Berkshire Healthcare
NHS Foundation Trust

Patient Safety Incident Response Plan

PSIRP

Effective date: January 2024

Estimated refresh date: January 2026

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Authoriser/s	**As per Policy CCR173**			
	For Review by end 2025			

Contents

1. Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how Berkshire Healthcare NHS Foundation Trust intends to respond to, and learn from, patient safety incidents reported by our staff, patients and their families and carers and third-parties such as the Coroner.

It is our plan for the next 18 – 24 months but we acknowledge that it 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 occur and the needs of those affected.

The document should be read alongside the national Patient Safety Incident Response Framework (PSIRF) (NHSE 2022), which sets out the requirement for this plan to be developed as well as our Trust Patient Safety Incident Response Policy.

Overall, PSIRF requires a fundamental shift in how the NHS responds to patient safety incidents for the purposes of learning and improvement. It makes no distinction between 'patient safety incidents' and 'serious incidents (SI)' and as such the SI Framework will cease to exist as this plan is being introduced. Some national requirements will however continue to influence some incident responses decisions, and these are considered within this plan.

In order to develop PSIRF-compliant and effective patient safety incident response systems, we need to ensure that we[1]:

- ***Compassionately engage and involve those affected by our patient safety incidents*** – seeking patient, family and staff input into a response and developing a shared understanding of what happened using approaches that prioritises and respects the needs of those affected.

- ***Apply a range of 'system-based approaches'*** *to learning from our patient safety incidents* – PSIRF recognises the complex interactions arising from the healthcare system and the need to move away from root-cause analysis approaches to system-based investigations.

- ***Decide on 'considered and proportionate responses'*** *to our patient safety incidents* – PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm. It promotes a range of learning responses which we can apply if an incident requires further review - meaning that an investigation is only one of a toolkit of methodologies that can be used.

[1] How we will achieve these 4 main areas is described in more detail in our Patient Safety Incident Response Policy

- ***Have supportive oversight*** *that focuses on improvement.*

The purpose of our plan is to specify the methods we intend to use to maximise learning and improvement and how these will be applied to different patient safety incidents that occur within our services.

It has been developed based on a thorough understanding of our current patient safety profile, ongoing improvement priorities and available resources. In addition, there has been collaboration and discussion with our key stakeholders as well as assistance from, and approval by, our local Integrated Care Boards (ICB's).

This plan will be updated regularly based on new learning, our changing risk profile and ongoing improvements. In this way, 'incident response' becomes part of a wider safety management system approach across Berkshire Healthcare.

It is important to remember that we have some robust and rigorous processes already in place for reviewing our patient safety incidents and, as a result, some of these will remain as we implement our PSIRP. We received accreditation in 2021 from the Royal College of Psychiatrists for our approach to investigating 'serious incidents' which encompassed how we engage with patients and their families during the process. We use a 'team approach' to completing our investigations which has been positively received by staff and seen as factor in supporting our 'Just Culture'. Over the past 12 months, we have also been Multidisciplinary Debriefs and After Action Reviews (AAR) to introduce staff to alternative methodologies to reviewing and responding to some of our incidents.

2. Glossary

After Action Review	A structured, facilitated discussion of a patient safety incident, the outcome of which gives the individuals involved an understanding of why the outcome differed from that expected and the learning to assist improvement.
Initial Findings Review	A written initial review of the incident/event, usually completed by one author. This will include a timeline of events, highlighting any immediate risks and whether there are any concerns that may require a subsequent learning response.
Learning Response	A tool that is designed to facilitate learning in response to a patient safety incident. This is a generic term for any of the methodologies included in the toolkit which are further covered in Appendix 4.
Multidisciplinary Roundtable Review	A multidisciplinary roundtable review supports teams to learn from patient safety incidents that may have occurred in the last few days or earlier. It may require some preparation including some focused areas for discussion/reflection and aims to bring together clinical staff with patient safety and governance support.
Patient Safety Incident	An unplanned, unexpected or unintended event where something has happened, or failed to happen, as a result of the care or treatment provided that could have or did lead to patient harm.
Patient Safety Incident Investigation	A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. It is an in-depth review of a single patient safety incident or cluster of events to understand what happened and how
Swarm Huddle	This is designed to be initiated as soon as possible after an event and involves an MDT discussion (could also be referred to as a hot debrief)

3. Our services

Berkshire Healthcare Foundation Trust (BHFT) is a community physical health and mental health organisation providing a wide range of services to people of all ages living within Berkshire County.

BHFT provides services to a population of approximately 915,000. Services cover mental health, physical health, and specialist services for young people.

On 01 April 2023 the organisation restructured, and its current set up includes three divisions:

- **Mental Health Services.** This includes three overarching services: Urgent Mental Health Care, Specialist Mental Health Services and Community Mental Health
- **Community Physical Health Services:** including Urgent Community Services and Scheduled Community Services
- **Children, Families and All Age Services** including CAMHS and Learning Disability and Neurodiversity and Universal Services and Perinatal, eating disorder all age

