Patient safety incident response plan

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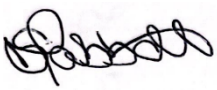
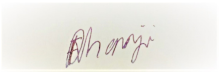
Author	**Sarah Mabbott**	**Quality and Patient Safety Lead Nurse**		**09/08/2023**
Reviewer	**Dr Fahreen Dhanji**	**Medical Director**		**21/09/2023**
Authoriser	**LLR ICB**	**Strategic Quality Group**	**-**	**21/09/2023**

Foreword

“The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them” (Aidan Fowler, National Director of Patient Safety, NHS England).

PSIRF is a different and exciting approach to how we respond to patient safety incidents. This is a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent incidents from happening again. Our challenge is to shift the focus away from investigating incidents and towards an emphasis on the outcomes of the patient safety incident responses that support learning and improvement to prevent recurrence.

PSIRF gives us a set of principles that we will work to, and we welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents.

We must engage meaningfully with our patients, families, and carers to ensure that their voice is the Golden Thread in any of our patient safety investigations. PSIRF sets out best practice for this engagement.

We are fostering a culture in which people feel they can highlight incidents in psychological safety. PSIRF asks that we have conversations with people who have been affected by a patient safety incident, no matter how difficult that is, and we will work to how we can best equip and support those affected in order to hear their voice. The process of reviewing an incident can help our staff validate the decisions they made in caring and treating for patients and facilitate psychological closure.

As we adopt this new way of managing our patient safety incidents, we accept that we may not get it right at the beginning and we will monitor the impact and effectiveness of PSIRF implementation continuously, responding and adapting as required if our approach is not achieving what we expect.

PSIRF offers us the opportunity to learn and improve, to promote safe, effective and compassionate care to our patients, their families and carers whilst also protecting the well-being of our staff.

Contents

Introduction

This patient safety incident response plan sets out how LLR PCL intends to respond to patient safety incidents over a period of the next 12 to 18 months.

The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This plan is underpinned by our existing policy on reporting and managing patient safety incidents and the new patient safety incident response policy.

Our services

LLR PCL is a system partner and provider of services in the community that have traditionally been delivered in secondary care but can be safely delivered in general practice and community settings by GP's with specialist interests (GPSI) and consultants.

We serve a population that includes residents of Leicester City, Leicestershire County and Rutland. This is approx. 1.1million people. The services provided serve the whole adult population.

The Diversity of the services include anti-coagulation services, Diagnostics such as Echocardiograms, Non-Obstetric Ultrasounds including MSK Ultrasounds, Renal and abdominal. Minor Surgeries such as Local Anaesthetic Hernia repair, Minor hand surgery, Cataracts, Dermatology minor procedures such as BCC's etc, Lesion removal and lumps and bumps. ENT services are provided across the region, an MSK one stop clinic being offered. Acne services are provided separate to the dermatology clinics. There is a provision for vasectomy and circumcision across the county.

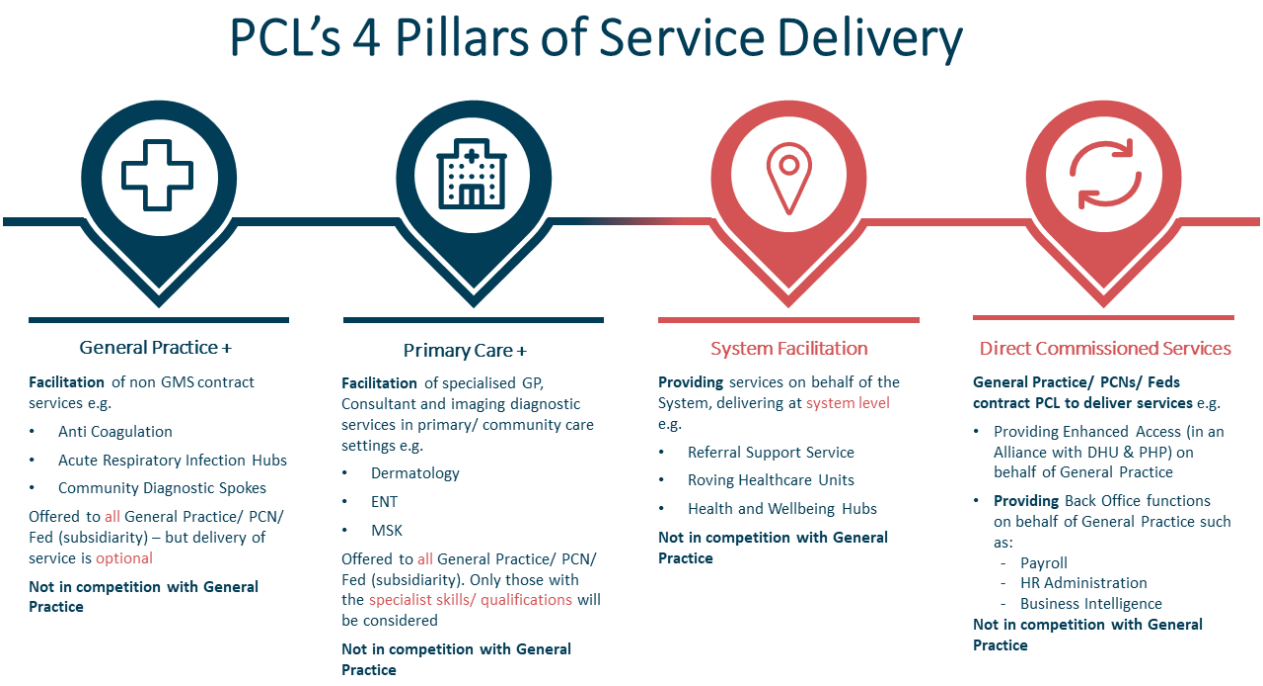
We also provide for patients that are on long waiting lists in secondary care by transferring their care into the community and allowing them to be seen more quickly and closer to home.

