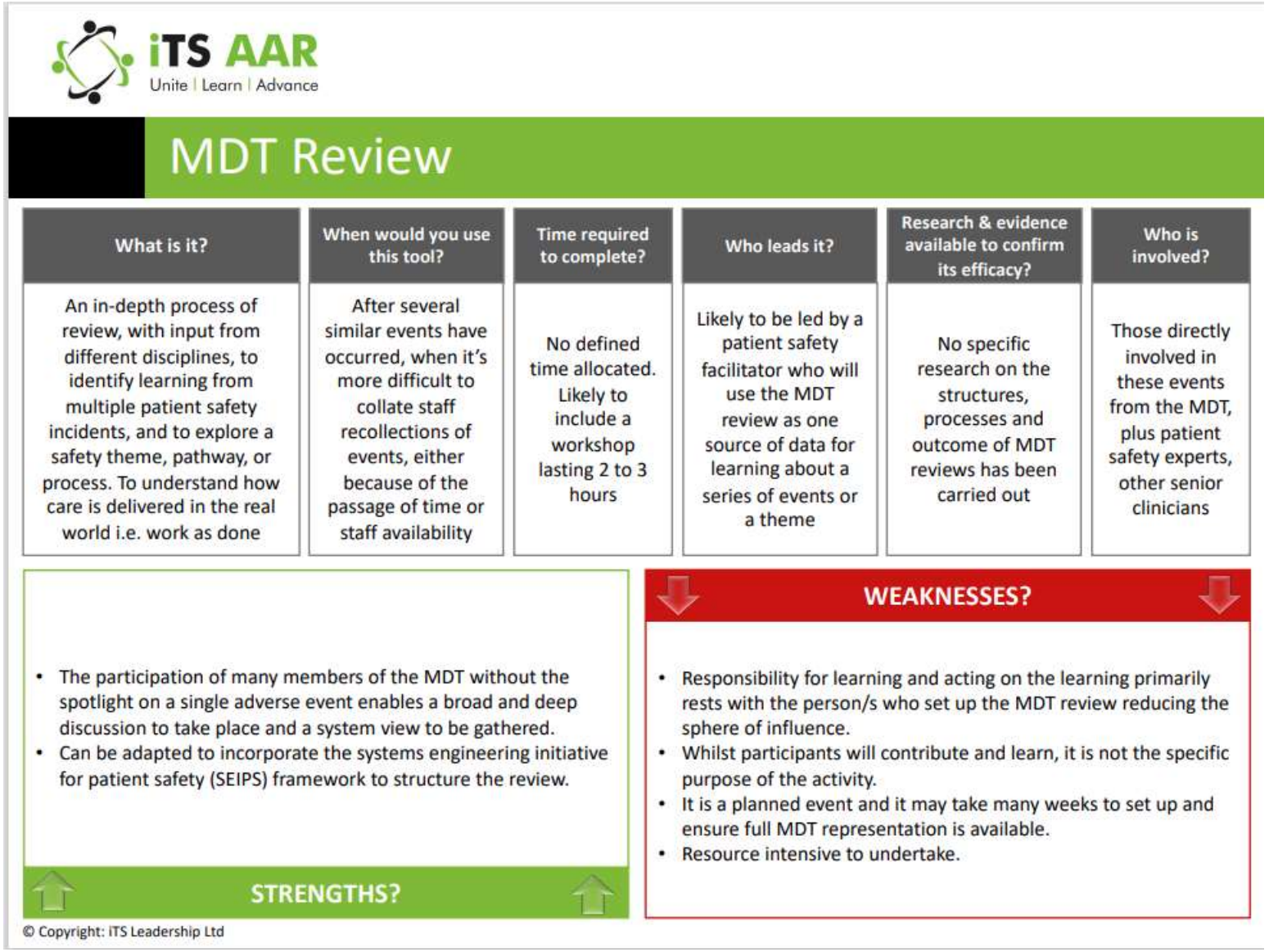
iTS AAR
Unite | Learn | Advance
MDT Review
What is it?
An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. To understand how care is delivered in the real world i.e. work as done
When would you use this tool?
After several similar events have occurred, when it's more difficult to collate staff recollections of events, either because of the passage of time or staff availability
Time required to complete?
No defined time allocated. Likely to include a workshop lasting 2 to 3 hours
Who leads it?
Likely to be led by a patient safety facilitator who will use the MDT review as one source of data for learning about a series of events or a theme
Research & evidence available to confirm its efficacy?
No specific research on the structures, processes and outcome of MDT reviews has been carried out
Who is involved?
Those directly involved in these events from the MDT, plus patient safety experts, other senior clinicians
STRENGTHS?
• The participation of many members of the MDT without the spotlight on a single adverse event enables a broad and deep discussion to take place and a system view to be gathered.
• Can be adapted to incorporate the systems engineering initiative for patient safety (SEIPS) framework to structure the review.
WEAKNESSES?
• Responsibility for learning and acting on the learning primarily rests with the person/s who set up the MDT review reducing the sphere of influence.
• Whilst participants will contribute and learn, it is not the specific purpose of the activity.
• It is a planned event and it may take many weeks to set up and ensure full MDT representation is available.
• Resource intensive to undertake.
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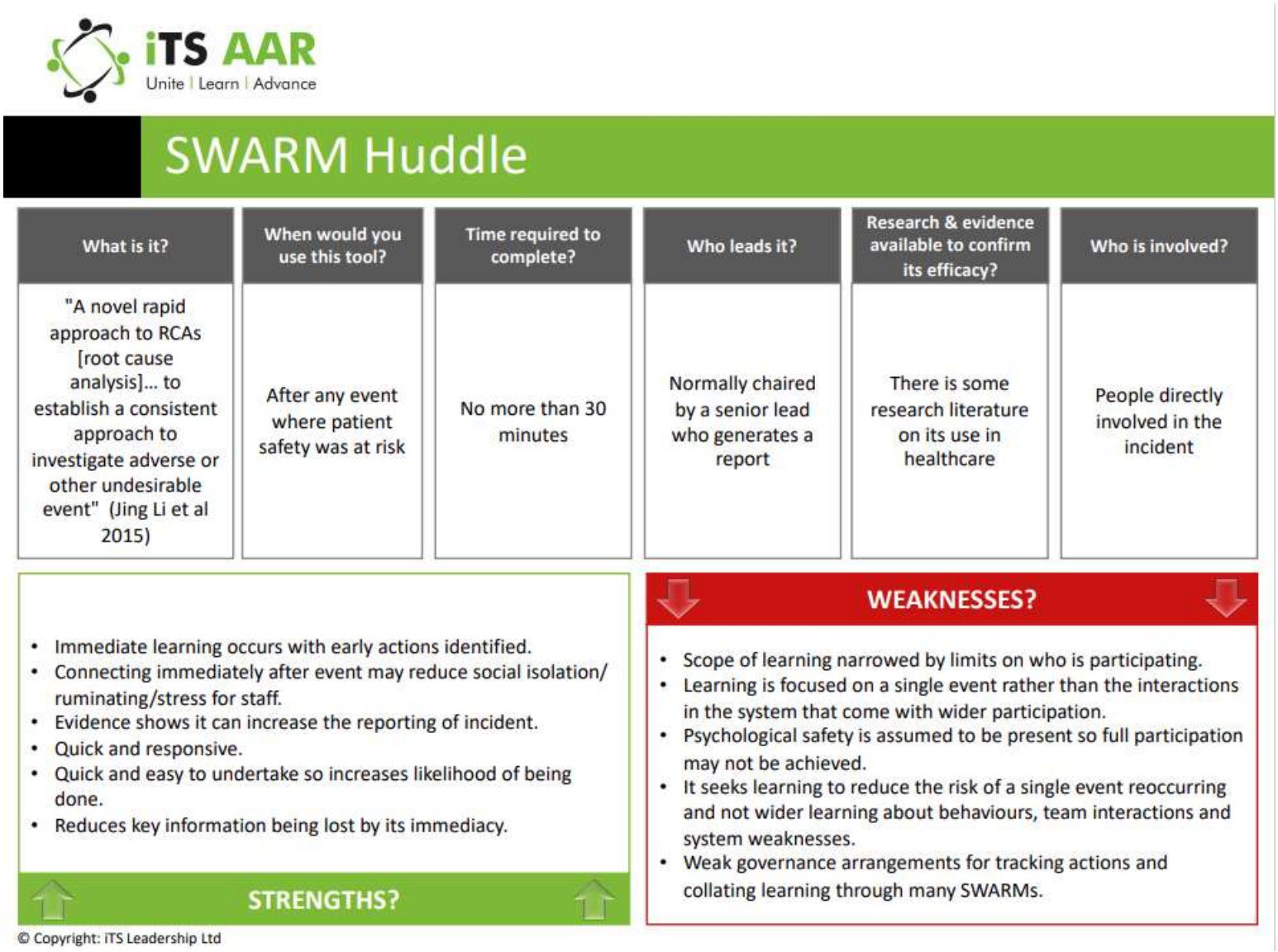
iTS AAR
Unite | Learn | Advance
SWARM Huddle
What is it?
