

# One size doesn’t always fit all

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# One size doesn't always fit all: Professional perspectives of serious incident management systems in mental healthcare


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## ABSTRACT

### Purpose

The need to develop effective approaches for responding to healthcare incidents for the purpose of learning and improving patient safety has been recognised in current national policy. However, research into this topic is limited. Our study aims to explore the perspectives of professionals in mental health Trusts in England about what works well and what could be done better when implementing serious incident management systems.

### Design/ methodology/ approach

This was a qualitative study using semi-structured interviews. Fifteen participants were recruited, comprising patient safety managers, serious incident investigators, and executive directors, from five mental health Trusts in England. The interview data were analysed using a qualitative descriptive approach to develop meaningful themes. Quotes were selected and presented based on their representation of the data.

### Findings

Participants were dissatisfied with current systems to manage serious incidents, including the root cause analysis approach, which they felt were not adequate for assisting learning and improvement. They described concerns about the capability of serious incident investigators, which was felt to impact on the quality of investigations. Processes to support people adversely affected by serious incidents was felt to be an important part of incident management systems, to maximise the learning impact of investigations.

### Originality

Our findings provide translatable implications for mental health Trusts and policymakers, informed by insights into how current approaches for learning from healthcare incidents can be transformed. Further research will build a more comprehensive understanding of mechanisms for responding to healthcare incidents.

## 1 Introduction

Improving patient safety is a challenging problem that has endured across international healthcare systems (Tingle, O'Neill and Shimwell, 2018). In England, particularly over the past two decades, many patient safety policies have been developed and complex patient safety systems have been established in response to this challenge (Vincent, Burnett and Carthey, 2013; Wood et al., 2022). National and local systems for both reporting patient safety events and managing serious incidents, and the system of oversight and scrutiny assurance from commissioners as set out in the current *Serious incident framework* (NHS England (NHSE), 2015), are being overhauled through implementation plans set out in *The NHS patient safety strategy* (NHS England and NHS Improvement (NHSE and NHSI), 2019). This strategy introduces new approaches to respond to all unintended or unexpected events that did or could have harmed patients and to identify learning and the requisite improvements. It explains that the National Health Service (NHS) needs to build on 'two foundations' for safer care, these being patient safety systems and a patient safety culture (NHSE and NHSI, 2019, p. 4).

In relation to the management of serious incidents, the root cause analysis (RCA) safety system has long purported to be a method of identifying service delivery system problems and apparent causes of incidents, so that preventative action can be taken to avoid future harm (Dorsch, Yasin and Czuchry, 1997; NHSE, 2015). However, RCA investigations have been considered to be limited in their effectiveness in reducing the risk of recurrence of incidents (Pham et al., 2010; Macrae, 2016). Recent research interest in the field of mental health has highlighted that the RCA approach can encourage a deterministic conceptualisation of risk and safety, which may undermine the operationalisability of the findings from investigations (Nathan, Whyler and Wilson, 2021). In addition, variation in the practice of RCA is a well known problem (Zimmerman and Amori, 2007; Pham et al., 2010; Wood et al., 2023). It follows that adequate capacity and training, as a support to investigators in undertaking reviews of incidents, competently, is a prerequisite. Cross-system incident investigations are now seen as a necessity, given the recognition that incidents often stem from weaknesses at the interface between agencies, particularly health and social care (NHSE and NHSI, 2020). However, multidisciplinary input and wider support to deliver effective investigations has been highlighted by staff as an unmet need (Ramsey et al., 2022). Therefore, the way investigations are conducted, and their focus, are significant determinants in identifying learning that can be applied to improve the safety of everyday practice.

The *Patient safety incident response framework* (*PSIRF*) is being introduced currently in the English NHS, through a graduated approach, in direct response to the limitations of the current system. It will introduce a range of system-based approaches for learning from incidents, moving away from RCA and approaches that assume simplistic, linear