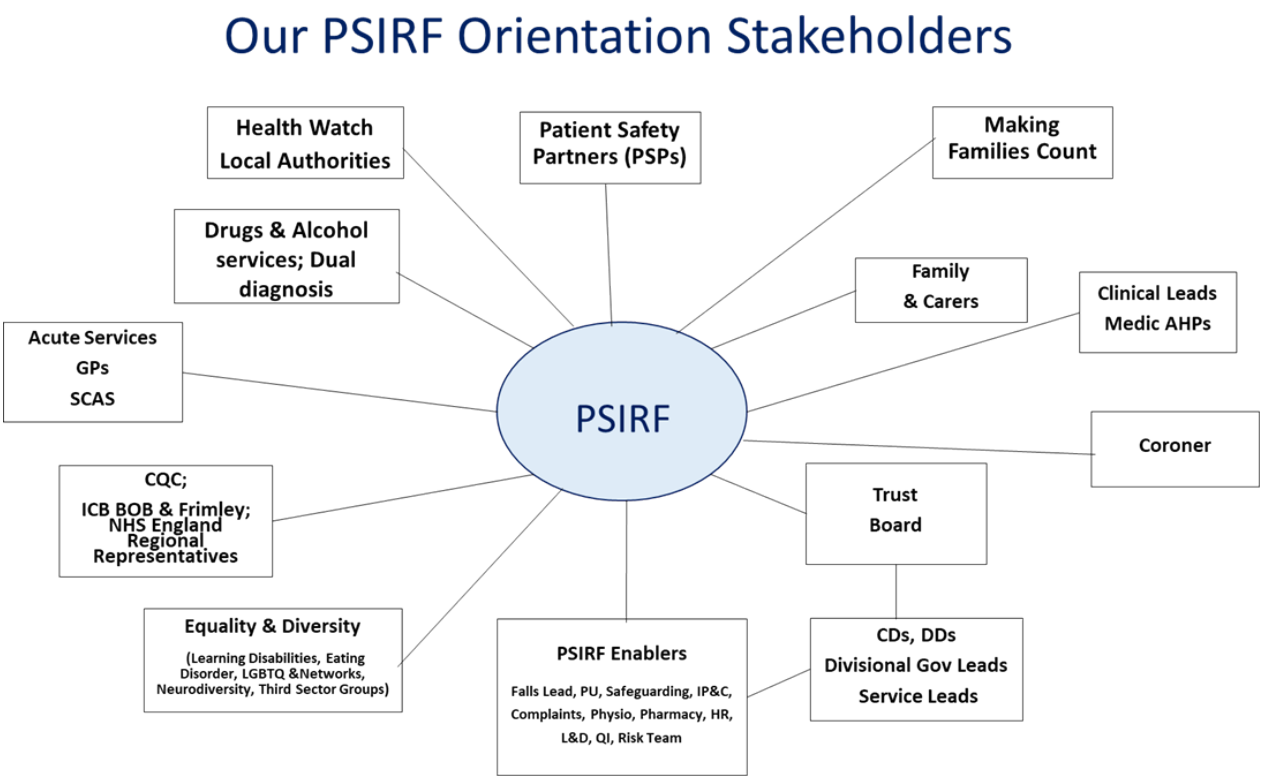
4. Defining our patient safety incident profile

In order to identify and agree the patient safety issues most pertinent to BHFT, as well as to inform and decide what our proportionate responses to patient safety incidents should be, we first had to start with a number of planning and scoping exercises.

Stakeholder engagement

A stakeholders' mapping exercise (see Fig 1) was undertaken during the PSIRF 'orientation[2]' phase and reviewed throughout our PSIRF implementation planning. This enabled the identification of key stakeholders within and outside BHFT. A range of opportunities were then offered by the Patient Safety Team to get stakeholder engagement in our planning processes and to seek their views on developing and understanding our incident profile. These opportunities included attendance at our main PSIRF event, along with completion of questionnaires and discussions at a variety of team/service/divisional meetings.

Fig. 1 – Stakeholder mapping



Data sources

In addition to our stakeholder feedback, a significant amount of data was reviewed to provide us with the current intelligence to develop a robust patient safety incident profile. Data from the last 2 years was reviewed from several sources including our:

- Patient safety incidents reported on our local risk management system (Datix)

[2] Orientation took place between October 2022 to January 2023. During this phase Patient Safety Specialists (PSSs) met with as many internal and external stakeholders of local safety as possible to discuss PSIRF and gather views and feedback

- Serious incidents
- Internal learning reviews
- Complaints
- Compliments
- Audit data
- Freedom to Speak Up reports
- Safeguarding reports and S42s
- Infection, Prevention & Control reports and post infection reviews
- Structure Judgement Reviews (Learning from Deaths)
- Prevention of Future Deaths (national recurring themes)
- Staff survey results
- Coroner feedback
- Medication reviews

Initially this data was used to develop individual local Patient Safety Incident Profiles for our divisions/services. An example of these are provided in Appendix 1. These profiles provided the focal point for discussions at our PSIRF stakeholder event.

Combining stakeholder feedback with data intelligence

Our individual local Patient Safety Incident Profiles and feedback obtained from multiple sources (see Table 1) have been used to develop:

- A collective understanding of what services/team's feel is already known about them
- What issues had already been reviewed and have associated action/improvement plans within their area
- Where energy and resources for responding to patient safety incidents should be directed in the future
- A comprehensive summary of key learning from multiple sources can be found in Appendix 2.

Table 1 – Sources of engagement and feedback

Trust-Wide PSIRF event of 30/01/23
ICB-led PSIRF events throughout 2022/2023
Trust PSIRF questionnaire
Presentation and feedback from BHFT Board
Presentation and feedback from the Patient Safety Strategy Implementation Group
Local benchmarking and network groups
Feedback from Patient Safety Partners

Feedback from our families and the Family Liaison Officer Feedback from Making Families Count Presentations and feedback from Divisional' Patient Safety Quality meetings (MH, PH and CYPAA) Meetings with specialist services including infection prevention and control; mortality; pressure ulcers; falls Meetings and feedback from local services Conversations with other stakeholders (substances misuse services/dual diagnosis services) BHFT QI and Transformation Leads Suicide Prevention Strategy Group MHICS Operational Group Digital Clinical Leadership Group

This work has allowed us to compile the patient safety issues most pertinent to BHFT presently. It is important to acknowledge that this list is not exhaustive however it reflects what our stakeholders and data show as our current profile. As the Trust progresses with the implementation of PSIRP some changes may emerge, and these would be addressed as appropriate.

They are summarised in Table 2.

Under the PSIRF principles of "considered and proportionate" responses to patient safety incidents, how these issues will be addressed is covered in Chapter 7 and 8.

Table 2 – Summary of patient safety issues for BHFT

Patient Safety Issue	Division	Service
Absent without leave (AWOL) and welfare escalations	Mental Health	Inpatients
An issue where significant concerns about communication have affected the patient journey and subsequent care.	Physical Health Mental Health Children, Families and All Age Services	All services across all 3 divisions
Communication with our neurodivergent population	Mental Health Children, Families and All Age Services	All services Mental health services (e.g. CAMHS, BEDS)
Falls with significant harm/injury	Physical Health Mental Health	Inpatients Inpatients

Handover processes	Physical Health Mental Health Children, Families and All Age Services	All services across all 3 divisions
Incidents of attempted suicide / significant self-harm	Mental Health Children, Families and All Age Services	All services Mental health services (e.g. CAMHS, BEDS)
IT systems and infrastructure	Physical Health Mental Health Children, Families and All Age Services	All services across all 3 divisions
Management of the deteriorating patient and escalation	Mental Health Physical Health	Inpatients Inpatients & community services
Management of mental health observations	Mental Health	Inpatients
Medication errors	Mental Health Physical Health	Inpatients Inpatients & community services
Missed visits	Physical Health Mental Health	Community services Community services
Movement between services	Physical Health Mental Health Children, Families and All Age Services	All services across all 3 divisions
New Pressure ulcers	Physical Health Mental Health	Inpatients & community services Inpatients
Restrictive interventions	Mental Health	Inpatients
Safety of patients on waiting lists	Physical Health Mental Health	Community services Community services
Suicides	Mental Health	Community services
Transitioning from children's to adults mental health services	Mental Health Children, Families and All Age Services	Community services All Mental Health services (e.g. CAMHS, BEDS)

5. Defining our Patient Safety Improvement and Transformation Profile

This section is about our improvement and service transformation work that has an impact on patient safety and that is already underway or planned across BHFT. It includes relevant national and regional improvement programmes as well as locally driven service improvements.

