Patient safety incident response plan

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1. Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how we, as an organisation, intend to respond to patient safety incidents reported by colleagues, patients, their families, and carers as part of our commitment and workstreams supporting continuous learning and improvement in relation to the quality and safety of the care we provide.

Our PSIRP is integral to the implementation of Patient Safety Incident Response Framework (PSIRF) and aligns with our strategic priorities.

This plan will cover a period of 12 to 18 months; however, 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.

The plan is underpinned by our organisational PSIRF and Incident Management policies, which includes detailed reference to our reporting culture and structures, internal classifications and triggers, timeframes, and Duty of Candour etc. In addition to incident and near miss reporting, colleagues have access to our Freedom to Speak Up Guardian; this is independently provided by the Guardian Service, the UK's leading provider of confidential staff liaison services (further details available in the Whistle Blowing Policy). These policies are available to colleagues and can be accessed via our organisation's intranet.

PSIRF is not an investigation framework that prescribes what to investigate, rather it:

- 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

This document sets out how responses will be conducted solely for the purpose of system learning and improvement.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'Patient Safety Incidents' (PSIs) and 'Serious Incidents' (SIs). As such it removes the SI classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

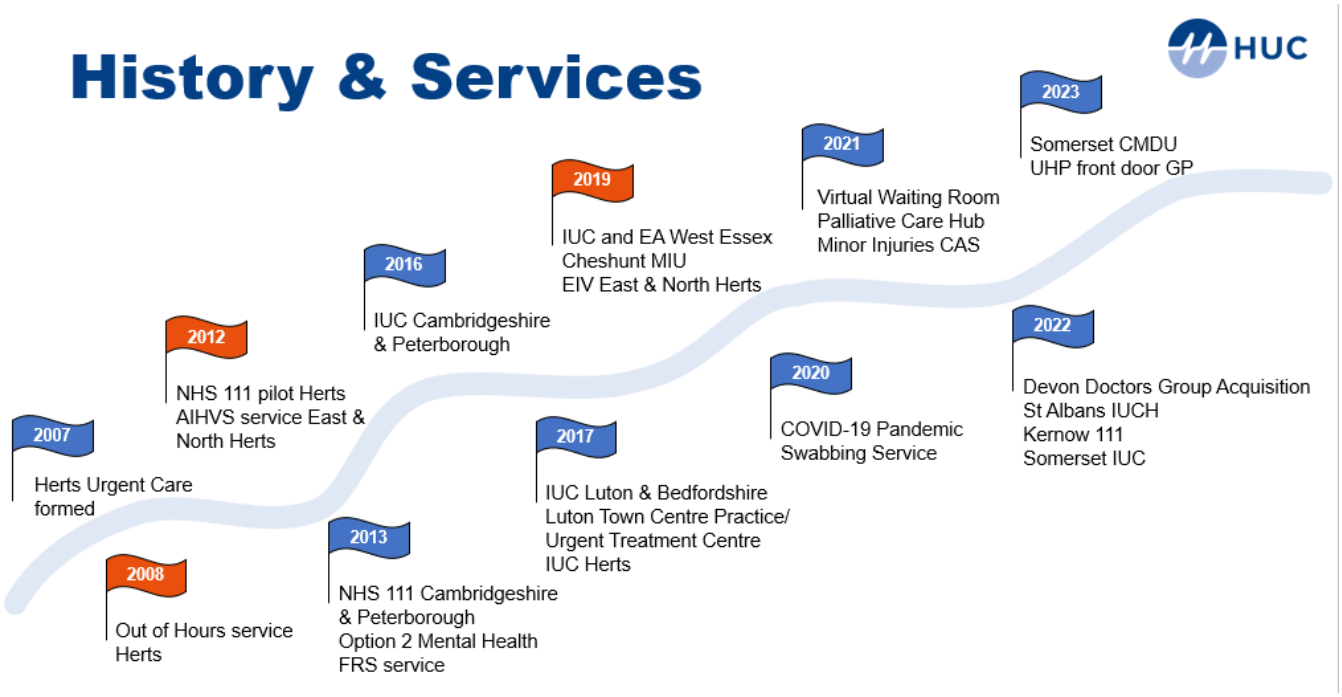
The framework does not apportion blame or seek to determine liability, preventability, or cause of death, rather it is a response conducted for the purpose of learning and improvement.