identification of the causes of incidents (NHSE, 2022a). The framework will require local, regional and national work to transform the way incidents are examined to bring about learning and improvement to services (NHSE and NHSI, 2019). This represents the most substantial change to the patient safety systems that have operated in the NHS over the last two decades. Supporting guidance, published alongside this framework, is encouraging more of a focus on engagement with families and carers, including when an incident requiring investigation occurs (NHSE, 2022b). This has been seen as another factor that can improve investigation quality (Bouwman et al., 2018). The 'duty of candour', which is both a statutory and professional requirement, aims to make sure that those delivering care are open and transparent with those people accessing their services when incidents occur (Department of Health (DH), 2014). It includes candour with patients, families and carers associated with incidents, as part of an effective patient safety system that is open to learning (Crane, 2001; Wood et al., 2023) and promotion of an open culture (Ramsey et al., 2022). Whilst engagement and involvement are current priorities for NHS Trusts (NHSE, 2022b), we are not aware of any specific research on perceptions of the local infrastructures that are required to be able to support those adversely affected by incidents, particularly staff. As a priority area concerning the way serious incidents are currently reviewed, if investigations are to have integrity, there is a need to better understand this support component of patient safety systems.

To-date, the only other professional perspectives concerning NHS patient safety investigations were obtained from feedback following a broad engagement programme to inform future national policy (NHS Improvement (NHSI), 2018). In presenting this study, we have used a qualitative approach to explore the perspectives of professionals in mental health Trusts in England about what works well and what could be done better to maximise the effectiveness of serious incident management systems. This is an approach typically used to focus on research gaps in a healthcare context (Neergaard et al., 2009). Furthermore, given that qualitative perspectives in translational research can help to address complex issues related to improving healthcare quality and implementing system change (Tripp-Reimer and Doebbeling, 2004), we have used this approach to identify findings for discussion in the context of their contribution to knowledge around the research gap.

## 2 Method

This is a qualitative interview study that will report on the data derived from the interviews in two parts. This first part reports on lines of inquiry concerning patient safety systems. Our research aims to build on the findings of our questionnaire study concerning the practice of incident reporting and management (Wood et al., 2023). Interviews were used to seek the perspectives of patient safety managers, serious incident investigators, and executive director leads for the oversight of serious incidents, as subject matter experts in this field in

mental health Trusts. Participants were asked about approaches to investigating serious patient safety incidents and the support provided to investigators. The aim was to seek insights into what works well and what could be done better in the way patient safety incidents are investigated. Ethics approval was obtained from The University of Manchester Proportionate Research Ethics Committee (Reference: 2020-10350-16789) and the NHS Health Research Authority (Reference: 20/HRA/6019). Informed consent was obtained and the purpose of the study was discussed with the participants. They were informed that they could withdraw at any time. Additionally, for the purposes of anonymity, the names of the participating mental health Trusts are not reported. However, to comply with best practice in qualitative research, the analytic methods are described in detail.

### 2.1 *Participants*

Participants were eligible to be included if they had previously participated in our questionnaire study (Wood et al., 2023) and if they agreed that their Trust may be contacted again about taking part in subsequent interviews. Trusts were intentionally selected by the first author, DW, on review of their questionnaire responses, where it was felt that follow-up would maximise the provision of relevant information (Malterud, Siersma and Guassora, 2016). For example, one participant reported that they were moving away fully from RCA training; therefore further information on this was relevant to one of the inquiries of this qualitative study, in particular, the support provided to investigators. The target was to recruit participants from five Trusts. During the course of recruitment, two Trusts were approached but declined to take part, due to not having capacity to participate. One Trust did not respond. Whilst specific methods were not employed to recruit participants with a diversity of experiences, the occupational groups were selected for holding characteristics highly specific for the study aim (Malterud, Siersma and Guassora, 2016). Fifteen participants were interviewed, with a diversity of characteristics in terms of sex, age and NHS experience (*Table 1*). The final sample included five Trusts, one from each of the regional boundaries of England (North, Midlands & East, London, South East, and South West).

*Table 1* Interview sample characteristics

| Identification code | Occupational title | Sex | Age range (years) | Experience in current role (years) | NHS experience (years) |
|---|---|---|---|---|---|
| MGR1 | Head of Patient Safety | Male | 45–54 | 10 | 25 |
| MGR2 | Patient Safety Manager | Female | 55–64 | 9 | 22 |
| MGR3 | Patient Safety Specialist | Female | 45–54 | 2 | 25 |
| MGR4 | Head of Patient Safety | Female | 35–44 | 2 | 10 |
| MGR5 | Head of Patient Safety | Male | 45–54 | 7 | 24 |
| INV1 | RCA Lead | Male | 45–54 | 12 | 21 |
| INV2 | Governance Lead | Female | 25–34 | 3 | 3 |
| INV3 | Investigating Manager | Female | 55–64 | 9 | 31 |
| INV4 | Investigating Officer | Female | 45–54 | 7 | 21 |
| INV5 | Lead Investigator | Female | 25–34 | 6 | 11 |
| DIR1 | Director of Nursing | Male | 55–64 | 4 | 4 |
| DIR2 | Director of Nursing | Female | 55–64 | 10 | 22 |