As part of this process, consideration was given to the wider local and national picture influencing patient safety reporting and improvement plans. The following were considered within the decision-making process and in conjunction to stakeholders' feedback:

- National Patient Safety Improvement Programmes
- Nationally defined never-event incidents requiring a local Patient Safety Incident Investigation (PSII) response.
- National Learning from Death guidance and Structured Judgement Review (SJR) guidance
- Other national guidelines linked to incidents reporting and improvements (I.e., NHS England Policy Guidance on Recording Patient Safety Events)

- Existing local agreements
- BHFT True North goals.
- Strategic Prioritisation Board and other Trust Quality Improvement Programmes

5.1 National Patient Safety Improvement Programmes

The **National Patient Safety Improvement Programmes (PSIPs)** are a key part of the NHS Patient Safety Strategy (2019/2021) to ensure the delivery of safe and quality care. PSIPs are delivered locally and they are supported through a number of initiatives including support from the Oxford Academic Health Science Network (OAHSN) - Patient Safety Collaborative (PSC) team. Of significant relevance to BHFT are 5.1.3 and 5.1.5

Currently the national priorities are:

5.1.1 ***Managing Deterioration safety improvement programme*** (ManDet SIP)

ManDetSIP focuses on managing deterioration at a system-wide level across both health and social care through Managing Deterioration Networks and Care Homes Patient Safety Networks. It supports the adoption and spread of pulse oximetry[3]

5.1.2 ***Maternity and Neonatal safety improvement programme*** (ManNeo SIP)

MatNeoSIP focuses on reducing smoking in pregnancy, support spread and adoption of preterm optimisation care, improve early recognition of mother/baby deterioration; support the development of early warning scores specifically for neonatal services.

5.1.3 **Medicines safety improvement programme** (Med SIP)

MedSIP addresses causes of severe harm associated to medicines and aims at reducing administration errors, reduce harm from opioids medicines by reducing high dose prescribing; reduce harm by reducing the prescription and supply of oral methotrexate.

5.1.4 **Adoption and Spread safety improvement programme** (A&S-SIP)

A&S-SIP supports the adoption and spread of safe evidence-based interventions and practice including tracheostomy[4] interventions, Chronic-Obstructive Pulmonary Disease (COPD) care bundle; Asthma discharge care bundles; emergency laparotomy care bundles.

5.1.5 **Mental Health safety improvement programme** (MH-SIP)

[3] Small medical device to measure peripheral oxygen saturation levels normally though a finger.
[4] It is an opening created in front of the neck so that a tube can be inserted in the windpipe to help breathing

MH-SIP aims at reducing variations in care and quality of care provided and focuses on reducing suicide and self-harm in both acute and non-acute mental health settings; reduce the incidence of restrictive practice, improve sexual safety for patients and staff on inpatients mental health units and within learning disabilities services.

5.2 Nationally defined incidents requiring a local PSII

5.2.1 Incidents meeting the **Never Event Criteria**

NHS England » Revised Never Events policy and framework

Of significant relevance to BHFT services are incidents including:

- Insulin overdoses due to abbreviations or incorrect device leading to ten time or greater overdose; failing to use a device (i.e., insulin syringe or pen) to measure insulin; withdrawing insulin from a pen or pen refill and then administering this using a syringe and needle.
- Overdoses of methotrexate for non-cancer treatment that is more than the intended weekly. dose and involving an electronic prescribing system.
- Failure to install functional collapsible shower or curtain rails in MH inpatient settings.
- Falls from poorly restricted window in all NHS settings.
- Chest or neck entrapment in bedrails in all NHS settings an patient own home where equipment has been provided by the NHS.
- Patient scalded by water used for washing/bathing

5.3 National 'Learning from Death' and 'SJR' guidance

ngb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

NMCRR clinical governance guide_1.pdf (rcplondon.ac.uk)

rcpsych_mortality_review_guidance.pdf

In mental health services there are significant considerations related to the review of unexpected deaths and/or suspected suicides within the principles of PSIRF that are further considered under Chapter 7 and Chapter 8.

5.4 Other National Guidelines linked to incident reporting and incident reviews

5.4.1 Guidance of reporting pressure ulcers

NHS England » Pressure ulcers: revised definition and measurement framework

5.4.2 Preventing Gram-negative bloodstream infections (GNBSI)

NHS England » Preventing healthcare associated Gram-negative bloodstream infections (GNBSI)

5.4.3 Communicable disease outbreak management (includes COVID)

Communicable Disease Outbreak Management (publishing.service.gov.uk)

5.5 Existing local agreements

There are a number of patient safety incidents that have had automatic declaration as an SI under existing arrangements and agreements with previous CCG's. All of these agreements will cease to exist as a result of PSIRF implementation, SI framework becoming redundant and the responsibility of the incident response moving from the ICB to NHS Trusts.

Amendments to local processes documented in guidelines and policies will also have to take place following the implementation of this plan.