This plan covers the following response methodologies that will be adopted:

- Patient Safety Incident Investigations (PSIIs)
- After Action Reviews (AARs)
- Patient Safety Audits (PSA)
- Multidisciplinary Team Review (MDTR)
- Timeline Mapping (TM)
- Plan-Do-Study-Act (PDSA) cycles
- Thematic Analysis (TA)
- System Engineering Initiative for Patient Safety (SEIPS)

2. Our services

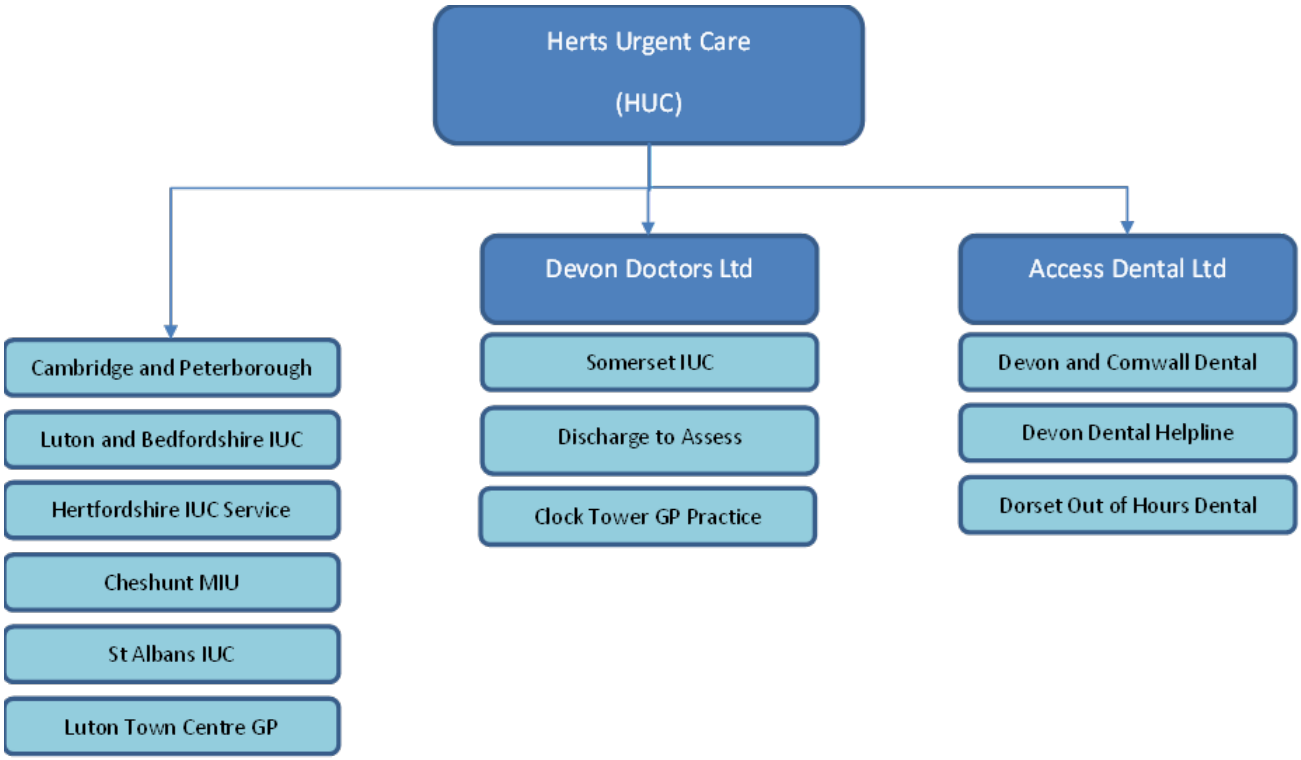
We deliver a range of NHS services, spanning 111, Clinical Assessment (CAS), Out of Hours, Minor Injuries Units, Urgent Treatment Centres, Dental Out of Hours services as well as a variety of different Primary Care Services including General Practice surgeries, an Acute in Hours Visiting service and Early Intervention Vehicles.



