Patient Safety Plan

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	NAME	TITLE	SIGNATURE	DATE
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Contents

Introduction

This patient safety incident response plan sets out how Elysium Healthcare intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This plan should be read in conjunction with the Patient Safety Incident Response Framework (PSIRF) Policy and Ch23 Incidents and Untoward Occurrences (inc PSIRF) Policy.

Our services

Elysium Healthcare is an Independent Healthcare Provider it is comprised of the following services:

- 88 sites with over 2600 beds across England and Wales
- Hosted Services in majority of ICBs across England with service users from all areas of England and Wales

PSIRF methodology will be used across all our services, including our services in Wales and Local Authority funded services, to ensure a consistent and safe system providing one patient safety system across the Elysium Group.

In providing a range of services we work with partner organisations across health and social care, as part of these partnership arrangements we may be in local networks or wider Provider Collaboratives. No matter what types of relationships we have it is always important that we as a company maintain our own clinical leadership and support our services to provide safe and good quality care. In ensuring we maintain corporate oversight of quality and safety we group our services within Clinical Networks, to ensure that we maintain through clinical governance good assurance and oversight that all our services are operating within their sector to establish best practice. Our services within Clinical Networks work together to ensure the support necessary to provide innovative care, quality assurance, patient safety, and inter-service peer support. The following are our Clinical Networks:

- Secure
- Acute
- CAMHS
- Neurological
- Rehabilitation Hospitals (Male)
- Rehabilitation Hospitals (Women)
- LD/ABI Hospitals and wards (secure and non-secure)
- Care Homes (Qualified Nurse)

- Care Homes (No Qualified Nurse)

The range and types of services that fall within these networks reflects all different types of services that Elysium provides across the country. In developing the structure of the Clinical Networks, we mapped out all of our services, linked to key stakeholders and sought the views of our senior clinicians and members of the Corporate Clinical Governance (CCG) meeting to test out the meaningfulness of the Clinical Network grouping. In establishing the nine networks we used the following principles:

- Natural clinical alignment either to national specifications or agreed service types.
- Meaningful number of services able to support a peer support network.
- Established Elysium networks (CAMHS, LD & Acute) supported to continue.
- Leadership and Peer support able to undertake task and finish functions for CCG.
- Networks chaired by senior clinicians from services.

The make-up, structure and utility of the Clinical Networks will be monitored through CCG to ensure their functionality within their defined role. It is of note that the type and range of inpatient services provided by Elysium is far wider than an NHS Trust and geographically distanced from each other. Secondary to the complexities of range and distances between services is that the individual services are separately registered to the CQC / HIW. This separation of registration between individual services means that an NHS Trust divisional approach to setting patient safety plans is more complicated within the independent sector. To ameliorate the risk of services with similar functions developing separate patient safety plans we chose to bring services together within a network model to ensure learning, the sharing of learning and the ability to effectively review the patient safety plans within a meaningful professional and service user grouping.

Defining our patient safety incident profile

Elysium has always maintained central corporate oversight of incidents both in the reporting (via IRIS) and the management of incidents using the Serious Incident Framework (SIF). The data that is available to us is extensive as it derives from such a large and complex organisation, therefore, to understand the whole organisation requires a detailed PSP to reflect the range of services provided by Elysium Healthcare. We decided as a mapping exercise that we would review three years' worth of IRIS (our incident recording system) and SIF data to extract themes and cross reference this with three years' worth of Safeguarding, Health and Safety, Human Resources (disciplinary), duty of candour, complaints, and claims information. This gave us a rich but complex data source. It should be noted by the very nature of the reporting systems used under the SIF system patient safety incidents involving

significant harm will have been shared externally for oversight with NHS and Social care partners.

With this large data set the working group agreed a set of key priorities to form an indicative patient safety incident profile that was used to map the data available on all our electronic systems to triangulate the key themes that derive from all incident reporting.