| Identification code | Occupational title | Sex | Age range (years) | Experience in current role (years) | NHS experience (years) |
|---|---|---|---|---|---|
| DIR3 | Director of Nursing | Male | 45–54 | 2 | 23 |
| DIR4 | Chief Nurse | Female | 55–64 | 4 | 41 |
| DIR5 | Director of Nursing | Female | 45–54 | 4 | 26 |
| | | | Mean (years) | 6 | 21 |

2.2 *Procedure*

DW led and facilitated all aspects of the data collection, transcription and analysis. This prolonged engagement with the dataset gave qualitative validity to this research (Lincoln and Guba, 1985). He conducted all of the one-to-one interviews remotely. Participants were at their place of work. There was no pre-existing relationship between him and the participants. Interviews were conducted between April 2022 and July 2022 and ranged from 30 to 102 minutes (mean = 55 minutes). Interviews were semi-structured and followed an interview guide (*Table 2*). The guide was piloted with three different professionals of a similar designation to the target population. It was also modified in discussion with the other authors. An example of a revision was when participants were asked about the support provided to investigators. Prompts were added to this question to seek perspectives around the adequacy of this support. Interviews were video recorded via Microsoft Teams, transcribed verbatim, and anonymised. The data were transferred into and managed in NVivo version 12 (QSR International Pty Ltd, 2018).

*Table 2* Interview guide

| **Discussion areas concerning patient safety systems to investigate serious incidents** |
|---|
| *Introduction to interviews*<br>Aims are to understand:<br>▪ Perspectives about what works well and what could be done better concerning patient safety systems to investigate serious incidents<br>▪ Perspectives on implementing The NHS patient safety strategy concerning the incoming framework for responding to patient safety incidents |
| *Topic 1: Approaches to investigating serious incidents*<br>▪ Ask about what methods are used to investigate serious incidents<br>▪ Ask about what works well in the way serious incidents are currently investigated<br>▪ Ask what the participant thinks could be done better to improve the way serious incidents are investigated<br>▪ Ask how duty of candour is addressed as part of the investigation process (Explore particular approaches) |
| *Topic 2: Support provided to staff who investigate serious incidents*<br>▪ Ask about the responsibilities of those who investigate serious incidents<br>▪ Ask about training provided to investigators (Is this adequate? What is good about the training? What can be improved?)<br>▪ Ask what kinds of things facilitate effective investigations when they involve partner organisations (Explore what the participant thinks acts as a support to the investigator and to the investigation process)<br>▪ Ask about any barriers faced when working with partner organisations as part of an investigation (Explore particular issues and what support could help to address these barriers) |

DW took a thematic analysis approach that was data-driven, with themes produced inductively from the raw data, rather than generated from theory. This involved the use of a

qualitative descriptive approach to analyse and present participants' perspectives, in which there was fidelity to the participants' own language (Neergaard et al., 2009). DW transcribed, read and re-read transcripts as the interviews with each participant progressed, and identified commonalities and differences among the data (Miles, Huberman and Saldana, 2019) so that data analysis informed later interviews (Department of Health and Social Care, 2020). Meaningful themes were generated inductively in standard stages (Braun and Clarke, 2006). During the final stages of analysis, DW re-read selected transcripts for further consideration and analysis to ensure a diverse range of participants' descriptions were presented (Miles, Huberman and Saldana, 2019).

The authors' contribution to the analysis procedure came from diverse professional and research experience. DW has postgraduate credentials in professional studies and is a patient safety professional in a mental health Trust, with experience in this field at operational and strategic levels. He also has practical experience of leading interviews, including with professionals involved in serious incidents. RM is an experienced qualitative researcher and has conducted qualitative research on patient perspectives of various aspects of healthcare, and also health and social care professionals' perspectives and experiences of working within various systems and roles. CR has a global research portfolio in mental health, social care and mixed methods research, including in the disciplines of healthcare policy and safety. RN is national mental health lead and has carried out extensive research in mental healthcare and patient safety. RM read the transcripts in full throughout the interview data collection process. Throughout the analysis procedure, RM queried the perspectives of DW, given his active professional background allied to the research subject (Kincheloe and McLaren, 2005). This supported ongoing review and refining of the themes. The other authors challenged the interpretations of the data during the analysis and report writing phase of the study (Creswell and Miller, 2000). This 'check and challenge' approach assured of analytic rigour (Whittemore, Chase and Mandle, 2001; Steinke, 2004) and supported a shared understanding of the themes that were created and interpreted by DW (Braun and Clarke, 2019).