Our dedicated team of nearly 1,400 employees and extended workforce of approximately 450 self-employed General Practitioners (GPs) and other clinical professionals, ensures the seamless provision of our services, enabling us to deliver high-quality healthcare services to more than 4.5 million patients across the East and Southwest of England.

Further information about our services can be found on our website: https://hucweb.co.uk/

2.1 Geographical and Service Line breakdown:



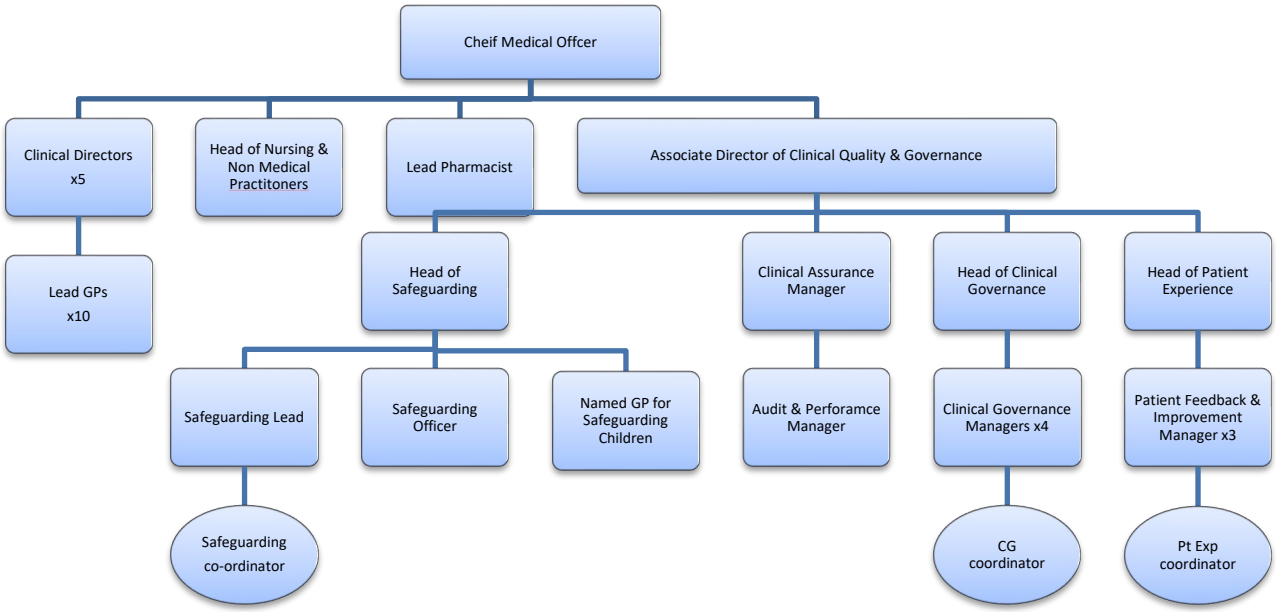
2.2 Governance and Oversight:

We are governed by a Board of Directors with the day-to-day running of the clinical and non-clinical services delegated to Executive Directors and their senior teams. The Board has overall responsibility for the activity, integrity, and strategy across the organisation.