The key themes (fig 1.) for the full detail please see appendix:

Direct - Patient safety issues that are well known to services and the company with associated data though reports and historic action plans	**Indirect -** Suspected or known patient safety issues, such as contributory factors with or without wider knowledge that are not always supported by direct correlation or specific mention in reports	**Unique -** One-off events are important as they will always require investigation and by their very nature cannot be covered in a patient safety plan, beyond the need to know that a response will be required.
1. Patient Supervision and Observations 2. Medication Management Errors 3. Self-Harm 4. Patient Violence towards others 5. Restrictive Practices 6. Accessing, granting, or breaching leave 7. Environmental factors 8. Physical Healthcare 9. Mental Health Act – process breaches of all types	10. Workforce 11. Patient Mix on ward/care home 12. Inappropriately placed Patients 13. Delayed Discharge 14. IT and BCP issues in care delivery 15. Care Planning Quality – or failure to follow. 16. Communication issues	17. Unexpected death will always fall into this category. 18. Random unique incidents that we would be negligent if we did not review/ investigate

These key patient safety themes were shared across CCG (and thereby to Regions and Services), Senior Clinicians who were part of the working group, senior managers, and service user representatives. The intention of sharing the key themes was to test validity of themes that were emerging from the mapping and to seek the wider company view on both the appropriateness of individual items inclusion and to check if any concerns or incident types had been missed. Feedback from this process supported by the data mapping of the volume and types of incidents have been used to set out our key patient safety priorities.

The key themes were also shared with NHS commissioner organisations through their participation in our working group and stakeholder events. It should be noted that as a large multi-site provider Elysium is a significant provider of NHS and Social care services but from

the point of view of the individual NHS and Social care commissioner it is more relevant for them looking at individual service user experience rather than a view of us as a large multi-site provider. This conflict in perception means that the NHS / Social Care view of the range and type of our patient safety incidents is wholly dependent on their use of our services, which may not include the wide spectrum of services that we provide and indeed mostly reflects an individual's care. Therefore, their ability to confirm or validate the range of patient safety incidents can be limited / biased on a companywide view. Although it is worth noting that from their wider system experience of all providers none of the NHS commissioners noted anything abnormal or missing from the key themes list.

We have therefore decided that the key themes list shall be the basis of the Elysium corporate patient safety plan and the profile that it will be based upon.

The process following the development of the corporate wide safety plan is as follows:

1) We will identify and undertake index case reviews (using PSII) to develop benchmark safety action plans that will form the basis of high-level quality improvement plans specific to each patient safety priority. These Patient Safety Priorities with their associated quality improvement plans will be the basis of specific clinical network and patient safety plans.

2) The clinical networks will identify key themes from the wider corporate list applicable to their services. They will then develop patient safety plans for their individual key patient safety issues in a collaborative way across all their member services.

3) The networks will produce their PSP's for sharing and ratification with the overarching corporate PSP at the quality and risk committee, having been first considered at CCG.

4) Inter-network learning and sharing will be encouraged where similar patient safety concerns (e.g. self-harm) are being considered across different networks. This is an enrichment process where learning may support multiple networks to develop best practice but does not impede the unique nature and presentation of those incidents within separate network populations e.g., the difference between severity, risk, frequency, options of treatment and management within the specific care environment.

5) Individual services within those networks will utilise the output to develop specific plans to implement the PSP within their service. This is particularly pertinent for some of our multi-service campus sites. This site level PSP will be shared through clinical governance to the region and CCG as well as for the opportunity to share best practice and learning back to the network.

6) Services with a significant proportion of temporary staff (including agency workers) on duty at the time of the incident should always opt to undertake a learning

response approach to an incident, especially where there is doubt an improvement response pathway/or local systems and polices would be known to the staff on duty in a meaningful way. The agency staff will be invited to attend.

7) Services that are new or undertaking a change in practice to a new client group will be supported by the relevant clinical network to establish a local patient safety plan but should ensure that all incidents are reviewed through a learning response process until assured practice is meeting the level of compliance to the planned patient safety plan in the improvement response.

8) The Patient Safety Meeting (PSM) will maintain a register of the corporate, network and service PSPs including date of implementation and all subsequent reviews. The purpose of which is to support the oversight function in relation to reported incidents and subsequent decisions on enacting either a learning response or the improvement response pathways.

9) The Patient Safety Meeting (PSM) will maintain a PSII (Patient Safety Incident Investigation) – database system centrally run and assign reference numbers to any incident being investigated using the PSII methodology and paperwork.