To support the presentation of the results, quotes from professionals were selected based on their representation of the data and to illustrate analytical points. They are presented with numerical identifiers, as per *Table 1*. Text in brackets provide explanatory comments; ellipses represent omitted words. This approach complemented the data-driven thematic analysis, with the aim of presenting generalisations that held true for the data collected (Miles, Huberman and Saldana, 2019). It facilitated a data-driven synthesis of professionals' accounts, rather than theory development (Neergaard et al., 2009).

## 3 Results

Three major themes were identified, as summarised in *Table 3* and described in detail below.

*Table 3* Summary of major themes

| | Theme | Summary description |
|---|---|---|
| **1** | Dissatisfaction with RCA and current serious incident management systems | Explores participants' views concerning current serious incident management frameworks and how future frameworks should be approached |
| **2** | Capability of serious incident investigators | Considers the impacts on the investigation process, and on investigators themselves, of not having the capacity to undertake quality investigations.<br>Explores means to assure of the delivery of competent investigations. |
| **3** | Support processes for people affected by serious incidents | Explores Trusts' approaches to engagement and involvement of patients, their supporters and staff during the investigation process |

### 3.1 *Dissatisfaction with RCA and current serious incident management systems*

Consistent with the national driver to improve the current patient safety system in the NHS, participants described dissatisfaction with the effectiveness of current frameworks to review serious incidents locally and across stakeholders. Our analysis attends to participants' perceptions concerning the suitability of the current national and local frameworks. We did not see views expressed that endorsed these frameworks as satisfactory.

#### 3.1.1 *Variation in local processes to investigate serious incidents*

Nearly all participants reported variation in their organisational processes for investigating serious incidents: 'there are a mixture of approaches' (MGR1); 'all of us [investigators] have very different styles of investigation' (INV2). This participant (INV2) thought that the incoming national framework for responding to patient safety incidents was an opportunity to mitigate this variation, but they felt that because, paradoxically, it would allow organisations to carry on doing things differently, the lack of consistency could be exacerbated:

> *There's a lot of thinking to be done about how we get consistency, which is the aim of the new framework, but … the variation in our [patient safety incident response] plans could make matters worse.* (INV2)

#### 3.1.2 *Variation in internal ownership of serious incident investigations*

Almost all Trusts, at the divisional level of their operating structures, described variation in processes to assure of quality of investigations. As a consequence, ownership of investigations in most Trusts was described as variable, which participants felt was not always supportive in assisting learning and improvement.

> *Taking this from my perspective … we might not always get the process right and we accept things being done differently, [so] the organisation's willingness to learn and improve and get it right is not exactly where it needs to be.* (INV4)

Furthermore, participants from two Trusts provided differing views around internal ownership of investigations. One participant said they felt that they, as the investigator, owned the investigation report, but the Trust's oversight group was seen as being the responsible authority: 'it feels a little bit like you have to obey [the group] that reviews the serious incident report' (INV3). Another participant felt differently, namely that their Trust's investigators were less inclined to consider they owned the investigation report: 'I always [have to remind] the investigators, you're in control of this, you're the investigator' (MGR5).

3.1.3 *Concern that the benefits of collaborative practices with partner organisations were not being realised due to a lack of co-ordination of the investigation process*
Participants from most Trusts felt that the product of sound engagement with partner organisations was better shared ownership and stimulation of learning from serious incidents to facilitate the provision of safer care. For example, DIR1 said: 'when you get the GP, a social worker or the District General Hospital that's engaged, there is really powerful learning'. However, there was a close inter-relationship between the previous sub-theme of ownership of investigations at Trust level and the challenges of achieving such sound engagement with other partner organisations when investigating incidents.