The Chief Executive Officer is supported by the Chief Medical Officer and is responsible for overseeing the management of risks, regulation, and accreditation. From a clinical perspective, all services across the organisation are grouped into portfolios. Each portfolio has a dedicated Clinical Director, Clinical Governance Manager and Patient Feedback and Improvement Manager.

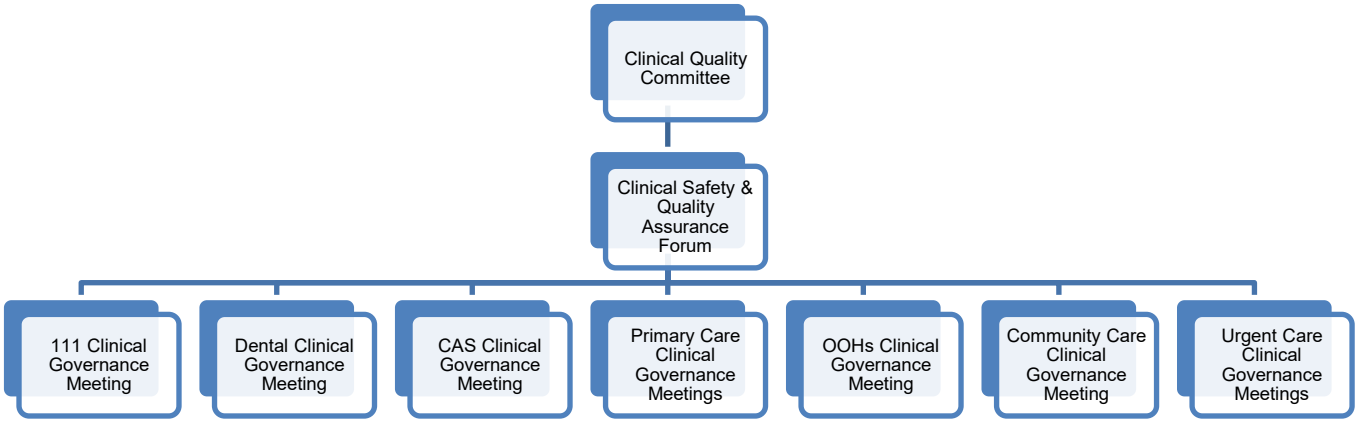
We have embedded safety and governance across the organisation. The Clinical Governance team have a dedicated role within their portfolio for improving, overseeing and co-ordinating governance-related activities to ensure high standards of patient safety.

2.3 Clinical Structures:



2.4 Clinical Governance Reporting Structure:

Our 'floor to board' approach is facilitated through each service line's monthly Clinical Governance meeting, that feeds up into the organisational Clinical Safety and Quality Assurance Forum and then to the Clinical Quality Committee, a sub-committee of the board chaired by a non-executive director, that feeds the Board.



3. Defining our patient safety incident profile

A key part of developing the PSIRF Plan is understanding the key issues that lead to risks for patient safety across the organisation, this is referred to as our Patient Safety Profile.

To explore and better understand our profile, we engaged with a wide variety of internal and external key stakeholders, to include but not limited to:

- Chief Medical Officer
- Associate Director of Clinal Quality and Governance
- Clinical Directors
    - & Lead GPs
- Head of Clinical Governance
    - & Clinical Governance team
- Head of Patient Experience
    - & Patient Experience team
- Head of Safeguarding
    - & Safeguarding team
- Senior leaders across the organisation
- Board
- Commissioners, with Herts and West Essex ICB acting as our lead commissioner
- Patients via feedback mechanisms

The patient safety profile was developed following review and analysis of internal data to strengthen our understanding of potential risk areas, and where improvements to patient safety and experience can be made. We reviewed intelligence collated from, but not limited to:

- Incident and near miss themes and trends
- Serious incident reports
- Complaints & concerns
- Compliments
- Patient feedback through surveys etc
- Safeguarding reviews
- Colleague feedback
- Risk Register
- Audits
- Inquests
- CQC Reports
- Soft markers picked up through ‘Blockers / Challenges’ at
    - Clinical Safety and Quality Assurance Forum
    - Clinical Quality Committee)

We have used this intelligence to develop guidance and local priorities for our plan and PSIIs incidents (detailed in our PSIRF and Incident Management policies).

