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Excellence • Compassion • Expertise

Patient Safety Incident Response Plan

2022/23

City Health Care Partnership CIC

Excellence. Compassion. Expertise.

Contents

Introduction to the Patient Safety Incident Response Plan

The NHS Patient Safety Strategy (2019) was published in 2019 and detailed the Patient Safety Incident Response Framework (PSIRF), that will replace the NHS Serious Incident Framework (SIF) (2015). This document, the Patient Safety Incident Response Plan (PSIRP), describes how at City Health Care Partnership CIC (CHCP) we are preparing for the transition to PSIRF in November 2023.

Our PSIRP details our patient safety incident profile and the tools and methods the organisation will adopt to respond to patient safety incidents to support continuous learning and improvement ensuring that there is compassionate engagement with all involved in patient safety incidents.

PSIRF brings a shift to what and how investigations are carried out with a focus on learning and improvement. This change enables us to think differently about how we respond to patient safety events when compared to the previous serious incident process and ensures that those responses are proportionate and maximise learning and improvement opportunities. The utilisation of systems-based methodologies will allow us to apply a greater focus on contributory and causal factors, to identify the effectiveness of systems and where improvements are needed.

The PSIRF focuses on the following in response to patient safety incidents:

- Compassionate engagement and involvement of those affected
- Adoption of a range of system-based methods to learning from patient safety events
- Proportionate responses
- Oversight to support system improvement

Underpinned by our governance processes, our PSIRP will support us in measuring how effective our responses are to patient safety incidents and how we can continue to learn and improve as well as creating and sustaining a safe and just culture for our staff.

The Scope of PSIRF and CHCP Vision

The PSIRF scope is to:

Improve the working **environment** for staff in relation to their experiences of patient safety incident response

Improve the use of valuable healthcare resources

Improve the experience for **patients**, their families and carers affected by patient safety incidents

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Vision:
Lead and inspire through excellence, compassion and expertise

Mission:
Deliver high quality care through colleagues who are competent and motivated

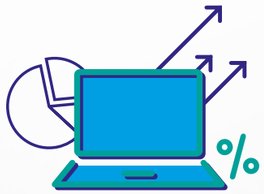
Values:
Service and Excellence/
Equality and Diversity/
Creativity and Innovation/
Co-operation and Partnership

Our Services

CHCP is an independent "for better profit" co-owned business providing a wide range of health and care services. We provide over 50 services to people in Hull, East Riding of Yorkshire, and Merseyside.

Operational services

- Medicines Services
- Nursing and Conditions
- Therapies and Rehabilitation
- Care Coordination Hub
- Integrated Urgent Care
- Psychological Well-being
- Sexual Health
- Public Health



Further information about CHCP can be found at www.chcpcic.co.uk

Developing Our Patient Safety Incident Profile

A key part of developing the PSIRF approach is to understand the patient safety activity CHCP has undertaken in the last few years. This will support us in how we will learn from patient safety incidents after we transition to PSIRF.

CHCP used a thematic analysis approach to identify our patient safety profile and our patient safety priorities.

Stakeholder engagement

The patient safety risk profile is collaborative, and the following stakeholders will be involved through the transitional phase of implementing PSIRF:

- Staff through the incident risk management reporting system
- Integrated Care Board (ICB) and Place based leads, and health partner organisations through partnership working with the ICB
- Service User Voice
- Voluntary and Community Sector
- Local Authority, i.e., Social Services, Care Quality Commission (CQC), NHS England, Healthwatch

Thematic Analysis

The thematic review looked at patient safety activity between 2017 – 2023 and involved the following sources of data and information:

- Analysis of 6 years of Serious Incident (SI) and Never Event reporting data and associated action plans
- Incidents reported via CHCP's Datix system
- End to end reviews
- Key themes from complaints/concerns/ comments/claims/inquests
- Themes from incidents with statutory requirements such as safeguarding, Learning Disability Mortality Review (LeDeR) and Freedom to Speak Up reports
- Case note reviews
- Staff survey results
- Health inequalities data
- Risk assessments

CHCP patient safety profile 2017-2023

- Pressure Ulcer Cat 3/4 **75**
- Serious Incidents **92**
- Incidents **22,946**
- Medicines **3,348**
- Communication **4,014**
- Information Governance **2,695**
- Health and Safety **2,306**
- Reportable Adult Deaths **142**
- Safeguarding **347**
- Inquests **35**
- Never Events **2**
- Concerns **8,359**
- Clinical Governance **2,306**
- Complaints **602**

When observing our patient safety profile, themes and trends identified that categories of Information Governance, Safeguarding, Clinical Governance, Health and Safety, medication related incidents and adult deaths were the higher reported incidents. Of the 142 adult deaths which relate to the statutory notifications; 35 deaths related to death in custody, 42 deaths although unexpected were unavoidable and 65 within the bedded units or within patient homes where the death was expected with a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form for end-of-life care and advanced care planning in place.