> *The biggest challenge is the ownership of that care or that case. Inevitably, we end up finding very little was to do with mental health and then the challenge starts around [the partner organisation] agreeing they need to lead or be part of the review.* (INV2)

Participants spoke of effective stakeholder collaboration being a challenge because of the lack of support from commissioners for co-ordinating investigations across multiple settings. This resulted in disagreements concerning which organisation 'owned' a particular serious incident. One participant felt that if the changes set out in the PSIRF were fully realised, concerning cessation of the performance management role of commissioners and instead their role being to facilitate integrated working across partner organisations, then stakeholder organisations would engage better when serious incidents needed to be investigated:

> *The difficulty we have is engaging with primary care, with our acute provider … [and] social care. They've got no obligation to be involved in these processes up to now, yet a lot of mental health Trust stuff involves those sort of intricate complex relationships between social care and mental health. So for me, the greatest*

> *improvement will come from that relationship between other agencies and breaking down some of those "who owns it?" [barriers]. Once you get rid of some of that performance management stuff [from commissioners] … and you can focus on engagement, that's when the magic will happen.* (MGR1)

Participants were asked further about the change to the longstanding governance and oversight role of commissioners. Most participants felt that, despite the responsibility for overseeing individual investigations shifting from commissioners to provider boards and leaders, that: 'commissioners are so used to performance managing us, despite what the intention of the PSIRF is ... they will still pass judgement on our reports' (INV1). However, it was felt that if the oversight of investigations changed from being a role for commissioners to being led by provider organisations, this could have a positive impact on commissioners' contributions to the investigation process, particularly around support for learning.

> *The willingness of commissioners to change their role and co-ordinate investigations across health, care and other settings will be a problem. Our board will become responsible for our reviews. So commissioners should have more capacity, which should be diverted to strengthen co-ordination of incident reviews across system partners.* (DIR1)

3.1.4 *Concern about the impact of governance systems where investigations require the input of multiple partner organisations*

Interviews further explored what was preventing organisations from acting and learning from incidents where patients had accessed care across multiple settings. The investigator cohort felt that shortfalls in communication, particularly because of the requirements around information governance, but also because of the requirements of local governance systems, was a hindrance: 'governance can be a barrier … if it's not complementary with partner organisations' governance' (INV5). A director illustrated the impact of governance processes that were not aligned, such that investigations were reviewed in isolation and from the perspective of the organisation rather than the patient:

> *We had an incident where the ambulance service were involved. We liaised with them … and pulled out some of their learning and reflected that in our report. But what we didn't do was a true case review. That's the patient journey, not the organisation's journey, but actually the patient's journey from the beginning to the end of accessing their healthcare. There's definitely a willingness to get there from a safety perspective. There aren't any real barriers, apart from information sharing, that's always a barrier.* (DIR4)

### 3.2 *Capability of serious incident investigators*

3.2.1 *Concerns about the impact of capacity constraints on investigators*

Investigators consistently described having capacity and time constraints that affected their ability to undertake effective investigations in their Trust, coupled with the impact on them as investigators. It was illustrated to be a long-term problem by INV1: 'because there are only two of us … we've been trying to keep up with our capacity issues about the last two and a half years'. The impact was further explored with the participants, with the consensus being that the main impact was on the quality of investigations, as MGR4 explained: 'definitely quality … of reports [and investigations] … because it's about having the time … as well as … processing our reports [and] attending training'. INV3 went further about the lack of capacity of investigators, feeling that the lack of support provided by her Trust, coupled with the role being demanding, had negative consequences on investigators themselves. She felt: 'you face scrutiny [and] also criticism from … clinical colleagues that information has not been shared with them timely enough, which is because of capacity', and that: 'it exhausts me …. I [have to] know a case inside out and I'm bound to be passionate about it, [but] it's very hard not to take it personally when you've tried really hard to get everything right … to get out of it with your dignity intact and … still feeling that you're able to offer the family and the patient something'.