LLR PCL are currently in the planning stages of building two Health and Wellbeing Hubs, one in Oakham and the other in Wigston. These will allow for a variety of other services to be offered such as Turning Point provision, social prescribing and other health and wellbeing services, such as mental health providers using the sites for consulting.

We also provide two Mobile units that are currently being used to aid in the covid vaccine delivery programme but can also be used for addressing health in equalities outside of vaccination seasons. These can be utilised to deliver hyperlocal health promotion, deliver health checks and support patients to access health care in a very local environment paying particular attention to the cultural diversity of the local population.

LLR PCL provide a wide range of services across Leicester, Leicestershire and Rutland, working in conjunction with the system to provide health care to communities. Because of this diversity

there is a frequent change to services and contracts, with new services coming onboard and other services or providers finishing, meaning that the PSIRF plan cannot be absolute. New services will be monitored and added to the plan as necessary.



Defining our patient safety incident profile

LLR PCL has a commitment to learning from patient safety incidents and we have developed our understanding and insights into patient safety matters over a period of rapid company growth during and following COVID 19. With the employment of a designated quality and patient safety nurse role, the oversight of the patient safety incidents has improved immeasurably. The Quality and Patient Safety Lead regularly reports to the monthly executive board meeting and links in with the Medical Director of LLR PCL to ensure robust and comprehensive oversight of any and all patient safety activity.

PSIRF sets no rules or thresholds to determine what needs to learn from to inform improvement apart from the national requirements set out below. To fully implement the framework LLR PCL has completed a review of patient safety incidents to understand what needs to be learned from to improve.

Stakeholder engagement

The Quality and Patient Safety Lead Nurse has consulted extensively with the ICB patient safety team to fully understand the requirements of PSIRF and to understand the practicalities of planning and implementation.

LLR PCL is conscious that PSIRF requires a very different approach to the oversight of patient safety incidents. Internally, the senior management team has been informed of the major differences between PSIRF and the SI framework. A presentation delivered by the ICB patient safety team will be delivered at one of the SMT meetings to fully engage the management team and answer any questions that may arise.

Our data sources and how they were used to define our safety profile is detailed below.

Data Sources

To define our patient safety response profile, we drew data from the previous years, starting Nov 2021 when the quality role came into existence.

We have considered feedback and information from the following sources:

- Patient safety incident investigation reports
- Complaints
- Freedom to Speak Up (Previously Whistleblowing)
- Safeguarding incidents
- Data from quality audit results
- LLR PCL Risk Register

Where possible we have considered what the data tells us about inequalities in patient safety.

Safety issues highlighted by the data.

From the data pull, we are able to identify 8 distinct types of incidents reported to LLR PCL from providers. All 393 incidents reported within the timeframe considered (Dec 2021 – May 2023)

were allocated to one of the 8 types and 13 themes identified. This reflects the diversity of the services contracted by LLR PCL and the types of incidents reported.

These are shown in the table below.

Type	Descriptor
Transferring Care Safely	All incidents reported through the Transferring Care safely system.
Incidents	All incidents not falling into the other categories
Complaints	All incidents reported through the complaints process.
Freedom to Speak Up (previously whistleblowing)	All incidents reported through the Freedom to Speak up/Whistleblowing process
Never Event	All incidents meeting the NHSE Never Event criteria
Safeguarding	All incidents where it has been reported or noted that a patient requires safeguarding
Significant Event	All incidents that meet the SI Framework criteria
Other	All incidents that do not fall into the other categories.