Our quality improvement and service transformation work

Through identification of our themes and trends from our safety profile there are existing workstreams in place for quality improvement and service transformation work as below:

Falls

Patient and care home Multi-Disciplinary Team meetings with the Frailty Team, Hull First Falls Response Service (Hull and East Riding), which capture patients who have had a history of falls where triage, face to face contact/assessment are undertaken. Links with Yorkshire Ambulance Service and the Accident/Emergency Department, implementing proactive management. Lifeline meetings look at receiving concerns around patients and implementing safety measures for falls. Implementation of the IStumble Assessment Tool. The Fracture Liaison Service; although primarily for secondary prevention, a business case is underway to incorporate primary prevention.

Information governance

Cyber security, contract monitoring, and business continuity plans will be areas for quality improvements.

Pressure ulcer

Humber Strategic Pressure Ulcer Group Meeting. Development of the pressure ulcer patient information leaflet. The identified key themes for the workplan are non-adherence to advice or treatment, end of life care, care home and communications and pressure ulcer relieving equipment. On-going work with the Purpose T Pressure Ulcer Risk Assessment Tool.

Medication

Introduction of the Medicines Safety and Governance training for clinical staff at induction. This covers medicines legislation and themes and trends from incidents. There is current work on the transcribing Standard Operating Procedure and training will be developed in the bedded units. Undertaking of audits around medicine incidents.

National Requirements

Deciding what to investigate is the most significant and challenging change between the SIF and PSIRF. PSIRF offers flexibility in what CHCP will appropriately and proportionately choose to investigate, rather than the SIF where criteria for what met the threshold was dictated with the focus on delivering the report in an inflexible timescale.

CHCP acknowledge that there are nationally mandated events where a Patient Safety Incident Investigation (PSII) must be undertaken or reported via national platforms, and we will ensure that these are reported appropriately.

Table 1 National requirements that require a response:

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria **E.g., wrong site surgery, maladministration of insulin resulting in death or severe harm**	PSII	Create local organisational actions and improvement plans and feed these into the quality strategy and Integrated Quality Forum, Safe Quality Services Committee and Safety and Quality meetings
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII)	PSII	Medical examiner/Learning from deaths. Create local organisational actions and improvement plans and feed these into the quality strategy and Integrated Quality Forum, Safe Quality Services Committee and Safety and Quality meetings
Deaths of persons with learning disabilities	LeDeR	As per requirement of the case. Create local organisational actions and improvement plans and feed these into the quality strategy and Integrated Quality Forum, Safe Quality Services Committee and Safety and Quality meetings
Safeguarding Incidents where adults or children are on a child protection plan/looked after plan or a victim of wilful neglect or domestic abuse/ violence or are in receipt of care and support needs from their local authority or incidents that relate to female genital mutilation, PREVENT, modern slavery and human trafficking	Refer to CHCP/ Local Authority Safeguarding Lead	As per requirement of the case. Create local organisational actions and improvement plans and feed these into the quality strategy and Integrated Quality Forum, Safe Quality Services Committee and Safety and Quality meetings
Healthcare acquired infections (HCAI)	Refer to CHCP Infection Prevention and Control (IPC) Practitioners and Director of Infection Prevention and Control	As per requirement of the case. Create local organisational actions and improvement plans and feed these into the quality strategy and Integrated Quality Forum, Safe Quality Services Committee and Safety and Quality meetings.

Local Focus

Our local priorities for PSII have been set out that defines patient safety incidents requiring a comprehensive investigation response (Table 2). This is where an unexpected patient safety incident signifies an extreme level of risk for patients, families and carers, staff, or organisations.

Criteria for selection of incidents within CHCP care for:

a. Actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)

b. Likelihood of recurrence (including scale, scope and spread)

c. Potential for learning in terms of enhanced knowledge and understanding, improved efficiency and effectiveness (control potential) and opportunity for influence on wider systems improvement

The tables to follow detail the different methodologies that we will use to undertake investigations and reviews, including the incident types in which they can be used to support learning and improvement.