10) As part of the regularly reviewed patient safety profile information, the Patient Safety Meeting (PSM) will receive reports detailing:

    a. The safety plan for those individual's collecting significant numbers of incidents (out of kilter with the usual presentation within service) – those falling into this category will be identified through the mapping reports.
    b. Those within our services escalating beyond the services expertise – where notice has been served to commissioners. The Patient Safety Meeting (PSM) should on a regular basis review the plan and actions being taken to resolve (see Form P2 in appendix).
    c. All delayed discharges and on a regular basis review the plan and actions being taken. (see Form P2 in appendix).
    d. Finishing the SIF system removes the harm threshold as the key driver for investigating but the Patient Safety Meeting (PSM) should still be aware of the harm happening within services. The Patient Safety Meeting (PSM) will be notified of any incidents that fall into the following categories, within the network / service PSP there is a pre-agreed response to some of these which will include to enact a learning response or confirm supported by the improvement response pathway (see Form P1 in appendix):

        i. Any safety incident that has required the individual to be escalated to acute hospital.
        ii. Any safety incident that potentially there will be staff disciplinary action undertaken.
        iii. Any safety incident that the police are asked to respond to / a 999 call made.
        iv. Missing service user.

v. Any safeguarding incident going to a Section 42 England; Section 126 Wales; Section 47 Children.
vi. Any incident that triggers Duty of Candour.
vii. Mental Health Act breach leading to illegal detention.
viii. Any incident that compromises the safety of the unit.
ix. Any incident that has media interest.
x. All deaths.
xi. In addition - All incidents that are not included in the above where the service, region, network, or the board chooses to have a discretionary PSII.

11) The Patient Safety Meeting (PSM) will maintain a register of all safety actions identified through PSII reviews demonstrating:
    a. A need to improve existing systems.
    b. Identified missing systems.

    This will also include the recording of decisions taken to prioritise actions to address / mitigate to ensure that themes and trends of findings are clearly understood and support future thinking within refreshed PSP.

12) There is an on-going constant review requirement to maintain effective relevant and up to date PSP. This review process will occur every 18 – 24 months no matter how many times individual service, network or corporate PSP has been amended. The reason for this is to ensure a whole refresh of the entire patient safety system to give assurance at board level that all patient safety processes are maintained to a high level of PSIRF compliance. This 18 – 24 month review process will be shared with all our stakeholders both statutory, staff and service user related.

Defining our patient safety improvement profile

Elysium developed its governance processes to continually gain insight from patient safety incidents and this feeds into quality improvement activity. We continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we undertake. The governance architecture supporting PSIRF, including the new networks, are being reported through Corporate Clinical Governance (CCG) to ensure there is timely engagement with the operational side of Elysium. Patient safety is the responsibility of the whole organisation and should never be seen solely as a clinical issue.

The Quality and Risk committee provides assurance to the Elysium Operational Board that quality improvement measures, including any safety improvement plans drawn up from the SIF system (completed and outstanding), or which require development and implementation in the future, continue to be of the highest standard. CCG will be responsible for the oversight of this quality improvement work including the robust use of quality improvement methodology

such as Qi (Quality Improvement) which is supported by the Quality Improvement Team. Services and regions also report through CCG on all types of improvement work and developments undertaken, that will also include patient safety actions. This process will continue through PSIRF and the new governance structure. *See PSIRF governance structure below fig 2.*