3.2.2 *Differential views on what constitutes competent investigators*

Descriptions of the adequacy of the training in RCA offered to investigators differed. Participants from two of the Trusts commented that the training they received was not contemporaneous. Descriptions ranged from a lack of training: 'I don't think any of us have done the old RCA training' (INV4), to people's training not being refreshed: 'we've had three rounds of RCA training from different companies. The last set of training that we had was probably 2018, if not way before that' (MGR2). However, when asked if shortfalls in training impacted on their competence, none of the investigators felt that it did. One investigator, who had been undertaking investigations for many years, had not received any training in RCA despite it being stipulated in their Trust policy; however, they did not feel that this necessarily reflected on their competence:

> *I've been doing [investigations] for about three years now. My training has been through the other postholders and supervision. Our policy says we should have RCA training. Obviously the most important bit is I've been shown how to apply it in a practical sense … I can probably demonstrate a knowledge of the RCA process, if not the full theory behind it. I can do an RCA of an incident in the way I've been shown.* (INV2)

Participants from the three other Trusts provided up-to-date RCA and additional training to investigators, which they considered strengthened their competence:

> *When it first came out, we did the multi-day RCA training. We've done bits of training along the way. Our safety and suicide teams did some training with us about the NCISH [National Confidential Inquiry into Suicide and Safety in Mental Health] standards. That's just facts, but it helps consider the standards when you are reviewing an incident, it brings a bit of evidence base.* (INV1)

> *The national patient safety training modules [have gone] … well with our people here*. (MGR3)

> *As well as RCA training, we secure stuff based on the appraisals I have with the investigators, anything they ask for or think they need in their role.* (MGR5)

Participants were asked about whether their Trusts were prepared for conducting investigations using the system-based method, from an investigatory competence perspective. One investigator said that they had received training in this newly introduced approach, but it had not yet shifted in its focus on RCA, which they felt was a step change that was needed in order to promote investigatory consistency:

> *RCA is still there in the system-based training. I think this needs looking at, on a national basis, or we will have a PSIRF and all the criticisms about variation with RCA will just become the same with system-based investigations.* (INV3)

Another participant, whose Trust had plans to move to training in system-based investigations, felt that effective and practicable support was required from their organisations to release investigators to undertake training and so build their competence in this method:

> *We're moving to the national training, which is going to be 30-40 hours in a portfolio. That's a big chunk of time for people to be attending training and demonstrating they've got to a certain standard.* (MGR4)

### 3.2.3 *The desire for an effective national offer to support the introduction of system-based investigations*

Building on participants' views about building investigators' competence in undertaking system-based investigations, it was suggested by one of the participants that an offer of support at a national level would complement local approaches and would promote fidelity to the system-based method:

> *It would be good to get some national offer, because otherwise we'll all go back to doing things ourselves. We want some similarity across the country, so we know we're all doing it as it should be done.* (MGR5)

One director, whose Trust had developed a local approach to system-based training, also advocated introduction of national standards. He suggested this would promote consistency across Trusts and promote a shared understanding, including the wider public's understanding that the incoming approach will be about improving healthcare systems and fair accountability, rather than root causes or culpability. However, it was felt that a national offer required a considered approach so that it was workable alongside local approaches:

> *It could be started off locally. By bringing a national training standard into it, all investigators will work to a certain standard, with resources that they could tap into to be able to do the job. In terms of a support offer, if you had a national approach, the general public would be able to look it up and understand it, so that they don't expect things that are unrealistic. The problem is, when things go national, they go too broad and then they're no use to anybody because nobody understands them or the best intentions are lost somewhere between idealistic and realistic.* (DIR3)

### 3.3 *Support processes for people affected by serious incidents*

#### 3.3.1 *Concerns that the duty of candour was devaluing the essence of engagement with patients, families and carers*

All participants felt that the professional and statutory duty of candour was a tenet of managing the response to serious incidents. However, all participants felt that since this duty had been introduced, it had unintended negative consequences on staff being able to engage with patients and/ or their supporters in the serious incident management process in a meaningful way. For example: 'sometimes the management of duty of candour is not good and it can go wrong [because] people are frightened of it' (MGR5); 'duty of candour should be really simple in terms of process, but it gets really difficult and we've become less open because we've attached the statutory requirement to it … when it was informal, it wasn't threatening' (MGR1); 'clinicians still struggle with this concept that you're not saying I did something wrong' (DIR1).

Many participants felt that a focus on performance management of the required timeframes for enacting the duty, rather than engaging at a time that was acceptable to patients and/ or their supporters, was not always achievable: 'compliance is a bit shaky' (MGR1); and not always person-centred: 'our families sometimes aren't ready to receive that duty of candour in 10 days and we've had many occasions when it's being missed because of that' (MGR2). Despite enduring difficulties with enacting the duty, many participants described

the ways in which their Trusts were improving the quality of duty of candour and engagement with families via training: ‘we’ve done some very tailored online mandatory training for staff’ (DIR4); ‘a duty of candour patient information leaflet is shared with anyone involved in an incident … we are also further developing our duty of candour training by making it standalone training’ (DIR5).