4. Engaging and involving patients, families, and Colleagues:

In line with the ethos and processes defined within the PSIRF and Incident Management policies we have a compassionate engagement approach towards everyone involved in patient safety incidents.

Patient and their families are contacted, in line with our Duty of Candour (DoC) processes for all patient safety incidents that undergo a full PSII, and where applicable workstreams related to our local focus areas. Links will be offered with the Patient Experience team to ensure they are fully supported, and patient / family focused information leaflets will be shared to explain the process and give single point of access details.

Colleagues involved in PSIIs are offered a debrief as soon as possible; this is facilitated by the local management team, although additional support can be sought from the Clinical Governance team, Quality Improvement team, or Clinical Director as required. Peer support is encouraged, and all colleagues benefit from access to our organisational Employee Assistance Programme (EAP) and free counselling service (via Care First).

5. Defining our patient safety improvement profile:

Over a period of a year (2023) we examined all patient safety data and themes and following analysis of our internal data and soft markers we agreed four priority areas of focus based on the data and opportunity they offer for learning and improvement across the organisation.

Patient Safety Incident	Percentage
Delays in care	11%
Safeguarding	8%
Management of palliative patients	6%
Incomplete documentation	4%

Through our commitment to continual development and maturation of our organisational behaviours and attitude to learning our aim is to reduce risk, increase patient safety by reducing harm, and improve patient experience, all of which is underpinned through our PSIRF and Incident Management policies.

Our local focus areas are:

- **Holistic review of Safeguarding Practices**

Incident data highlighted issues regarding the access to referral portals across the various Local Authorities (LAs) our services cover and the difficulties encountered by colleagues when completing safeguarding referrals. Additional data held by the Safeguarding team highlighted that a high volume / percentage of referrals required further information after the event / referral

was submitted and a significant proportion of referrals are not accepted by the respective LAs. Through partnership working with our ICBs and LAs we recognised potential improvements areas regarding the types, volume and quality of referrals being made.

As the Clinical Directorate has grown and matured over the previous 18 months, we have recognised the opportunity to review the clinical care and service delivery, in addition to safeguarding related care, of cases requested through but not limited to: Child death overview panel, Serious Case Reviews, Domestic Homicide reviews etc for additional scrutiny, learning and safety improvement actions.

- **Care and treatment of palliative care patients in the out of hours period**

This priority area was agreed upon following review of data pulled from our incident and near miss, Health Care Professional, and patient / family feedback themes. In addition, this theme was identified from cases reviewed in the Rapid Review & Decision Meeting (RRDM) that did not reach the Serious Incident (SI) threshold (under the Serious Incident Framework- SIF).

These cases present a significant opportunity for learning and safety actions to improve care, treatment and experience of palliative care patients requiring urgent review in the out of hours period.

- **Maintaining safety in the clinical call-back queues in times of high demand**

Across the organisation incidents and near misses related to delays in clinical calls following initial Health Advisor (HA) assessment after a 111 call is consistently a top reported category. This theme is also present across our patient feedback and complaint data.

Pilot projects and mitigations, to include the use of Comfort Callers during times of high demand to ensure patients do not deteriorate unrecognised in the clinical queues demonstrated effective possible actions in relation to the management of clinical risk associated with delays in care. Internal data also provided proof of concept to the pilot mitigations with the identification and timely management of deteriorating patients and positive comments from patients during pilot workstreams.

This priority area will facilitate enhanced review of possible safety actions and PDSA (Plan, Do, Check, Act) cycles regarding how clinical queues are managed and the level of safety and satisfaction achieved.