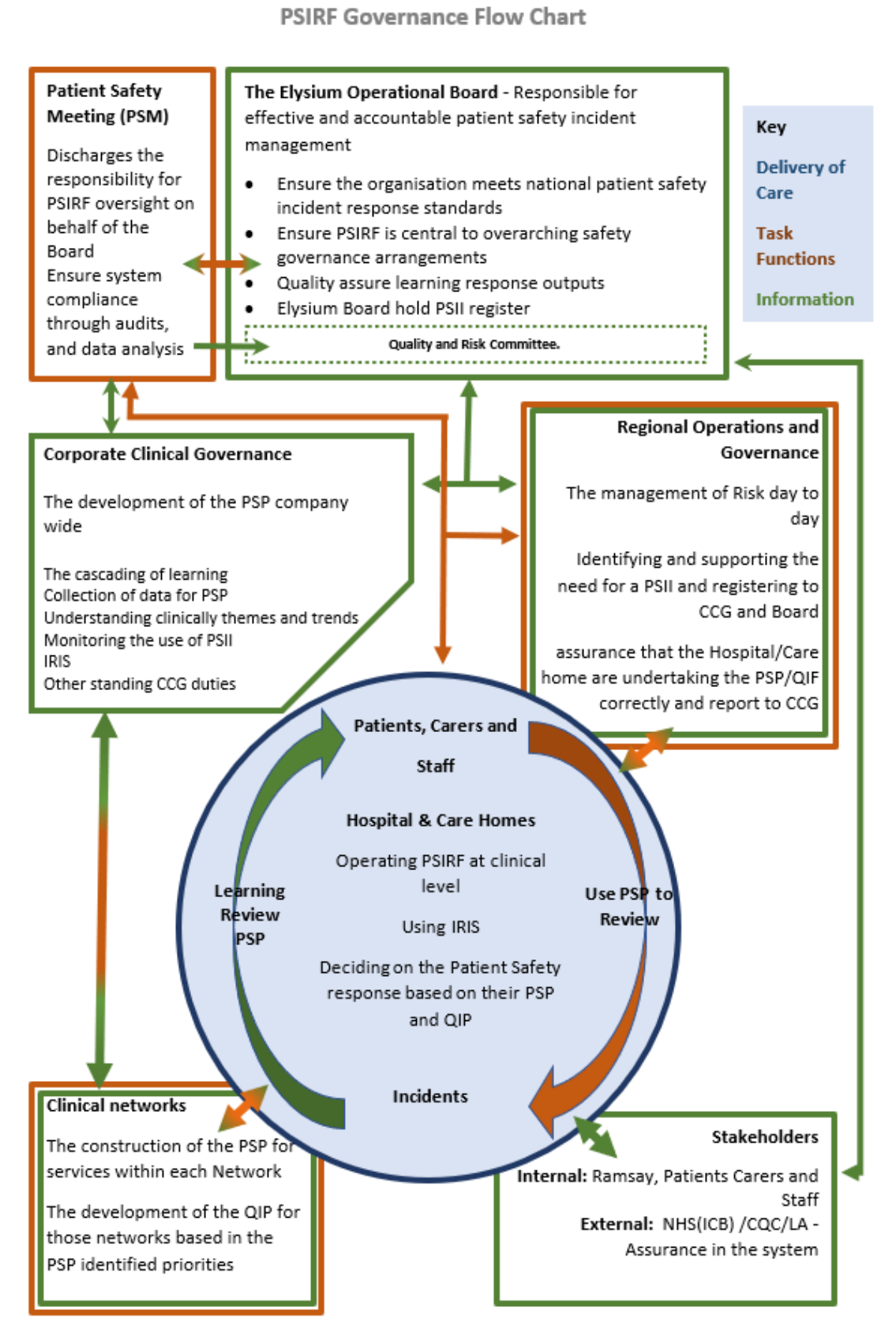
Our clinical networks and regions are required to report to our CCG in order to monitor and measure improvement activity across the organisation. This provides assurance during the development of new safety improvement plans following reviews undertaken within PSIRF to ensure they have followed robust processes during development and fulfil SMART (Specific, Measurable, Attainable, Relevant and Time Bound) requirements and are sufficient to support Elysium to improve patient safety in the future.

We have identified in the local patient safety priorities plans (see below) to index review four key patient priority areas to ensure that we develop quality improvement plans and agree safety actions for these high-level priorities.

A list of Qi improvement work and outstanding incident action plans currently underway can be found in the Qi Hub. Not all the Qi projects will be linked or derived from a patient safety incident, but the developmental nature of practice development and improvement includes a range of service specific projects.

It is important to note that flexibility to consider improvements as required, where a patient safety issue emerges from ongoing internal review or external information, remains supported.

PSIRF Governance Structure fig 2.



Our patient safety incident response plan: national requirements

Elysium, as with all healthcare providers resourced through the public sector, has finite resources for patient safety incident response. We intend to use those resources to maximise improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but Elysium fully supports this approach as it fits with our aim to learn and improve within a just culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed. For clarity, all types of incidents that have been nationally defined as requiring a specific response will be reviewed according to the suggested methods and are detailed in the table below.