To ensure our staff are adequately trained to use these different methodologies, we have undertaken a training needs analysis. This will allow us to continuously ensure that our staff have the knowledge and skills to successfully utilise these methodologies and maximise learning opportunities.

Table 2

Incident type	Investigation response	Response links
Diagnostic incident including delay in care resulting in severe harm	PSII	Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Sub-optimal care of a deteriorating patient resulting in severe harm	PSII	Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings

Where an incident does not fall into any of the categories above an investigation and/or review method described in table 3 may be used.

Table 3 Sets out patient safety themes and investigation review options:

Incident type	Incident review method options	Learning response	Response links
Harm identified in the improvement plan and service transformation work **Falls** **Pressure Ulcers category 3 and 4** **Medication errors** **IG**	3 working days for review SWARM After Action Review (AAR) MDT review Walkthrough analysis Observation analysis Quarterly thematic review	One page learning response method	Update on quality improvement programmes Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Abuse/alleged abuse of adult patient by third party. Neglect, Safeguarding.	3 working days for review SWARM SAR LeDeR AAR MDT review Walkthrough analysis Observation analysis Quarterly thematic review	One page learning response methods Statutory investigation	Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Service level determined reviews **E.g. communication; missed appointments.** **Emergency situations**	AAR MDT Walkthrough analysis Observation analysis	One page learning response method	Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Moderate and above harms	3 working days for review SWARM AAR MDT review Walkthrough analysis Observation analysis Link analysis	One page learning response method	Safety Action Plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Cluster of near miss, no/low harm	Thematic review	Thematic review	Thematic review report and improvement plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Potential patient safety risks/themes	Thematic review	Thematic review	Thematic review report and improvement plan Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings
Learning from best practice	AAR Thematic review	One page learning response method	Thematic review report Safe Quality Services Committee Integrated Quality Forum Safety and Quality meetings

Table 4: description of planned response options to a patient safety incident:

Planned response to a patient safety incident	Aim
Multi-disciplinary (MDT) review	MDT reviews support learning from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of incidents either because of the passage of time or staff availability. 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.
Swarm huddle	To be initiated as soon as possible after an incident 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 with immediate effect to mitigate reoccurrence of the same thing happening in future.
AAR	Is a structured facilitated discussion of an incident, the outcome of which gives individuals involved in the incident 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 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 incident? What is the learning?
Walkthrough analysis	Walkthrough analysis will enable analysis about a process or task or any future developments (i.e., designing a new protocol). It is used to enable understanding how work is performed rather than how we think work is undertaken.
Observational analysis	Observation helps us understand how work is performed rather than what is documented in training, procedures, or equipment operating manuals (work as prescribed), how we think work is undertaken (work as imagined) or how people tell us how work is undertaken (work as disclosed).

CHCP Local Requirements

We will continue to use existing governance structures to support the process of transition to PSIRF. The responsibility for selection of the most appropriate level of patient safety review will be delegated to services with governance oversight and will be led locally by staff who have undertaken the PSIRF training.

PSIIs for local and national priorities will commence as soon as possible after the patient safety incident.

Duty of Candour

At CHCP every healthcare professional will be open and honest with patients, their families and carers when something goes wrong with their care and offered an apology. An apology is not an admission of guilt and is the right thing to do. It also supports the learning process from identifying that things have not gone right or as planned and mitigate against recurrence.

CHCP will always apologise to patient, families and their carers if something has gone wrong that has caused harm.

Further information can be found in our Duty of Candour Policy which is available in the document management system My Compliance.

Involvement and Support For Patients, Their Families and Carers

The patient, family and carer's voices are vital for learning from incidents and putting actions into place to prevent reoccurrence. They should be viewed as credible sources of information in response to any patient safety incident. Engagement and involvement will be individual and adapted to changing needs. These needs could be practical, physical, or emotional.

Discussions will be had with those affected about the structure of engagement and involvement. There will be a duty of care to everyone involved in the incident and subsequent response and opportunity provided for open communication and support. All communications will clearly describe the process and its purpose to ensure understanding.

An investigation process that is collaborative and open with information, and provides answers, can reduce the chance of litigation where they feel this is the only route to be heard.

Involvement and Support For Staff

The personal and professional impact that a patient safety incident can have on staff can be detrimental; providing them with appropriate support is crucial. We will identify support for our staff and have clear signposting to pathways to achieve this.