- **Quality and documentation standards relating to history of presenting complaint**

Internal data collated from our bespoke clinical consultation audit cycles consistently identified improvement opportunities in relation to the detail documented regarding the history of a patient's presenting complaint, especially in face to face, in-person consultations.

A common learning theme ascertained from our recent Serious Incident Investigations also involved missed opportunities to explore details of a patient's episode of illness in relation to duration, previous medical attention sought and evolution of symptoms. Feedback from speaking with these patients and their families also included aspects of a perceived lack of

coherence between in and out of hours care and across provider boundaries, and the ability to pull together a thorough history.

Our organisational philosophy is that all incidents and near misses offer invaluable learning opportunities and as such, reporting is viewed as a positive action. We nurture an open, transparent, and learning culture focused on continuous improvement. Colleagues are trained, supported, empowered, and encouraged to feel confident to report all incidents and near misses freely in the knowledge that each one has a detailed, proportionate, and thorough investigation (in line with our internal Incident Mapping, detailed in our Incident Management Policy).

Learning will be used to develop safety actions and safety improvement plans; monitoring of these will be presented to the Clinical Safety and Quality Assurance Forum and the Clinical Quality Committee.

Evidence of good practice identified through any PSI response or workstream related to our local areas of focus will be celebrated and shared, in the same way as all learning and safety actions, these include, but are not limited to:

- Individual and team feedback
- Presented under 'Learning Through Excellence' Clinical Governance agenda item
- Highlight escalation to the
    - Clinical Safety and Quality Assurance Forum
    - Clinical Quality Committee
    - Board
- Service Level Learning 'Blog'
- Organisational newsletter
- Considered when developing / amending pathways, standard operating procedures etc.

5.1 Multi-Organisation and Cross-System Learning:

In line with the standards and processes outlined in the organisational PSIRF policy, we are committed to nurturing positive relationships with partner providers and our ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system patient safety incidents.

The Clinical Governance team will lead on and be the liaison point to ensure any incidents or near misses that require cross system or partnership engagement are identified and shared through existing channels and networks, and that partnership colleagues are fully engaged in investigations and learning as required. We will reciprocate and fully engage in a proportionate and meaningful way to cases led externally to HUC.

6. Our PSIRP: National Requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses include mandatory PSIIs.

The guide to responding proportionately to patient safety incidents defines this requirement and sets out whether mandated responses trigger a full PSII. In addition, as guidance develops and is updated, there may be times that a response type is mandated but not yet available in the current national guidance. The Clinical Governance Team will track these and ensure that HUC respond appropriately.

Patient safety events relevant to HUC that are mandated to have a full locally led PSII are Never Events and deaths that are thought, more likely than not, due to problems in care.

Patient safety incident type	**Required response**	**Anticipated improvement route**
Incidents meeting the Never Events criteria	Locally led PSII	Create local organisational safety actions and feed these into the Clinical Safety and Quality Assurance Forum and Clinical Quality Committee
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSIIs.	Locally led PSII	Create local organisational actions and feed these into the Clinical Safety and Quality Assurance Forum and Clinical Quality Committee

For further details of mandated requirements see the NHSE PSIRF supporting guidance, Guide to responding proportionately to patient safety incidents.