Patient Safety Event Occurs	Patient Safety Incident Investigation	National Priorities	Event	Approach	Improvement
			Maternity and neonatal incidents meeting HSIB and Special Healthcare Authority referral criteria	Work with partners to ensure cases are referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
			Child death	Refer for Child Death Overview Panel (CDOP) and liaise with panel as locally led PSII may be required	
			Death of a person who has lived with a Learning Disability or autism.	Refer for Learning Disabilities Mortality Review (LeDeR) liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required	
			Safeguarding incidents in which: Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. Adults over 18 years old are in receipt of care and support needs from their local authority. The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic	Refer to local authority safeguarding lead and notify Elysium named safeguarding lead. Elysium will contribute to domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and the local safeguarding adults boards	

abuse/violence.		
Domestic homicide	Identified by the police usually in partnership with the local community safety partnership with whom the overall responsibility lies for establishing review of the case. Where the CSP considers that the criteria for a domestic homicide review are met and establishment of a DHR panel, Elysium will contribute as required by the DHR panel.	
Death of patients in custody/prison/probation	Refer to Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC)	
Mental health-related homicides	Refer to the NHS England Regional Independent Investigation Team for consideration for an independent PSII, locally led PSII may be required	
Patient Safety incidents meeting the Never Event criteria 2018 or its replacement	Patient Safety Incident Investigation	Create local organisational recommendations and actions and feed these into the quality improvement strategy
Deaths of patients detained under the MHA (1983) or where the MCA (2005) applies, where there is reason to think that the death may be linked to problems in care	Patient Safety Incident Investigation	
Patient Safety incidents resulting in death where the death is thought more likely than not to be due to problems in care	Patient Safety Incident Investigation	

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety insights, based on the review of incidents and engagement meetings and workshops we have determined that Elysium requires four patient safety priorities as local focus. We have selected this number due to the breadth of services that Elysium provides. We will undertake index case reviews (PSII) to develop benchmark safety action plans that will form the basis of high-level quality improvement plans specific to each patient safety priority. These Patient Safety Priorities with their associated quality improvement plans will be the basis of specific clinical network and

site patient safety plans. This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

The following vignette is to demonstrate how this process will work:

A worked through example looking at self-harm patient safety incidents.

We will undertake for the self-harm patient safety priority a series of index PSII reviews across a range of self-harm incidents. The investigators for each PSII will receive supervision from the Patient Safety team to ensure that the process of the PSII ensures an outcome that we can use as a benchmark patient safety action plan. The selected incidents will be a variety of forms of self-harm which have been identified through the data as high frequency incidents (ingestion, insertion, ligature and one "other" incident type depending on occurrence such as cutting or headbanging). We will use incidents from both our adult and children's services to review applicability across all types of services.

The patient safety action plans will then be collated and with the support of a range of clinicians and service users reviewed to highlight the following:

- Similarity of themes in relation to systems and processes used to manage self-harm.
- Similarity in safety issues identified (work as done vs work as prescribed).
- Similarity in prevention and incident management themes.
- Significant differences in the presentation and management that would indicate a separate safety action plan to address system issues identified.

We will use the outcomes of PSII and the thematic MDT review to inform and develop our patient safety improvement planning and work.

Key Patient Safety Priorities

The following table lists our patient safety incidents against type, and this is based on the mapping of all incidents reported from 2020 -2023.

As PSIRF is being introduced we cannot prioritise all types of safety incident, as we develop skills and knowledge, we will be able to review our PSP over time. The previous system was not aligned to achieve symmetry between the practice of patient safety and the identification of the themes that needed to be addressed. PSIRF is more aligned to learning and using data to formulate PSPs. We will aim to reprioritise the management of a wider range of incidents going forwards. It is worth noting that the management of patient risk is not solely a PSIRF issue, as the need to develop systems and models of care will always include practice development and learning from research and best practice. Patient safety incidents and their outcome with the subsequent learning will always be used to improve the planning to manage incidents.

There are two PSIRF responses that feature in the decision pathway[1]

1. **Improvement Response Pathway** – defined improvement plans in place.
2. **Learning Response Pathway** – a range of proportionate learning responses (such as PSII or other tools).

The following table is the key priorities analysed by the data from IRIS and is different from the original key working priorities. See appendix for the Working Assumptions (Key Priorities Document) for reference and record.

