Patient safety incident response plan

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Introduction

The **Patient Safety Incident Response Framework** (PSIRF) fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. PSIRF is not an investigation framework that prescribes what to investigate, instead, PSIRF:

- Advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected.
- Embeds patient safety incident response within a wider system of improvement.
- Prompts a significant cultural shift towards systematic patient safety management.
- allows for a proportionate and considered learning response to patient safety incidents

Totally is committed to improving patient safety through the adoption of the Patient Safety Incident Response Framework (PSIRF), supporting a systematic, compassionate and proportionate response to patient safety incidents. The framework sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. Totally prioritises compassionate engagement with patients, family and staff affected by incidents. Our focus is on understanding how incidents happen – including the factors which contribute to them.

A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, but simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents whilst allowing time to learn thematically from the other patient safety insights.

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

This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed.

Our services

Our organisation delivers a wide range of services across a large geographical area which we mapped as part of PSIRF preparation through engagement sessions with the services to understand their patient safety concerns.

Examples of the services we provide are as follows:

Urgent Care Services

- **UTC across multiple locations including as example:**
  - GP and/or ANP provision into co-located UTC eg 8am-midnight 7 days a week
  - Illness cover 10:00 – 22:00 7 days a week.
  - 24/7 services 7 days a week

- **GP OOH across multiple locations including as example:**
  - GP led OOH service evenings and overnight plus weekends (booked appointments, telephone triage, home visits and centre visits/MIUs)
  - GP and streaming support 10am-10pm every day
  - GP provision in UTCs Mon to Fri 08:00-22:00 and weekends 08:00-22:00

- **Acute Visiting Service** – providing GP home visits
- **Talk Before You Walk** - out of hours telephone triage service of 111 referrals.
- **Practice Learning Time sessions -** These are sessions booked by a surgery or ICB when they wish to close for training or team meetings etc. These are usually carried out between 12:00-18:00 and can be booked in Monday – Friday. GP or ANP Led.
- **Receptionist Telephone Answering -** Monday-Friday 08:00-09:00 & 17:00-18:00. Providing receptionist cover when surgeries are closed. Surgeries can request this at any time.
- **Blood Bikes -** Operational support for Blood Bike Charity overnight Sunday to Thursday.

UK and Ireland Elective/ Planned Care: Insourcing and outsourcing surgery and Out Patients

Multiple insourcing and outsourcing services for surgical or outpatient services provided across multiple specialties including:

- Gynaecology
- Oral and Maxillofacial Surgery
- ENT
- Neurology
- Ophthalmology
- Spinal Injections
- General/Colorectal Surgery
- Haematology
- Urology
- Plastic Surgery
- Endocrinology

- Spinal
- Neuro spinal
- Urogynae
- Ortho spinal
- Dermatology
- Endoscopy
- Nerve conductive study
- Theatre Insourcing
- Paediatric Urology

111 services

Multiple services for 111 including:

- 111 phone
- 111 digital
- Clinical assessment services

Physiotherapy/MSK

- MSK physio only at multiple HMP locations
- Direct Access MSK Physio at GP surgeries
- MSK Assessment clinic/ First Contact Practitioner (FCP) at GP surgeries
- GP referred Physical Therapies Service, Approved Qualified Practitioner (AQP)
- Occupational health services provided to multiple organisations including councils and police services

Podiatry

- standard podiatry and additional work of nail surgery and MSK/ biomechanics at multiple HMP locations

Defining our patient safety incident profile

The patient safety incident risks for this organisation have been profiled using organisational data including:

Incident reports: Recent data has been reviewed and a thematic analysis undertaken.

Service Risk Registers: reviewed with a focus on risks related to patient safety and this was triangulated with incidents and complaint themes

Complaints: themes were reviewed and a thematic analysis undertaken which was triangulated with other data sources.

Clinical Audit: outcomes and recommendations were reviewed and the themes triangulated with other data.

SCIF: reviews of SCIFs held in the organisation to establish themes.