Having identified the types of incidents being reported we then considered the themes, this identified 13 broad themes as set out below.

Theme	Descriptor
Administration	All incidents involving administration events
Cancellations	All incidents involving cancellation of patient appointments, cancellation of clinics etc.
Attitude	All incidents involving the Attitude of staff, patients, families, or carers.
Bookings	All incidents involving the booking of appointments
Clinical concern	All incidents involving concerns highlighted by the clinician.
Referrals	All incidents involving referrals from GPs
Service set up inappropriate	All incidents involving the service set up – environment, facilities etc.
Surgical	All incidents involving surgery.

Information Governance breach	All incidents involving breach of information
Post-operative complications	All incidents involving post-operative complications.
Medicines Management	All incidents involving medication
Other	All incidents that do not fit into the above themes.

Identification of the above types and themes led to the local focus priorities and will be our priorities for review under PSIRF.

We appreciate that the final list is not fixed, and we will consider additional capacity for ad-hoc Patient Safety Incident Investigation, where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

Defining our patient safety improvement profile

In recent years LLR PCL has developed its governance processes to ensure it gains insight from patient safety incidents and that this feeds into quality improvement activity. LLR PCL will continue to draw upon guidance and feedback from national and regional level NHS bodies, regulators, commissioners, providers, and other key stakeholders to identify and define the quality improvement work we need to undertake.

Please see table for National Guidance plus what is happening at a local level.

This has been rag rated - green shows practice is embedded; Amber is work being undertaken and Red is work to be commenced.

National guidance	Regional guidance	Local guidance (RAG rated)	Comments on National guidance

Dermatology: Under the Wrong Site surgery category, incorrect skin lesion removals or biopsies are the third most common incident subtype of Never Events. Lessons-Learned-Skin-Cancer-Treatments-Never-Events.pdf (bad.org.uk)		• All Clinicians are required to confirm that they use LocSSIPS and the WHO surgical safety checklist as part of the OPC/Quality annual audit. • Changes made to the referral service to include supporting photography and body maps. • Changes made to referral system to ensure clear documentation on the referral. • Clinician CV/ Qualifications ratified by PCL MD to ensure qualifications are appropriate. • IPC audit performed annually. • Adherence to LLR ARP	• All clinicians must have induction and training on LocSSIPS. • All clinicians can confirm skin lesion site prior to any surgery taking place with a consultant when uncertainty exists. • All clinicians should have the requisite clinical information and be able to confirm the lesion before removal. • Site marking; use of the WHO surgical checklist, body maps and photography. • Clear documentation regarding the lesions to be excised or biopsied.

Ophthalmology, Cataracts: [Cataracts in adults: management (nice.org.uk)] Preventing wrong lens implant errors.		• 3 identifiers are used to ensure correct patient. • Uncertainty with how biometry results are transferred to the patients record. • Patient identity is confirmed in theatre. • Eye is clearly checked and marked. • There is only 1 lens in theatre that matches the patient. • Uncertainty around whether 2 members of the surgical team check the accuracy, consistency, and appropriateness of all formulas, calculations, and constants. • Surgeons verifies lens. • WHO surgical checklist is used. • Safety Huddle completed prior to theatre list. • IPC audit completed annually, checklist and safety huddle observed. • Clinician CV/ qualifications ratified by PCL MD	Prior to surgery: • 3 identifiers used to ensure correct patient records. • 3 identifiers used on pre-op biometry results. • Ensure biometry results are either electronically transferred o patient record or a printed biometry result has a patient label and is securely fixed to patients record. • Do not transcribe results by hand. • In theatre confirm patient identity. • Eye to be operated on is clearly marked and checked. • There is only 1 intraocular lens in theatre that matches the persons selected lens type and prescription. • At least 2 members of the surgical team have checked the appropriateness, consistency and accuracy of all formulas, calculations, and constants. • Surgeon should verify the correct intraocular lens has been selected and is available in theatre.

Surgery: Vasectomy Circumcision Hernia Hand Surgery Minor Ops Report template - NHSI website (england.nhs.uk)		Providers are required to report any post-operative complications including infections and anti-biotic use on a monthly basis. Providers are required to complete bi-annual clinical audits which ask about infections, complications and anti-biotic use. • IPC audit completed annually, checklist and safety huddle observed. • Clinician CV/ qualifications ratified by PCL MD	Anti-microbial resistance and HCAI's: The GIRFT surgical site infection survey 94 started in 2017 seeks to complement the work of PHE by engaging frontline clinicians in exploring variation in surgical practice and infection outcomes for a wider range of procedures and specialties.
ENT:	-	• IPC audit completed annually, checklist and safety huddle observed. • Clinician CV/ qualifications ratified by PCL MD	-
Anti-coagulation: Report template - NHSI website (england.nhs.uk) The Medication Safety Improvement Programme.		• Anti-coagulant monitoring delivered within a specified time. • Complete and accurate records. • Appropriate prescribing • Correct dosing and information given to patient, family, carers in an appropriate timeframe.	• Define and achieve measurable reductions in medication harm. • Implement an action plan for continuous improvement in medication safety. • Empower patients and professionals to share decision making. • Focus on patient outcomes related to medicine safety. • Develop a plan to sustain improvement.