Patient Safety Priorities (IRIS Data) with PSIRF decision Response

Event[2]	Approach	Improvement
Patient Violence towards others		
Abuse Aggression Physical	**PSII Index Review and full thematic review to develop PSP**	**Create recommendations to develop Network and site improvement strategy**
Abuse Aggression Verbal (including Hate incidents)	Not prioritised in PSP this year	Managed by Safeguarding
Hostage Taking and disturbance	A learning response will always be required	Create recommendations to develop Network and site improvement strategy
Sexual safety	Not prioritised in PSP this year	Managed by Safeguarding
Weapons	A learning response will always be required	Create recommendations to develop Network and site improvement strategy
Abuse – Neglect and Omission	Not prioritised in PSP this year	Managed by Safeguarding
Self-Harm		
All categories of self-harm are being reviewed through and INDEX PSII process	**PSII Index Review and full thematic review to develop PSP**	**Create recommendations to develop Network and site improvement strategy**
Suicide including those incidents with the potential to cause death	A learning response will always be required	Create recommendations to develop Network and site improvement strategy.
Physical Health Care - Neurological services Only		
Pressure Ulcers	A learning response will always be required	Create recommendations to develop Network and site improvement strategy
Falls	A learning response will always be required	Create recommendations to develop Network and site improvement strategy
All other Patient Safety Physical Health Incident Types	**PSII Index Review and full thematic review to develop PSP**	**Create recommendations to develop Network and site improvement strategy**

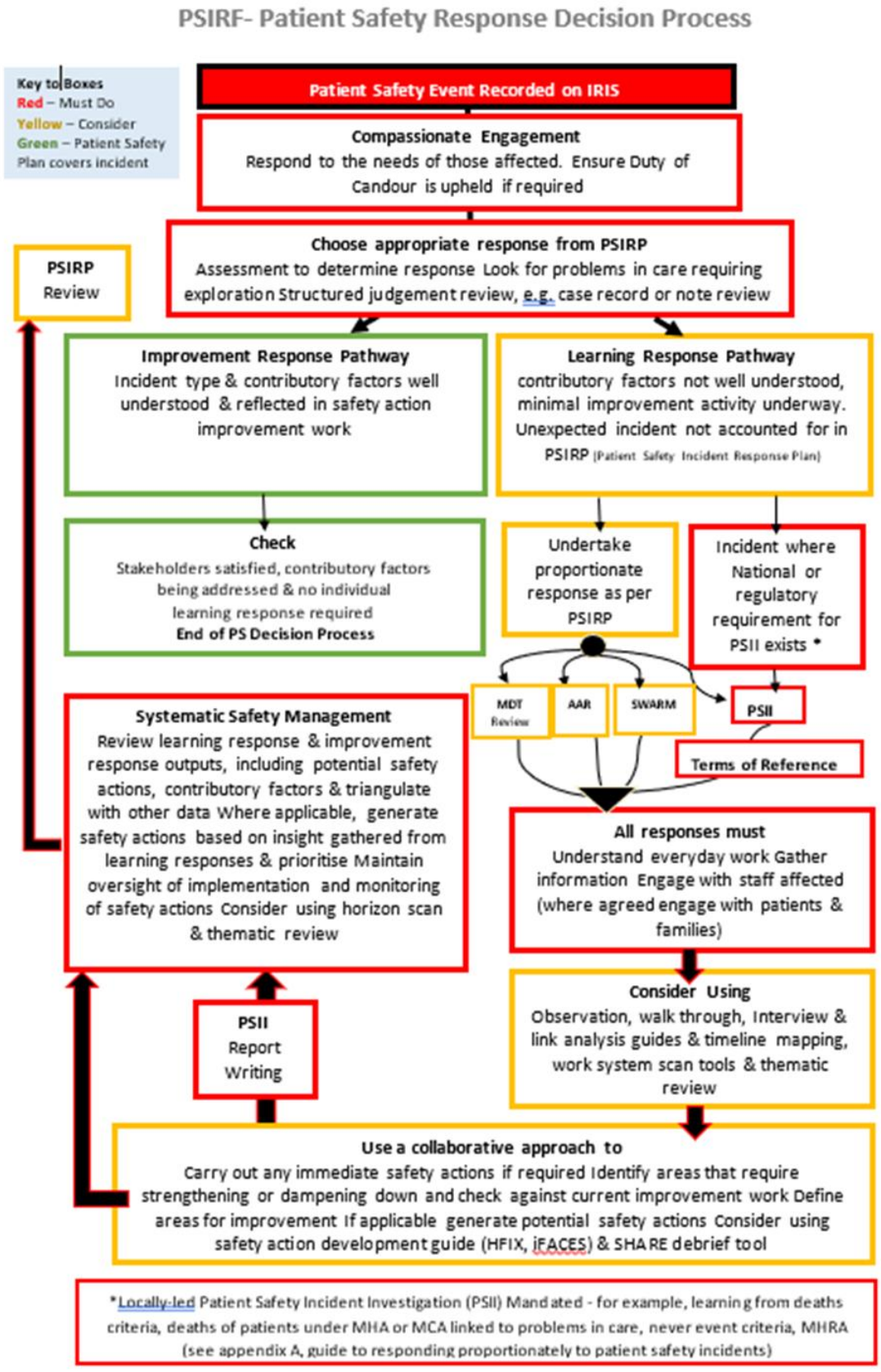
[1] *Decision Chart following patient safety event – see flow chart below Fig 3.*