3.3.2 *The valuable role of the family liaison officer*

A common approach described by participants across all Trusts, to improve engagement and involvement of those affected by incidents, was the involvement of family liaison officers (FLOs) in the serious incident management process. INV1 explained: ‘the FLO is crucial in terms of getting the best value out of the process because, as investigators, we tend to get too immersed in the relationship with the families and the carers’. The role of the FLO was described by DIR3 as: ‘to ensure patients, their families and carers are central to reviews of care, they are connected with, that we communicate with them, and we ensure their feedback is acted upon and incorporated into care delivery’. Participants described how their Trusts approached engagement, with different approaches reported, however the underlying commonality was that the FLO provided individualised support that was adapted based on people’s needs.

> *When investigations begin, a letter is sent in all serious incident cases. This letter invites families to share their views and to be involved in the investigation process. On completion, families are invited to meet to discuss the findings and any learning, facilitated by the FLO.* (DIR2)

> *The FLO can be the go between, the mediator, if that’s needed. She can really understand what the questions are that the families have and help the investigating officer to frame it and to understand it.* (MGR4)

3.3.3 *Support to wider patient groups and staff affected by serious incidents*

Whilst participants described the valuable role of the FLO in supporting patients, families and carers, all participants also described the support their Trusts provided to wider patient groups and staff, for example, those in the ward environment during the time of an incident. DIR2 said: ‘if other patients are present during, or affected by a serious incident, we offer support, for example details of bereavement services or a facilitated group meeting’. Investigators and directors considered that the provision of support to staff, whose confidence had been affected by incidents, to be an integral component of their serious incident management processes, with DIR4 explaining that: ‘developing and building the confidence of staff is the most important part of achieving excellence in care, so staff support is a key element to serious incident management’. Participants described the processes they had in place to support the emotional wellbeing of their staff following a

traumatic incident, which they felt was important to help them process their feelings and subsequently enable the learning response and facilitate improvement.

> *If the team have a suicide or an inpatient death, we debrief and support staff and work through what could have gone better, but also in terms of their emotional support as well by [taking] into consideration timely access to post-traumatic stress counselling.* (INV2)

> *It can be incredibly stressful for our staff and we need to make sure that we have support for them as they navigate that very emotive journey [and so] increase psychological safety so we can have open and honest conversations about things.* (INV5)

## 4 Discussion

The participants in this study, who all had key roles and responsibilities for delivering the incident management system in their mental health Trust, described dissatisfaction with the current frameworks at a national and local level for responding to serious incidents. Their professional insights are subsequently discussed, in order to consider how future frameworks can be transformed to maximise opportunities to improve current practice and system change. Many professionals were conflicted in their anticipation of the transition to the *PSIRF* (NHSE, 2022a). Whilst there was optimism because of the shift from the current *Serious incident framework* (NHSE, 2015), which all participants felt was not fit for purpose, this was coupled with reticence about the 'real-world' implementation changes to the process. These feelings of reservation, in most instances, were rooted in their past experiences of ineffective implementation of patient safety policy initiatives, reflecting evidence from our previous study (Wood et al., 2022).

Based on their professional experience and expertise, participants had a diverse range of perspectives concerning how to prepare for, and navigate, the potential challenges with implementing the national plans to improve the current serious incident management systems. Perspectives were provided concerning the different levels of the NHS safety system, which comprises local systems and various regional and national healthcare organisations (NHSE and NHSI, 2019). At a local level, Trusts are required to develop a 'patient safety incident response plan' as part of their 'patient safety incident response policy', but they are only required to consult a national template for both (NHSE, 2022a). There was concern that this could exacerbate variation between organisations in the processes used to respond to incidents, which was felt would contribute to the delivery of unwarranted differential learning outcomes. However, in their patient safety incident response plans, Trusts will have an opportunity to identify, define and clarify the roles and responsibilities at their Trust with respect to the ownership of the different aspects of their

management responses to incidents. Additionally, the incoming national framework may give more opportunities for good approaches to emerge. When considering cross-setting investigations, our findings go beyond suggesting a change in the roles and responsibilities of subregional organisations to 'support investigation of complex cross-system incidents', as described in *The NHS patient safety strategy* (NHSE and NHSI, 2019, p. 24). An important element of our findings was the view that information sharing constraints will need to be addressed to make it easier for incidents to be co-ordinated at a regional level. Consequently, it was felt that this would facilitate a shift from the current focus of incidents being reviewed from the perspective of organisations, to being reviewed from the perspective of the patient.