We will continue to promote a "just culture" and an open reporting culture where staff do not fear being blamed. We will ensure that we are consistent and fair when staff report an incident or are providing their insights into care of a patient for investigation. We will actively encourage a safe space to discuss the incident, explore the system in which they work and listen openly without judgement.

CHCP's policy on involving staff and the support available to them can be found on the document management system My Compliance.

Patient Safety Partners

The NHS Patient Safety Strategy (July 2019) recognises the importance of involving patients, their families and carers and other lay people in improving the safety of NHS care and this is a priority for the NHS.

Patient Safety Partners (PSPs) are patients, carers, family members or other lay people who join and work in partnership with organisations and their staff to improve the patient safety culture. This will be achieved through PSPs being embedded within the organisational Integrated Governance Strategic Framework, engaging PSPs within our established committees, groups, and forums or equivalent, where they can provide appropriate challenge, contribute to the development of organisational policies, and play a crucial part in how patient safety issues should be managed. We will engage proactively with our Service User Voice (SUV) existing members to promote the PSP role and welcome the opportunity to work with them in improving safety.

Our Quality Improvement Approach

Our key function is to embed a culture of continuous Quality Improvement (QI) rooted in evidence-based high quality care and working across systems and teams to facilitate support, tools and resources.

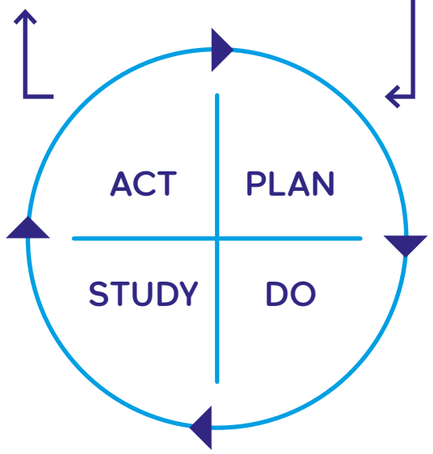
The methodology we use is the Plan, Do, Study, Act (PDSA) Model for Improvement to support our QI programmes. We are committed to continuing QI programmes and implementing QI programmes arising from patient safety investigations and identification of themes as well as improvement priorities.

Model for improvement:

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in an improvement?