[2] These are the general rules for managing incidents with PSIRF – although it must be understood that any incident can be investigated as requested by the Patient Safety Meeting (PSM), the service, or external stakeholders request.

Physical Health Care - All other services		
Injury sustained during restraint (may reflect learning from a restraint itself)	A learning response will always be required	Create recommendations to develop Network and site improvement strategy
Accidents and Falls	Not prioritised in PSP this year	Managed by care plan review
Choking and Poisoning	Consider a learning response – if contributory factors not well understood and learning is indicated	To review care plan and potentially to create recommendations to develop Network and site improvement strategy
Substance Use	Not prioritised in PSP this year	Managed by care plan review
Infection Control	Not prioritised in PSP this year	Managed by referring to Policy
Failure to ensure safe use of equipment	Not prioritised in PSP this year	Managed by referring to Health and Safety
Urgent transfer to Acute setting (when not self-harm related)	Not prioritised in PSP this year	Managed by care plan review
Other Physical health patient safety incidents	Not prioritised in PSP this year	Managed by care plan review
Medication Management		
Administration and Dispensing Errors	**PSII Index Review and full thematic review to develop PSP**	**Create recommendations to develop Network and site improvement strategy**
All other medication incidents	Not prioritised in PSP this year	Managed by referring to Policy
Environmental		
Fire	Consider a learning response – if contributory factors not well understood and learning is indicated	Potentially to create recommendations to develop Network and site improvement strategy
Property and Equipment	Review as part of Violence to others	Managed by referring to Health and Safety
Cyber Breaches	Not prioritised in PSP this year	Managed by referring to Policy
Loss of service	Not prioritised in PSP this year	Managed by referring to Business Continuity Plan (BCP)
System Outage	Not prioritised in PSP this year	Managed by referring to BCP
Absent without Leave		
Escape from Secure Unit – from within the secure perimeter or whilst on escorted leave	A learning response will always be required	Create recommendations to develop Network and site improvement strategy
All other leave issues	Not prioritised in PSP this year	Managed by referring to Policy and a care plan review
Mental Health Act		
All mental health act issues including errors in administration, illegal detention, breaches in leave reporting etc	Not prioritised in PSP this year	Managed by referring to Policy

The above was agreed at the Quality and Risk Committee meeting on 7th July 2023 and has been verified by the Elysium Operational Board.