Arguably, the primary complaint of most investigatory professionals in healthcare provider organisations has been the lack of dedicated time and resources to undertake adequate serious incident investigations (NHSI, 2018; NHSE and NHSI, 2019). Consequently, this has informed the most substantial change set out in the incoming national framework for responding to patient safety incidents; namely, the implementation of a proportionate, risk-based approach, rather than the 'one size fits all' approach of RCA. In our study, most participants felt that this was likely to address current capacity constraints and, in turn, improve the quality of investigations. However, from the perspective of investigators, a more fundamental concern was exposed, that will not be addressed by merely improving safety investigation training and expertise as set out in current national plans (NHSE and NHSI, 2019). Our findings point to a 'systems and structures' paradigm in healthcare, which is not seen in other safety critical industries. In healthcare, investigators are not always recognised as a standalone profession and there is not always a resourced and resilient supporting infrastructure for them within the organisation (Macrae and Stewart, 2019). Despite this, and despite different investigatory training provided by mental health Trusts, the accounts of all investigators in our study have indicated that they felt they were competent in their role as a safety investigation professional. Competence is a more subjective concept than proficiency, therefore translation of our findings around what participants considered to be shortfalls in investigatory training for staff can enhance the expertise of investigators going forwards. Namely, despite the laudable efforts to introduce local approaches to training in system-based investigations, a national training management system involving accreditation and revalidation will ensure all investigators have a common proficiency level.

Finally, our findings suggest that processes to support people adversely affected by incidents are an essential component of serious incident management systems. In relation to supporting patients, the participants in our study placed value on compassion, effective communication and facilitation of post-incident support informed by opportunities to debrief. In relation to supporting staff involved in patient safety incidents in healthcare, despite early

research recognising that there is an impact on staff (and healthcare organisations) as well as patients (Wu, 2000), formal evaluations and high quality research describing the effectiveness of interventions to support them is lacking. The literature does suggest that this support need is not always met (Healthcare Safety Investigation Branch (HSIB), 2021). However, our research has evidenced that some of the mental health Trusts in our study provided support to staff affected by serious incidents. This provides examples for other Trusts who might not emphasise a staff support programme in their incident management systems. In particular, such programmes should consider the novel finding of our study that concern for 'staff' should extend to those undertaking investigations and not just clinicians.

Further research and national guidance may be an effective approach to support in identifying systems to mitigate the traumatic consequences on staff involved in serious incidents, which was highlighted in the accounts of the participants in our study. Tending to people's wellbeing as a factor in a safety management system would likely promote psychological safety and create a compassionate climate and learning environment that increases the potential to improve care. This patient safety system approach characterises and is aligned to the principles of a patient safety culture (NHSE and NHSI, 2019). Furthermore, it is clear in *The NHS patient safety strategy* that there is an interdependence between a patient safety system and a patient safety culture (NHSE and NHSI, 2019). We go on to explore findings from the interview data around patient safety culture in the second part of our study. This will present professional perspectives about what works well and what could be done better concerning patient safety culture so that the response to incidents, for the purpose of learning and improving patient safety, can be more effective.

## 5 Conclusions

This study has explored the perspectives of healthcare professionals in mental health Trusts regarding frameworks for responding to and investigating patient safety incidents. It is the first to present insights into how future frameworks can be transformed and as such provides translatable implications for mental health Trusts and policymakers, which may be explored further. A specific area for future exploration is the impact and consequences of the incoming national framework, given the potential to introduce further variation in local processes and approaches to investigating serious incidents. At a time of active and significant change for the NHS in England in relation to serious incident management systems and the endeavour to support patient safety learning, the suggestions put forward by participants, and our analysis of the findings, provides a helpful indication of which processes, if bolstered, can maximise the impact of investigations. Finally, there is scope to extend this research to other organisations that make up the English healthcare system, both NHS and non-NHS, to assess transferability and to build a more comprehensive understanding of the challenges and mitigations in relation to implementing the changes to serious incident management systems.

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