"A novel rapid approach to RCAs [root cause analysis]... to establish a consistent approach to investigate adverse or other undesirable event" (Jing Li et al 2015)
When would you use this tool?
After any event where patient safety was at risk
Time required to complete?
No more than 30 minutes
Who leads it?
Normally chaired by a senior lead who generates a report
Research & evidence available to confirm its efficacy?
There is some research literature on its use in healthcare
Who is involved?
People directly involved in the incident
Immediate learning occurs with early actions identified.
Connecting immediately after event may reduce social isolation/ ruminating/stress for staff.
Evidence shows it can increase the reporting of incident.
Quick and responsive.
Quick and easy to undertake so increases likelihood of being done.
Reduces key information being lost by its immediacy.
STRENGTHS?
WEAKNESSES?
Scope of learning narrowed by limits on who is participating.
Learning is focused on a single event rather than the interactions in the system that come with wider participation.
Psychological safety is assumed to be present so full participation may not be achieved.
It seeks learning to reduce the risk of a single event reoccurring and not wider learning about behaviours, team interactions and system weaknesses.
Weak governance arrangements for tracking actions and collating learning through many SWARMs.
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# Appendix D – YH Investigation Tool

YH PSII Terms of Reference Template

YH PSII Report Template

YH After-Action Review Process

YH After Action Facilitator Prompt Sheet

YH After Action Review Template

YH Specialist Incident Review Group maps- Medicines and skin integrity

YH Specialist Medicines and Skin integrity group Terms of Reference.

Patient Safety Oversight Group- Terms of Reference

PSOG Decision making template