Fig 3


PSIRF- Patient Safety Response Decision Process
Key to Boxes
Red – Must Do
Yellow – Consider
Green – Patient Safety Plan covers incident
Patient Safety Event Recorded on IRIS
Compassionate Engagement
Respond to the needs of those affected. Ensure Duty of Candour is upheld if required
Choose appropriate response from PSIRP
Assessment to determine response Look for problems in care requiring exploration Structured judgement review, e.g. case record or note review
PSIRP Review
Improvement Response Pathway
Incident type & contributory factors well understood & reflected in safety action improvement work
Learning Response Pathway
contributory factors not well understood, minimal improvement activity underway. Unexpected incident not accounted for in PSIRP (Patient Safety Incident Response Plan)
Check
Stakeholders satisfied, contributory factors being addressed & no individual learning response required
End of PS Decision Process
Undertake proportionate response as per PSIRP
Incident where National or regulatory requirement for PSII exists *
MDT Review
AAR
SWARM
PSII
Terms of Reference
Systematic Safety Management
Review learning response & improvement response outputs, including potential safety actions, contributory factors & triangulate with other data Where applicable, generate safety actions based on insight gathered from learning responses & prioritise Maintain oversight of implementation and monitoring of safety actions Consider using horizon scan & thematic review
All responses must
Understand everyday work Gather information Engage with staff affected (where agreed engage with patients & families)
Consider Using
Observation, walk through, Interview & link analysis guides & timeline mapping, work system scan tools & thematic review
PSII Report Writing
Use a collaborative approach to
Carry out any immediate safety actions if required Identify areas that require strengthening or dampening down and check against current improvement work Define areas for improvement If applicable generate potential safety actions Consider using safety action development guide (HFIX, iFACES) & SHARE debrief tool
*Locally-led Patient Safety Incident Investigation (PSII) Mandated - for example, learning from deaths criteria, deaths of patients under MHA or MCA linked to problems in care, never event criteria, MHRA (see appendix A, guide to responding proportionately to patient safety incidents)

Assurance of the mapping process – ensuring validity

Reviewing large data sets will without doubt present a challenge on many fronts, both from ensuring inclusivity and relevance through to accuracy. The systems at Elysium have a series of checks and balances to maintain an oversight of compliance to the company policy and wider system expectations. These checks include a range of second step checks and oversight from other parts of the company and are integral to the clinical governance system. Historically and up to the point the Serious Incident Framework was closed NHS commissioners also had a direct scrutiny role over all RCA (Root Cause Analysis) reports and action plans. The data we used for the process of prioritisation has been through this historical review process. In the future the Patient Safety Meeting (PSM) will maintain a process of quality control and oversight to ensure compliance to our high-quality expectations for the patient safety system, this will be overseen by the Quality and Risk Committee as a standing subgroup of the Elysium Operational Board.

The volume of incidents is large, but the following table sets out our key priorities in relation to the number of incidents.

Fig 4

Event Category	Events Recorded				
	2020	**2021**	**2022**	**2023 (6 mths)**	**Average**
All Violence & Aggression (Physical Violence)	16,541 (10,858)	18,839 (12,009)	18,555 (11,698)	8,485 (4,932)	17,834 (11,285)
Self-Harm	7[3]	8,148	13,470	5,946	11,026
Physical Health (Neuro)	17,915[3] (1104)	12,742 (789)	7,303 (1034)	4,177 (664)	9,689 (1026)
Environmental	1,279	1,632	1,624	701	1,496
Medication	741	1,398	1,550	652	1,240
Breaching Leave	161	242	224	95	206
Mental Health Act	41	87	86	20	67

Assurance of Patient safety planning effectiveness

PSIRF was created to address the well understood problem with SIF, namely that immediate actions were usually implemented well (as achieving safety was an immediate goal) and long-

[3] Data excluded from the average as abnormal.

term action planning was strife with difficulties as the nature of monotonous repetition of the same action plans yet again being developed made evident. PSIRF encourages the retention of immediate safety actions as this is an effective tool. It moves away from disjointed repetitive action planning and builds on the need to invest in a learning culture, where the process of learning maintains momentum supported by oversight, skills and learning to ensure that the review of PSPs and the development of new PSP is evidence and learning based.

The safety plans developed through the improvement response pathway will include the intended aim and the agreed measurement of change. This will enable audit of the system to maintain an awareness of effectiveness of the system. It is recognised that the developed safety actions will take time to embed and see measurable change. The Patient Safety Meeting (PSM) will pre-agree the review and testing period prior to the review of the success and failure of any plan, sustaining change is the goal of patient safety, the iterations of the plan must build on that improvement. Each safety action plan will be subject to formal recording, audit, and scrutiny to ensure effective records of the plans, so that we have a library to review change against any shift in safety profile. This is in effect organisational memory to avoid repeat learning of known issues.

Appendix

P1 – The PSIRF Escalation Form

P1 - PSIRF ESCALATION FORM

P2 - The PSIRF Delayed Discharge and Notice Served Form

P2 - PSIRF delayed discharge and notic

Working assumption – Key Priorities

Working Assumption of Key F

Key Priorities reference to Operational Policies

PSIRF Key Priorities Referenced to OPS F