We plan to focus our efforts on development of safety improvement plans across our most significant incident types, either those within the national priorities or those that we have

identified locally. We will remain flexible and consider improvement plans as required where a risk or a patient safety issue emerges from our own or external insights.

Our patient safety incident response plan: national requirements

LLR PCL has limited resources for patient safety incident response, we intend to use those resources to maximise improvement. PSIRF allows us to do this, rather than repeatedly respond to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

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

As well as PSII, some incident types require specific reporting and/or review processes to be followed.

For clarity, all types of incidents that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods and are detailed in the table below.

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events (2018) criteria or its replacement	Locally led PSII in the organisation in which the event occurred.	Create local organisational actions and feed these into the quality improvement strategy
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority Safeguarding lead. LLR PCL will contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	LLR PCL safeguarding lead will liaise with the ICB safeguarding team and other organisations as required.

Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)	Create local organisational actions and feed these into the quality improvement strategy

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety insights, based on the reviews of incidents we have identified the patient safety priorities set out below.

This will allow us to apply a systems-based approach to learning from these incidents and exploring multiple contributory factors.

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

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Anti-coagulation incidents, INR errors or dosing errors	Patient Safety Incident Investigation where agreed locally, dependent upon incident it may require a PSII, After Action review or thematic analysis of events. All events will discussed with the provider and	create local safety actions and feed these into the quality improvement strategy. Due to the potential low numbers of incidents, a thematic review will be undertaken quarterly to identify improvement efforts.
Incident resulting in moderate or severe harm to patient.	Statutory duty or candour and appropriate toolkit item Escalation plan and risk assessments to be carried out by LLR PCL Quality team	Inform thematic analysis of ongoing patient safety risks and use to build a case for a new improvement plan or inform ongoing improvement efforts.
No/low Harm patient safety incident	Validation of facts at local level – thematic analysis	Inform thematic analysis of ongoing patient safety risks and use to build a case for a new improvement plan or inform ongoing improvement efforts.

Surgical Incidents including Post-Operative Complications.	Statutory duty or candour and appropriate toolkit item if required. Escalation plan and risk assessments to be carried out by LLR PCL Quality team if required. May require PSII or After action review, SWARM huddle – response to be agreed locally and discussion with provider.	Inform thematic analysis of ongoing patient safety risks and use to build a case for a new improvement plan or inform ongoing improvement efforts.
Provider staffing levels resulting in reduction or no service. (Risk ID 7)	Review by contract team and quality team as appropriate in conjunction with the provider. Continued monitoring of patient safety incidents to determine any emerging risks/issues.	Inform ongoing improvement efforts
PCLs Service Provider(s) unable to fulfill contract. Possibility of service provider being unable to deliver contract - causes may be illness, premises failure, closure of practice etc. (Risk ID 7)	Review by contract team and quality team as appropriate in conjunction with the provider. Continued monitoring of patient safety incidents to determine any emerging risks/issues.	Inform ongoing improvement efforts
Significant number of patients waiting longer than 6 weeks for diagnostic ECHO and NOUS (Risk ID 48)	Review by contract team and quality team as appropriate in conjunction with the provider. Continued monitoring of patient safety incidents to determine any emerging risks/issues.	Inform ongoing improvement efforts
Documentation/IG breach	Review by Quality Lead and DPO. Continued monitoring of patient safety incidents to identify any emerging risks/ issues	Inform ongoing improvement efforts.

Safeguarding	Review by Quality Lead Nurse in conjunction with the ICB safeguarding team to ensure referral and review. Continued monitoring of patient safety incidents to identify any emerging risks/ issues.	Inform ongoing improvement efforts.
Infection Prevention and Control	Review by Quality Lead Nurse in conjunction with relevant providers and third parties as required. Continue nationally required external reporting for specific infection groups. Continued monitoring of patient safety incidents to identify any emerging risks or issues. May require PSII or After	Inform ongoing improvement efforts

All incidents will be reported through LFPSE regardless of level of investigation required.

Plan reviewed and updated.

Date of Review	Comments	Next review date	Initials of reviewer and title
08/01/2024	Minor amendments made to themes and trends where titles have changed, e.g. clinician concern is now clinical concern	07/2024	SM – Quality and Patient Safety Lead Nurse