5.5 BHFT Breakthrough Objectives

- Reducing self-harm
- Reducing physical assaults on staff
- Reducing lost bed days
- Reducing restrictive practices

5.6 Strategic Prioritisation Board and other Trust Quality Improvement Programmes

Mission-Critical Projects

Project	Key dates	Rationale for Status
Community Mental Health Transformation Programme - System projects East and West	Mar-24	Implementation of the National Community Mental Health Framework requirements
BHFT Project One Team (CMHT Transformation) and Alternative to CPA.	Sep-24	In accordance with Community MH transformation framework and NHS Long Term plan. Reduces waiting lists and unwieldy/unrealistic OPA caseload. More clarity re. CMHT offer; removal of multiple referral routes. Reducing/removing variation.
EDI Strategy (inc.BAME Transformation Plan)	Mar-24	Part of the Trusts "our people" Strategic Initiative and People Strategy but includes patient elements so presented as a separate item here.
PPH Bed Optimisation	Mar-24	National requirement NHSE/I trajectory to achieve zero inappropriate acute OAPs by 31st March 2024
Virtual Wards - East and West Berkshire	Apr-24	NHSIE initiative to improve capacity & flow. Initial ticket raised for working in partnership with RBH to deliver the Berkshire West element of the BOB VW plan. Now includes Berkshire East as well.
CREST (Community Rehabilitation Enhanced Support Team)	Apr-24	Berkshire wide initiative to adhere to National CMH guidance, NICE guidance, CQC and GIRFT to reduce number of locked rehab placements (part of 2022/23 and 2023/24 CIPs). **Soft launch in progress - potential to move to transitioning to BAU in June 23**

Important Projects

Project	Key dates	Rationale for Status
ePMA	Jul-23	Implementation of electronic prescribing and medicines administration (ePMA) integrated withTrust-Wide EPR and Pharmacy stock management and dispensing systems. **Project will move to BAU from July 23.**
Green Plan	Mar-25	Requirement for all Trusts
Neurodiversity Strategy Implementation	Mar-24	Part of the National Autism Strategy. Implementation plan approved in Nov 22.
CYPF Referral Management System	Mar-24	Involves a number of functions including the Health Hub.

Table 3 – National requirements for patient safety responses

Patient safety incident type	Required response	Anticipated improvement route
Never Events	PSII	Create local organisational actions and feed these into the quality improvement strategy
Death thought more likely than not due to problems in care (>50% probability)[5]	PSII	Create local organisational actions and feed these into the quality improvement strategy
Death of patients - under MH Act 1983 or MH Capacity Act 2005 apply – where there is reason to think the death may be linked to problems in care	PSII	
Mental Health related homicides	Refer to NHS Regional Team for consideration for an independent PSII - or else a local PSII may be required	
Child death	Refer to child death overview panel and liaise with panel as to whether PSII is required	
Death of person with Learning Disability	LeDeR to review and inform if further PSII is required	
Safeguarding incident of: Young individuals under child protection plan, looked after plan or victims of neglect/domestic abuse	Refer to Trust Safeguarding Team that will refer to Local Authority, contribute to multi-agency reviews and advice further on appropriate response	

[5] Also please see Chapter 8

Adults >18 years in receipt of care and support needs from their Local Authority Relating to female genital mutilation, prevent, modern slavery or domestic abuse/violence		
Death of person in custody	Refer to prison and probation ombudsman or the independent office for police conduct and support their investigation where required	
Domestic Homicide	Refer to Trust Safeguarding to ensure liaisons with police and community safety partnership and contribute to any required review as appropriate	

6. Our patient safety incident response plan: local focus

This section will outline the considered and proportionate response methods for the issues/incidents listed in Chapter 4 of this plan. The list is not exhaustive of all patient safety incidents in BHFT but provides guidance for what the focus of our local priorities will be over the next 18-24 months.

This plan should be read in conjunction with our Patient Safety Incident Response Policy which provides additional information regarding the processes of Datix triage, decision making and oversight responsibilities.

The type of learning response suggested will depend on:

- The view of those affected – including patient and family.
- Capacity to undertake a learning response.
- What is known about the factors that led to the incident.
- Whether improvement work is already underway to address the identified contributory factors.
- Whether there is evidence that improvement work is having the intended effect.

- If BHFT and its' ICBs are satisfied that risks are being appropriately managed.

Please note incident types described in Table 4 that are not chosen for a PSII will still be reviewed under patient safety processes to decide if:

a) a further learning response is required (from the toolkit) and/or
b) what steps are required to engage with the family and ensure their questions are answered. For those incident types that are reportable deaths this is further detailed in Chapter 8.

National Guidance suggests that a key element of PSIRF is setting out the number of PSII's that will be completed per year to support prioritisation and management of resources. However, it is at the discretion of the Trust to remain flexible and objective in our approach if this is felt necessary to support learning and meet the needs of our patient and families. Completion of PSIIs will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

Table 4

Patient safety incident type or issue	**Planned learning response**	**Anticipated improvement route (if currently known)**
An incident of suspected suicide involving individuals with neurodiverse traits and currently open to our mental health services	Consider PSII[6], up to 5 per year	Suicide Prevention and Neurodiversity workstreams
An incident of suspected suicide involving individuals that had 3 or more contacts with mental heath urgent care services but otherwise not receiving coordinated mental health interventions	Consider PSII, up to 3 per year.	Suicide Prevention and Neurodiversity workstreams
An incident of significant harm or learning occurring to a mental health inpatient (i.e., deteriorating patient, self-harm, absent without leave and welfare escalations)	Consider PSII, up to 5 per year.	MHIP improvement plans
An issue where significant concerns about communication have affected the patient journey and subsequent care (i.e., discharge/ admissions planning, children transitioning to adult services)	Consider PSII, up to 5 per year. These reviews should be conducted jointly with other involved organisations.	Project One Team, virtual wards, bed optimisation

[6] Statutory Duty of Candour to be applied to any incident that is a PSII

All other suicides which are not thought to be due to problems in care (>50%) and not falling under local priority PSIIs.	Refer to Chapter 8	Suicide Prevention and Neurodiversity workstreams and Project One Team
Near miss incidents where Datix and/or initial Patient Safety Team desktop review highlight opportunities for learning, prevention of harm and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	
Incidents of missed visits where Datix and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	
Incidents of medication errors where Datix and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	Medication improvement plans
Safety of patients on waiting lists where Datix and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	Project One team
Issues where communication with neurodivergent population where Datix and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	Suicide Prevention and Neurodiversity workstreams
Falls with fractured large bones where Datix, ward debrief and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	Trust improvement plan for falls
New pressure ulcers where Datix and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	Trust improvement plan for pressure ulcers
Incidents of attempted suicide / significant self-harm where Datix and/or initial Patient Safety Team desktop review	Look at toolbox of methodologies and consider an appropriate learning response.	

highlight opportunities for learning and improvement		
Any other patient safety incident highlighting significant concerns, learning or new emerging themes	Look at toolbox of methodologies and consider an appropriate learning response.	
Infection Prevention and Control (IPC) reportable infections whereby after initial IPC desktop review opportunities for learning are identified	Use IPC methodologies in line with national IPC guidance.	