The PSIRF Implementation Group reviewed the themes and trends including low harm, no harm and near misses, complaints and concerns, learning and recommendations from Serious Incidents (conducted under the previous framework), mortality reviews, legal claims and inquests, risks and risk registers and feedback from staff and patients to identify our five key priority areas. These priorities will be regularly reviewed against quality governance reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

Our group includes representation from all our services and has Executive sponsorship from the Group Medical Director as well as our Group Director of Nursing. As a group using all the information described we have agreed that we will focus on the following categories for improvement:

- Admin Processes
- Delay in care
- Communication
- Death
- Medication / Prescription

We will also focus our Quality Improvement Projects around:

- Datix admin data quality
- Staff attitudes
- Safeguarding referral process
- IPC review of elective care
- Missed fracture review

National guidance recommends that 3-6 investigations per priority are conducted per year, when combined with investigations from the national priorities this will likely result in 20-25 investigations per year. Attempting to do more could impede our ability to adopt a system-based learning approach from thematic analysis and learning from good practice.

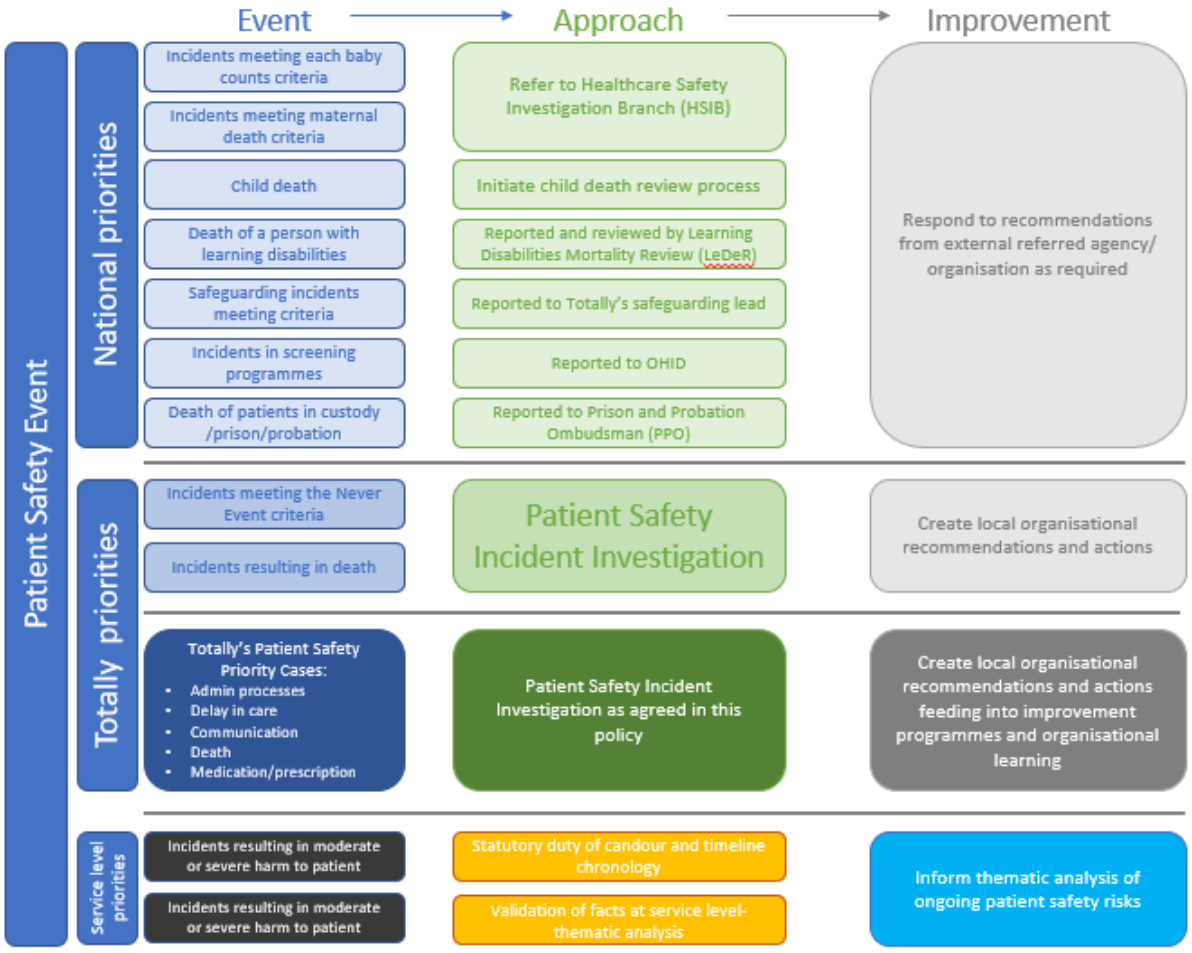
On a daily basis our services will hold a huddle meeting to 'triage' incidents, complaints and feedback and collaboratively agree a proportionate response. Responses may include:

Daily Huddle (review incidents, complaints and feedback)	**Incident review Meeting** Senior MDT reviews incident and agrees appropriate learning response
	SWARM 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.
	Quick resolution/ simple actions to resolve Note outcome and actions on datix

We have started to move to a less RCA/SI focussed framework when incidents need escalating and use an Incident Review Meeting to understand if an incident has affected Patient Safety and agree a learning response. A learning lead and engagement lead will be identified at this stage to support the process.

We have added the 'SWARM' meeting into our incident responses as a less formal quick review of an incident recognising that we may need to implement actions immediately to keep patients safe.

How we will respond to patient safety incidents



As we transition over to implementing PSIRF we will use existing structures to support the process of decision making. There are established daily governance huddles in all our services which will look back over the previous day and review incidents, feedback and complaints identifying a proportionate response to the issue.

Whilst we recognise that deciding what to investigate through a Patient Safety Incident Investigation (PSII) process will be a flexible approach, informed by the local and national priorities there will still be categories of Patient Safety incidents that must be investigated under PSIRF, these are;

1. Patient safety incident that is a Never Event

2. Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.

3. National priorities for investigations (at the time of developing this plan, there are none apart from those already listed below. We will include any new priorities as they emerge).

Apart from the "must investigate" points above, the decision to carry out a patient safety incident investigation should be based on the following:

• the patient safety incident is linked to one of Totally's Patient Safety Priorities that were agreed as part of understanding our incident profile

• the patient safety incident is an emergent area of risk. For example, a cluster of patient safety incidents of a similar type or theme may indicate a new priority emerging. In this situation, a proactive investigation can be commenced, using a single or group of incidents as index cases.

There is no legal duty to investigate a patient safety incident, however, once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

1. Tell the person/people involved (including family where appropriate) that the safety incident has taken place.

2. Apologise.

3. Provide a true account of what happened, explaining whatever you know at that point.

4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.

5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.

6. Keep a secure written record of all meetings and communications.

These incidents would have automatically been a 'serious incident' under the Serious Incident Framework but it is crucial that these incidents are not routinely investigated using the PSII process, otherwise we will be recreating the Serious Incident Framework. The routine response to an incident that results in severe harm will be to follow the Statutory Duty of Candour requirements. This will both provide insights to thematic learning and provide information about the events to share with those involved.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by

patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Involving Patients & Families

Our organisation recognises the importance of and is committed to involving patients and families following patient safety incidents, engaging them in the investigation process and to fulfil the duty of candour requirements. It is recognised from experience and research that patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents, and / or may have different questions or needs to that of the organisation. This policy therefore reinforces existing guidance relating to the duty of candour and 'being open' and recognises the need to involve patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved.

Involving Staff, Colleagues and Partners

Similarly, involvement of staff and colleagues (including partner agencies) is of paramount importance when responding to a patient safety incident to ensure a holistic and inclusive approach from the outset. We will continue to promote, support and encourage our colleagues and partners to report any incident or near-misses, with a shift in focus to incidents, or groups of incidents, which provide the greatest opportunities for learning and improvement.

It is also recognised that staff and colleagues need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame. We will continue to closely monitor incident reporting levels and continue promote an open and just culture to support this.

Our patient safety incident response plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
Eg incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
Eg death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into the quality improvement strategy
Eg incident meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required and feed actions into the quality improvement strategy

Our patient safety incident response plan: local focus

The table below describes how we will respond to patient safety incidents relating to the key patient safety risks identified in our thematic analysis.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Admin process	Thematic review	Support development of new improvement plan to understand how admin processes may be contributing to patient harm.
Delay in care	Thematic review/ PSII	Inform improvement strategy
Communication	Thematic review	Support development of new improvement plan to understand how admin processes may be contributing to patient harm.
Death (in care)	Thematic review/ PSII	Inform improvement strategy.
Medication/Prescription	Thematic review/ PSII	Create local safety actions and feed these into the quality improvement strategy.

Appendix A: Managing incidents