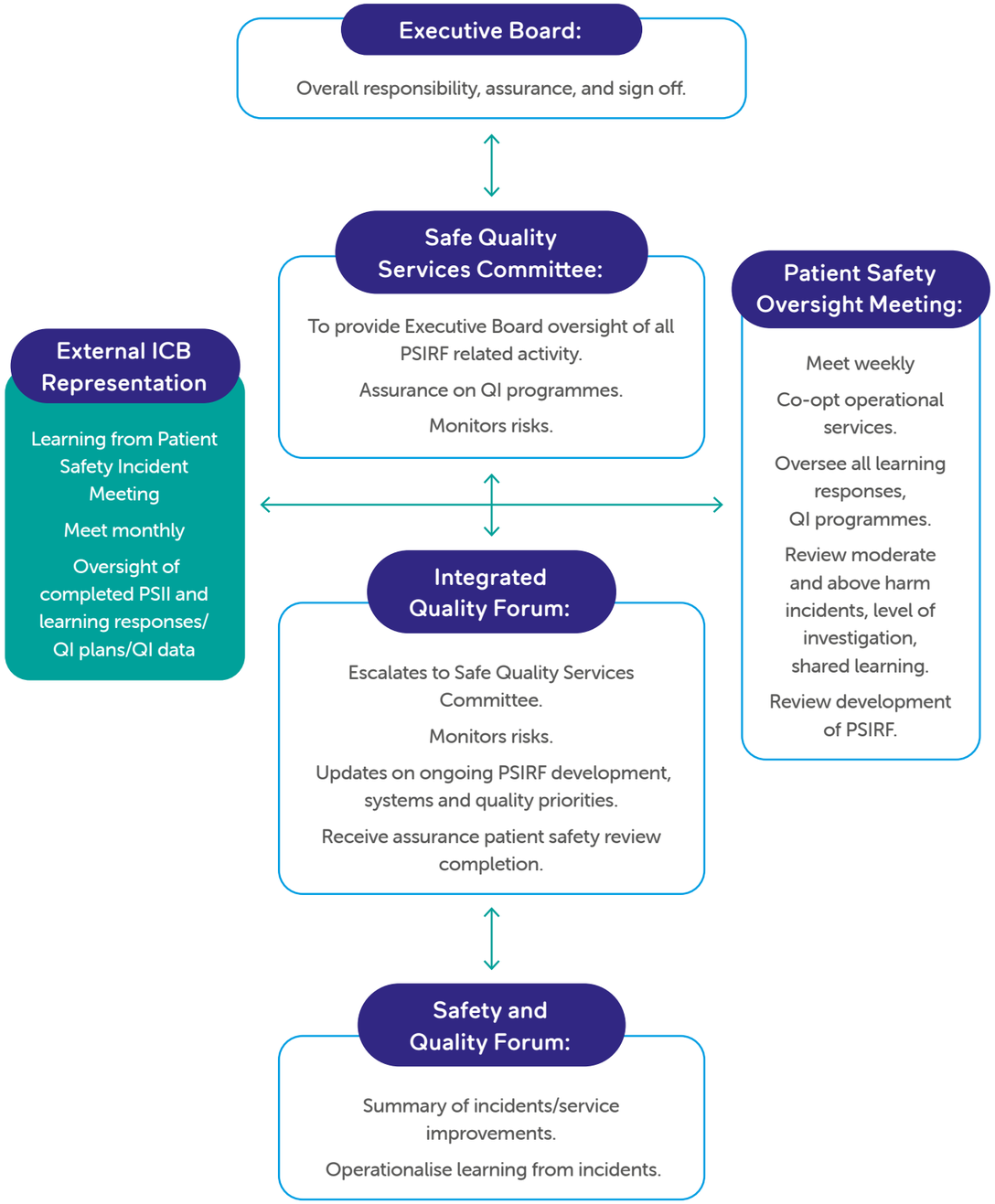
Oversight Governance Structure

Oversight under PSIRF focuses on engagement and empowerment rather than more traditional command and control. We will work in collaboration with our commissioners and regulators where oversight will enable us to demonstrate continuous improvement rather than compliance against Key Performance Indicators.

In collaboration with our ICB colleagues CHCP are committed to delivering on the following standards:

- Policy, planning and oversight: develop a patient safety incident response policy which will describe the systems and processes to facilitate learning and improvement following a PSII.
- Competence and capacity: Learning response leads, those leading engagement and involvement as well as those in oversight roles will have specific knowledge and experience. They will apply human factors and system thinking principles to gather information from a wide range of sources.
- Engagement and involvement of those affected by patient safety incidents: Those affected by PSIIs will be led by individuals with a specified level of training. Duty of candour principles will be upheld.
- Proportionate response: Patient safety learning responses will begin as soon as possible after the incident has been identified and are conducted for the sole purpose of learning, identifying improvements that reduce risk and preventing reoccurrence that do not determine liability or blame.

Internal and external oversight structure is described below:



Glossary

CQC – Care Quality Commission
The CQC regulates all the health and social care services in England.

LeDeR – Learning Disabilities Mortality Review
LeDeR is a national service improvement programme looking at the lives and deaths of people with a learning disability and autistic people. The programme aims to improve care, reduce health inequalities, and prevent premature mortality.

Never Event
Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at national level and have been implemented by healthcare providers.

PDSA – Plan, Do, Study and Act model For Improvement

PSII – Patient Safety Incident Investigation
A system-based response to a single patient safety incident or cluster of incidents for learning and improvement and to understand any system factors that contributed to the incident. Typically, a PSII includes four phases: planning, information gathering, synthesis, and interpreting and improving.

PSIRF – Patient Safety Incident Response Framework
The Patient Safety Incident Response Framework (PSIRF) 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.

PSIRP – Patient Safety Incident Response Plan
CHCP plan - In response to the framework. It describes what is being done to prepare for "go live" with PSIRF and what comes next. These have been developed by analysis of local data.

SIF – Serious Incident Framework
Framework to manage reporting of serious incidents. Is being replaced by PSIRF.

Patient Safety Incident Response Plan 2022/23

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Polish
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Kurdish
نەگەر حەز دەکەیت نەم بەڵگەنامەیەت بە زمان یاخود شێوازێکی دیکە بەدەست بگات وەک شریتی دەنگ، چاپی گەورە یاخود برایل (هەڵنتوقیو)، تکایە تەلەفون بکە بۆ 01482 347649.

Mandarin
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Arabic
"إذا كنت ترغب في الحصول على هذه الوثيقة بلغة أخرى أو بتنسيق مختلف مثل شريط صوتي، أو طباعة بحروف كبيرة أو بطريقة "برايل"، يرجى الاتصال على الرقم: 01482 347649".

Russian
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