If we cannot easily identify where an incident fits in relation to this plan i.e. whether a learning response is required, we will perform an assessment to determine whether there are any problems in care that require further exploration and potentially action. This will be a critical role of our multidisciplinary Patient Safety Incident Review Group (PSIRG) as further elaborated in the Patient Safety Incident Response Policy.

It is important to remember that under PSIRF, incident responses are not necessarily associated to the degree of harm. However, the principles of Duty of Candour and our responsibility (as per Regulation 20 of the CQC guidance) will always apply to notifiable patient safety incidents. This is further explained in the Patient Safety Incident Response Policy and our Duty of Candour Policy. In summary, if it is a PSII, professional and statutory Duty of Candour will apply; if an incident is identified as not requiring further learning response but a degree of harm is identified, plans would be considered and agreed to ensure Duty of Candour requirements are fulfilled as appropriate. An example of a letter can be seen in Appendix 3.

7. Our patient safety incident response plan: mortality

1st stage review

1st stage reviews will continue to be discussed at weekly Executive Mortality Review Group (EMRG) looking at all deaths reported via Datix.

2nd stage review - Mental Health Deaths

	Incident type	2nd stage review required	Incident Response Plan (if applicable)

1	Suspected suicides of patients open to BHFT Mental Health Services and those who were closed to BHFT Mental Health Services within 6 months of the death.	If potentially PSII / one of PSIRP priorities = IFR If not likely PSII / one of PSIRP priorities = decide most appropriate 2nd stage review i.e IFR, MDT Roundtable, Desktop Review. Duty of Candour to be applied (Patient Safety Team will advise whether the statutory duty applies).	PSII if death thought more likely than not due to problems in care (>50%). PSII if involving individuals with neurodiverse traits and currently open to our mental health services (max 5 PSIIs/year). PSII if involving individuals that had 3 or more contacts with MH urgent care services but otherwise not receiving coordinated MH interventions (max 3 PSIIs/year). If family concerns are raised, an appropriate review of care/learning response will be agreed with family (refer to Appendix 4) this will include agreeing the format of report/letter they will receive. If death thought less likely than not due to problems in care and no family concerns, no further learning response. However, if family wish to hear findings from 2nd stage review they will be written to with an overview of the findings (see Appendix 3 for example template).
2	Suspected suicides and unexpected deaths of patients closed more than 6 months prior to the death.	Close at first stage review Consider whether condolence letter is	If concerns are raised, an appropriate review of care/learning response will be considered

		appropriate. Reopen at Patient Safety Incident Review Group (PSIRG) if questions come back from family or coroner.	
3	Unexpected deaths judged at 1st stage review to be more than 50% likely to be suicides. They must have been open to BHFT Mental Health Services or closed within 6 months of the death.	If potentially PSII / one of PSIRP priorities = IFR If not likely PSII / one of PSIRP priorities = decide most appropriate 2nd stage review i.e IFR, MDT Roundtable, Desktop Review. Duty of Candour to be applied (Patient Safety Team will advise whether the statutory duty applies).	PSII if death thought more likely than not due to problems in care (>50%) If family concerns are raised, an appropriate review of care/learning response will be agreed with family (refer to Appendix 4) If death thought less likely than not due to problems in care and no family concerns, no further learning response. However, if family wish to hear findings from 2nd stage review they will be written to with an overview of the findings (see Appendix 4 for example template)
4	Unexpected deaths judged at 1st stage review to be less than 50% likely due to suicide. Please see Physical Health Deaths below.	Structured judgement review	PSII if death thought more likely than not due to problems in care (>50%)

2nd stage - Learning Disability Deaths

	Incident type	2nd stage review required	Incident Response Plan (if applicable)
1	All deaths of patients with learning disability and/or a confirmed diagnosis of	Structured judgement review	PSII if death thought more likely than not due to problems in care (>50%)

	autism who received care in the last 12 months[7]		

2nd stage - Physical Health Deaths

	Incident type	2nd stage review required	Incident Response Plan (if applicable)
1	Physical Health unexpected deaths where 1st stage review highlight more likely than not due to problems in care (>50%)	If potentially PSII / one of PSIRP priorities = IFR Duty of Candour to be applied (Patient Safety Team will advise whether the statutory duty applies).	PSII if death thought more likely than not due to problems in care (>50%) – (after 2nd stage review) If family concerns are raised, an appropriate review of care/learning response will be agreed with family (refer to Appendix 3) If death thought less likely than not due to problems in care and no family concerns, no further learning response
2	Physical Health unexpected deaths highlighting new themes, potential for learning	If potentially PSII / one of PSIRP priorities = IFR	PSII if death thought more likely than not due to problems in care (>50%) – (after 2nd stage review) If highlighting new learning themes, look at toolbox of methodologies and consider an appropriate learning response.

[7] LeDer process is same for people with a learning disability and autistic people and the same level of review is conducted by ICB.

In line with the Learning from Deaths policy the following types of deaths will all require a 2nd stage review in the form of a Structured Judgement Review. Those not covered in previous sections of this PSIRP include:

- There was an open safeguarding referral relating to the patient at the time of their death.
- Bereaved families and carers or staff have raised concern about the quality of care provision.
- Another organisation notifies us and suggests that BHFT should review the care provided to the patient but who were not under our care at the time of death.
- The patient was an inpatient on an Older Persons Mental Health Ward at the time of their death (informal and those identified as receiving end of life care).
- All mental health inpatients and those who have been discharged within a month of their death.
- They were a physical health inpatient and the death was unexpected.
- Patient was detained under Mental Health Act (MHA) – (if there is reason to think the death may be linked to problems in care then it will be a PSII).
- The death has been reported to the coroner or concerns have been raised by an individual or organisation as to the circumstances surrounding the death .
- The patient was transferred from BHFT mental health ward to an Acute Hospital and died within 7 days.
- All patients with a criteria of psychosis or eating disorder during their last episode of care who were under the care of services at the time of their death or had been discharged 6 months prior to death
- All patients under the crisis resolution and home treatment team (or equivalent) at the time of their death

Decision making following 2nd stage review

Decision regarding next steps following IFRs or MDT roundtable/desktop reviews will be made at the Patient Safety Incident Review Group (PSIRG).

Structured Judgement Reviews considered more than likely avoidable will also come to PSIRG to consider further learning response prior to coming to the Patient Safety and Mortality Learning Group

Structured Judgement Reviews considered less than likely to be avoidable will return directly to the Patient Safety and Mortality Learning Group (including deaths).

Completed PSII's and all other learning response relating to deaths (including letters to families responding to questions) will be approved at the Patient Safety and Mortality Learning Group.

Appendix 1 – Safety Profile Example – Community Mental Health

Incidents that have been reported January 2022 – December 2022

During the last calendar year, Community MH services reported 1154 incidents. The top 10 reported categories are seen below:

Category	Count in 2022
Self Harm/Self Harming Behaviour	337
Other incident	321
Confidentiality Issues	109
Drug Incident	88
Procedures not carried out	51
Assault	49
Behavioural/ Personal Conduct	30
Inappropriate Care	26
Falls, slips and trips	24
Assault - Non Physical	24

Of the 1154 incidents reported, 39 were then reported and investigated as serious incidents. They included 23 suspected suicides, 10 unexpected deaths, 1 self-harm (cutting), 1 Information Governance breach, and 4 attempted suicides.

A further 26 incidents went through an Internal Learning Review. These included 9 suspected suicides, 3 incidents of self-harm (2 from cutting and 1 from ingestion), 9 unexpected deaths, 1 attempted suicide, 1 alleged assault , 1 alleged murder, 1 road traffic accident of a patient under Community MH services and 1 IT failure.

Compliments reported January 2022 – December 2022

2210 compliments received. General themes on time spent with patients and support given.

Learning from Safeguarding Reviews

There is learning across all services from Safeguarding Adults reviews around MCA and professional curiosity. Specifically for our community MH services, there have been very few safeguarding concerns raised. Only issue has been about inappropriate staff behaviour including allegation of theft by staff.

100 Formal Complaints were received in the calendar year. Top complaint themes are:

Theme	Number of Formal Complaints
Care and Treatment	**47**
Clinical Care Received	38
Delay or failure to visit	4
Failure to examine/examination cursory	1
Failure/Delay in specialist Referral	3
Failure/incorrect diagnosis	1
Communication	**14**
Communication with Other Organisations	3
Verbal to Patients	5
Written to Patients	2
not stated	4
Attitude of Staff	**11**
Healthcare Professional	11
Confidentiality	7
Breach of Patient Confidentiality	4
Breach of third Party Confidentiality	3
Medication	**5**
Failure to prescribe/incorrect prescription	4
not stated	1
Medical Records	**5**
Inaccurate Records	4
Not stated	1

The top theme of the 100 formal complaints was **care and treatment** with the sub-theme as **clinical care received**.

Key themes from complaints: Attitude of staff features fairly highly across the community mental health services, with healthcare professionals being accused of being rude, unprofessional and/or intimidating or patients not feeling listened to.

Learning from Medicines' Datix reviews

- Omitted visit leading to omitted doses
- Omitted prescribing
- Wrong dose administered (old doses being administered)
- Administration at wrong time
- Wrong doses administered
- Duplication of administration
- Lack of response to reported constipation in patient on clozapine
- Lack of plan for long term sick cover – omitted prescribing

Opportunities for learning identified from Serious Incidents & Learning Reviews

- Risk assessments and safety planning: frequency of completion not in line with Trust guidance; themes around quality of risk assessments/safety planning and content (variable); triangulation of risk
- Clinical plans: not being followed through (i.e. On discharge from MHIP; following MDT meetings); lack of standardisation of clinics/appointments booking; IT inadequacies to support cancellations/rebooking/administrative staff (i.e., during sickness);
- Medications: lack of consistency in documentation protocols (some paper, some electronic); unclear guidance/protocols around titrations and monitoring of adherence/non-concordance;
- Variable support to patients that may be on long waiting lists for interventions (i.e. IPT/EUPD pathways) and that are falling outside crises interventions, CHMT CCO and MHICS; local approaches, variations in approaches, variable degrees of support, commissioning and guidance unclear;
- Challenges associated with allocating CCO, cover during sickness/leave/vacancies;
- Challenges surrounding PH, MH and ASC work; silos work, capacity issues; complex patients;
- Safeguarding issues: raising Datix to inform BHFT safeguarding team, safeguarding concerns raised by various services/agencies with lack of clarity on who is leading on what; IT difficulties to access ASC information; some safeguarding, social, carer concerns not being escalated to relevant services;
- Specific patients' group (i.e., neurodiverse/ASD) suggest a higher risk of suicide. It is currently unclear if our tools/processes/approaches are 'fit for purpose' for specific groups
- Variation across the Trust in the allocation of care cluster and pathway. This is also impacted by differing thresholds for acceptance; Gaps in the outpatient review system; Lack of adaptations to the safety plan to ensure understanding
- Communication to patients who are not in the planner – maybe be missed as there is no open referral for them;
- Discrepancies between family perception of risk, expectation from services and services risk evaluation and what can be offered

Appendix 1 – Safety Profile Example – Physical Health Wards

Incidents that have been reported January 2022 – December 2022

During the last calendar year, Physical services reported 1567 incidents. The top 10 reported categories are seen below:

Category of Incident	Number in 2022
Pressure Ulcers	397

Ill Health	294
Falls, slips and trips	217
Drug Incident	160
Moisture Damage	132
Other incident	125
Skin Damage - Other	60
Procedures not carried out	55
Medical Emergency	32
Infection	17

Of the 1567 incidents reported, **9** were then reported and investigated as **serious incidents.** They included 4 falls, 3 deaths as a result of Healthcare Acquired Infection (Covid/pneumonia), 1 unexpected death and one pressure ulcer. There were no serious incidents reported during this period for East Wards

A further **29** incidents went through an **Internal Learning Review**. These included 4 Falls, 3 pressure ulcers, 1 physical assault, 1 episode of care received as a complaint from a patient and 4 unexpected deaths. There were 16 infections acquired whilst on the wards (Pseudomonas Aeruginosa x1, C. difficile x 6, E. Coli. X 6, Staphylococcus bacteraemia x 1 and MSSA x 2)

Opportunities for learning identified from Serious Incidents & Learning Reviews

- Assessing patient's capacity and appropriate documentation in relation to this
- Medication error caused by ward team not having full details of patient's presentation - poor external communication/documentation between the acute and us as well as poor internal communication within own team
- VTE assessment was not completed and documented as per policy
- Management of dyshapgia
- Completion of accurate and consistent food and drink charts as well as fluid balance monitoring
- Review of care plans on weekly basis and lack of individualised care planning
- Management of the deteriorating patient (frequency of observations / escalation; use of correct NEWS score)
- Overall safety concerns about quality of discharge information received from acutes

Complaints reported January 2022 – December 2022

14 complaints were received. Top complaint themes are as below:

Theme	Number of Formal Complaints
Care and Treatment	**10**
Clinical Care Received	10
Discharge Arrangements	**2**
Discharge Planning	2
Patients Property and Valuables	**1**
Lost Property	1
Alleged Abuse, Bullying, Physical, Sexual, Verbal	**1**
Verbal Abuse	1

In addition, 3 complaints were taken forward to the Parliamentary and Health Service Ombudsman.

Key themes from complaints: There are no themes from the data however anecdotally, call bell response times and concerns about personal care (removing beards in particular) crop up.

Compliments reported January 2022 – December 2022

345 compliments received. General themes around commitment to patients, good clinical care/service, patience, kindness and compassion shown - especially to patients who had passed away.

Freedom to Speak Up: 2 cases involving patient safety.

S42s: Very few concerns, however some concerns against staff raised for racist behaviour and assault by staff

Learning from Medicines' Datix reviews

- Failure to reconcile discharge letters and medicines handing back including PODS, previously dispensed items and TTOs particularly medicines stored in fridges and CD cupboards.
- Omitted doses
- Errors in choice of formulation MR vs plain for example
- Wrong frequency – admin boxes not crossed off / incomplete prescriptions.
- Not administering full dose when dose is made up of multiple dose units – i.e. vitamin D, methotrexate are reported but likely to be much wider range of medicines as also reported in the observation audit completed previously.
- Anticoagulant doses not modified for improving renal function or weight changes DURING stay.
- Omitted anticoagulation (prescribing particularly when courses completed and review required and administration)
- Patches omitted to be replaced or left in situ.
- Medicines put in wrong lockers leading to missed doses
- Medicines left unattended then leading to errors
- Following admin boxes and not the prescription. i.e. giving BD multiple times rather OD when the times have changed.

What have our infection control incidents told us?

- Staff to ensure to keep the door to isolation area closed to prevent patients from other areas entering
- Potential risk of contamination injury due to one faulty needle.
- Staff to ensure to lock the sharps bin when reaches the fill line to prevent needle stick injury
- Staff to ensure to be vigilant when handling sharp items.
- Staff must assemble sharps bin in line with the policy.
- Staff must ensure to immediately dispose all used sharps into the sharps bins.
- No evidence of a sepsis tool being commenced
- Inaccuracy in documentation of urinary symptoms in patient records regarding urinary symptoms
- Delay in patients being risk assessed within 48hrs for treatment and prophylaxis of flu
- NEWS2 score not implemented as per policy

Appendix 1 – Safety Profile Example – Childrens and Young People

Incidents that have been reported January 2022 – December 2022

During the last calendar year, CYPF services reported **703** incidents. The top 10 reported categories are seen below:

Category	Number in 2022
Self Harm/Self Harming Behaviour	138
Procedures not carried out	137
Confidentiality Issues	115
Other incident	69
Drug Incident	35
Assault	22
Assault - Non Physical	21
Behavioural/ Personal Conduct	21
Ill Health	21
Privacy and Dignity Issue	20

Of the 703 incidents reported, **2** were then reported and investigated as **serious incidents.** They included 1 unexpected death and 1 confidentiality breach.

A further 4 incidents went through an Internal Learning Review. These included2 unexpected deaths, 1 pressure ulcer and 1 suspected suicide.

Opportunities for learning identified from Serious Incidents & Learning Reviews

- Poor referral (not enough information)
- Delayed referral to Tissue Viability
- Policies not in place when patient moved from RBH to BHFT, to service the needs of the patient for instance risk assessment
- Datix is adult specific and does not meet the needs of the service.
- Educational thematic learning event around Autism and Suicide took place.
- The use of Opt-In letters is very important
- Transition from CAMHS to adult community MH services

Complaints reported January 2022 – December 2022

50 complaints were received in the calendar year. The top complaint themes are:

Theme	Number of Formal Complaints
Care and Treatment	**18**
Clinical Care Received	11
Delay or failure to visit	2
Failure/Delay in specialist Referral	5
Communication	**12**
Communication with Other Organisations	4
Verbal to Patients	3
Written to Patients	4
Not stated	1
Waiting Times for Treatment	**9**
Long Wait for an appointment	9
Attitude of Staff	**4**
Healthcare Professional	4
Medication	**2**
Failure to prescribe/incorrect prescription	1
Wrong medication dispensed/wrong dose,	1

In addition to Formal Complaints, there were MP concerns/enquiries about waiting times and access to services. Key themes from complaints: Of the 50 for CYPF, 9 related to waiting times for ADHD assessments. To help with the flow of complaints and consistency of responses, they have designed a series of templates, which is easing pressure on IOs. Additionally, when assessments are written or reports for other organisations complainants sometimes say it is inaccurate.

Compliments reported January 2022 – December 2022

246 compliments received. General themes around collaborative working across teams, listening to patients and their parents, excellent clinical care was delivered – parents felt at ease, and the quality of advice/support given.

MDT

Safeguarding reviews

Learning from Safeguarding reviews across the Trust is around MCA and professional curiosity. In addition, our safeguarding team has identified a concern regarding lack of professional curiosity including not just being a passive recipient of information and having consideration of extrafamilial harm and the associated

red flags

What have our medication incidents told us?

- Vaccine errors – duplication, given early or given when not consented or consent withdrawn
- Medicines not reconciled (demographics checked) when hand back.
- Confusion with MR and plain formulations
- Omitted doses

Appendix 2 - Feedback from our stakeholders

What we asked	Summary of responses
What BHFT patient safety processes already work well	*Comprehensiveness of process:* Robust; thorough; balanced; objective; in-depth focus on issues where they may be learning *Inclusivity of process:* MDT engagement and viewpoint; team-review approach; inviting the right people into our team-review process; inclusion of services; range of views; bringing all parties together *Culture:* Positive culture; safe *Patient/family:* Involving patients / family *Learning:* Provides opportunities to learn
What positive changes is PSIRF going to bring	*Impact on staff:* Opportunity to remove the blame culture; more inclusive process; understanding how staff may be feeling (conversation not an interview); learning + improvement for staff (= better engagement from staff); opportunity for clinicians to determine part of the change (bottom up); getting the right people being part of the review; decreased workload?; shared ownership- not just patient safety team *Impact on patient / family:* More patient / service user collaboration; truly placing families/patients at the centre of incidents / reviews; more focus on family being central to the process *Process:* Not having to 'find' learning; Not having to investigate everything / stopping investigations for the sake of investigating/ less investigating for investigating sake; More focus on meaningful reviews and improvement; learning from all incidents, not just moderate / severe; Looking at issues that have wider implications / learning; A more systems approach; Links with QMIS; Decreased repetition of investigations

	Learning opportunities: Shifting resources and greater potential for learning & improvement; Shared learning & better sharing to frontline staff; Learning + improvement for staff = better engagement from staff; Learning disseminated more widely – improved feedback loop
What are the concerns about PSIRF changes	*Impact on staff:* Staff capacity to deal with change; Increase workload (particularly for frontline staff); More acronyms / new acronyms / changing language; Staff training and educational needs; Cultural shift; May feel there are more 'reviews/investigations'. *Impact on families:* How we will approach family feedback without a comprehensive report; How we communicate to families about our approaches; Assurance that families wish around investigations are taken into consideration *Process:* Robust process required to decide which incidents should be reviewed; How will we know what needs an investigation vs another review approach; Will we miss something? Lack of scrutiny where scrutiny is required; More steps to the process Complacency for what were previous SIs; Understanding why we no longer investigate all serious incidents (differences between review and investigation); Not throwing baby out with bathwater. *Learning and improvement:* How to identify added value to learning; Need time to implement learning; How does this link to QI *Support for the changes:* Do we have exec backing?; Requires a big cultural shift; Will we have support at a governance level; Integration with other national processes (mortality, IPC, PU) *Coroner:* Will this lead to staff less supported for inquest; Will we be prepared enough?; Need to ensure we have enough information for coroner's report
Where we should focus future energy	*On getting the learning out there:* Sharing the learning, incident stories, case studies; Implementing the learning; Looking for immediate ways to learn *On using our staff:* Involving staff and using other resources/evidence in our investigations; Ensuring a just culture (no blame approach); Training staff to ensure a whole system approach to investigations; to understand how to find improvement areas *On our processes:* Hearing the patient / family; Near misses learning; Don't focus on small elements, take a macro approach; Look for themes; Don't focus on areas which are already QMIS trackers / QI projects; Overall both PH and MH services felt enough investigations have been done for PUs & Falls; opportunities to review COVID investigations and consider other options; Patient representatives felt that suicides have a significant impact on families

	and that a form of review is required (although this does not have to be a serious investigation). *Overall comments around incident reporting and Datix system*: General noise / concern about overall incident reporting process. Datix reporting form (too long, too complicated, too many questions; specifically around present on admission PUs; clarity on what self-harm incidents need reporting; how to learn for incidents with no harm
Where we should focus energy for Physical Health	Missed visits including forward planning; drug errors / incidents; poor discharges from acute hospitals (perhaps with a focus on hub referral)– sharing of essential information / handovers; learning from low and no harm incidents and near misses; focus on learning in smaller services and incidents with low reporting volume
Where we should focus energy for Mental Health	Non-lethal self-harm; psychiatric wait lists / times; patients on wait lists for treatment; initial engagement with services; cannot and should not ignore suicides; physical health monitoring on MH wards
Where should we focus energy for Children Families and All Ages	Transition to adult services, wait lists; neurodiversity in young adults

Appendix 3 – Example letter for patient / family who have asked for response to 2nd stage review (to be personalised for each situation)

Service Details Here
Including a key contact name, telephone number and e-mail

Private & Confidential
Family details here

Date here

Dear Mr/Mrs/Other

RE: Relationship/Patient Details - Family feedback letter

I hope this letter will not cause you unnecessary additional distress and I would like once more to express my sincere condolences for the loss of your relationship/patient name. I am writing to inform you that following on from our previous condolence's liaisons with your/your family we have completed a review into the care provided to your relationship/patient's name during the time preceding his/her unexpected death.

When unexpected, significant 'events' occur to patients/service-users under the care of Berkshire Healthcare Foundation Trust, the organisation is committed to ensuring opportunities for continuous learning and service improvement. As part of this pledge, our Trust is committed to engage with families to gather their views and feedback and ensure they have a 'voice' as part of the review process - if they wish to become involved.

Our organisation adopts a range of review methodologies that are in line with national best-practice guidance[8]. The decisions about what methodology to adopt for the review is agreed within a multi-disciplinary team approach and it is in line with Trust agreed processes[9]. Family feedback and views are considered and where appropriate an event may be escalated to a higher level of scrutiny if either family or the initial review highlight significant concerns.

From previous conversations with you/your family my understanding is that there were no concerns of significance being raised and our trust has therefore progressed with the agreed review methodology that in this case was (enter here). This consisted of (briefly explain the methodology).

I am writing this letter to you to provide assurance that we have completed our review process and that we have not identified any gaps in care or significant learning that could have substantially altered the outcome of this event. Our review indicates that the overall care provided was adequate/good/very good/excellent. We identified examples of good practice including: (add here).

(Remove if not applicable) Some incidental learning was identified including: (add here). Whilst this would have not changed the outcome of this event, we have agreed to undertake the following actions to improve future services and care experience: (add actions)

[8] NHS England Patient Safety Incident Response Framework
[9] Patient Safety Policy and Patient Safety Incident Response Plan.

Please if you would like to find out more about this review or if you have any further questions or clarifications required do not hesitate to contact me (see contact details on top of this letter).

I have included in this letter a list of local/national organisations that provide further support with bereavement/suicides. Bereavement / suicide support info may have ben sent out with the condolences letter – whether any further information is required will be decided on a case-by-case basis.

May I extend to your whole family our deepest condolences and best wishes for the future.

Yours Sincerely

Name, Surname

Signature

Title

Appendix 4 – Toolbox of methodologies

PSIRF promotes a range of system-based approaches for learning from patient safety incidents. National tools have been developed that incorporate the well-established SEIPS framework (Systems Engineering Initiative for Patient Safety).

We are encouraged to use the national system-based learning response tools and guides, or other system-based equivalents, to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement.

National learning response methods	Description
Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how
Multidisciplinary Roundtable Review	A multidisciplinary roundtable review supports teams to learn from patient safety incidents that may have occurred in the last few days or earlier. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care. It may require some preparation including some focused areas for discussion/reflection and aims to bring together clinical staff with patient safety and governance support.
Swarm Huddle (could also be called a 'hot debrief')	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
After Action Review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives 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 and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened?

	What was the difference between the expected outcome and the event? What is the learning?