7. Our patient safety incident response plan: local focus

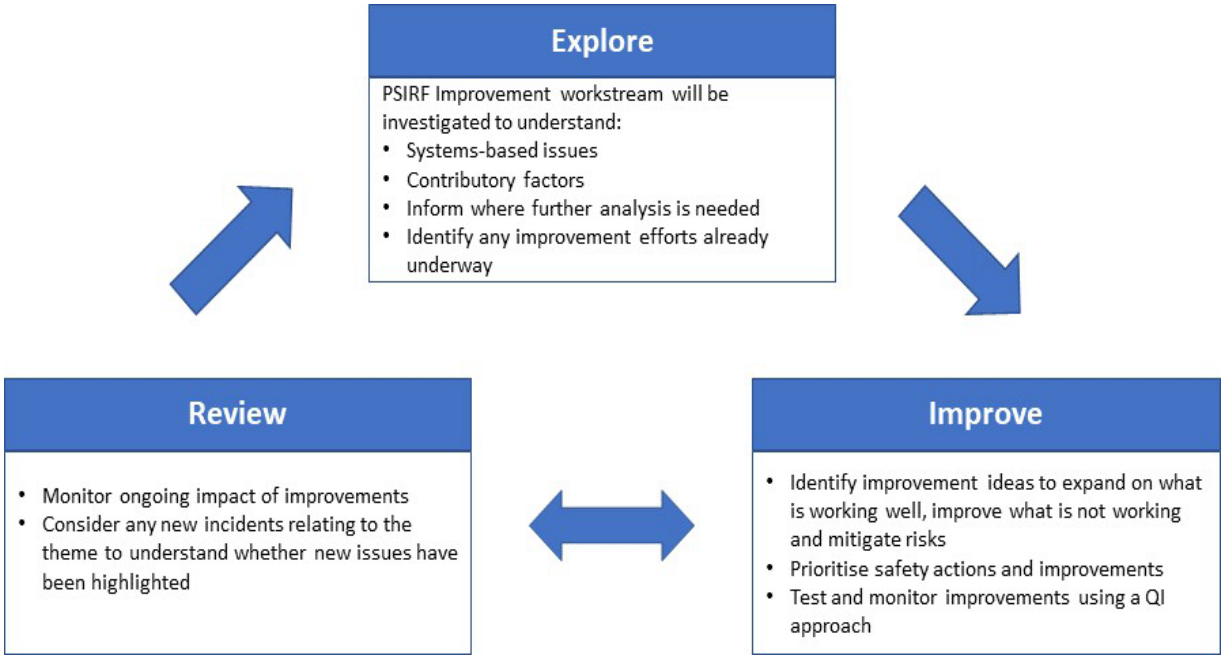
Incidents relating to our four priority areas of focus will be reviewed to understand whether they highlight any new issues that may not have already been identified. By proactively focusing on the four thematic workstreams, resources for investigation are used more efficiently. The newer, varied learning response methods provide robust learning responses with a more effective use of time, allowing a focus on learning and improvement. Identified incidents within the focus areas will still be subject to review at the Rapid Review and Decision Meeting (RRDM) as applicable and will undergo a full PSII if appropriate.

Quality improvement methods will be undertaken to explore the issues in detail and identify any factors contributing to risk in these areas, areas for improvement and recommendations to address these.

Each local focus area will be clinically led by a dedicated Clinical Director and Clinical Governance Manager, supported by relevant internal and external Subject Matter Experts (SMEs) and our Patient Safety Partner(s) (PSPs) as applicable.

Regular updates will be provided to the collective senior clinical directorate, with formal progress monitored through the Clinical Safety and Quality Assurance Forum and the Clinical Quality Committee, a sub-committee of the Board, chaired by a non-executive director, who holds delegated responsibility to share oversight with the Board.

The table below describes the proposed, varied methods we plan on utilising to respond to PSIs relating to the four priority areas and to support the wider improvement workstream



	Patient safety incident type or issue	Planned response(s)	Anticipated improvement
1	Holistic Review of Safeguarding Practices	PSII PSA MDTR AAR TM PDSA SEIPS	Improved safety Improved quality of safeguarding referrals and acceptance rate from LAs Improved relationships with LAs Support to wider system with the reduction of unnecessary referrals and enhanced relationships and information sharing with our healthcare partners across the system Clinical learning and safety actions in addition to the traditional safeguarding learning Reduction in shop floor time / resource completing various safeguarding referral forms / portals, leading to improved colleague moral and safety levels from reduced call answering times
2	Care and Treatment of Palliative Care Patients in the Out of Hours Period	PSII PSA AAR MDTR TA SEIPS	Improved patient journey, clinical safety, pathway, and experience Improved family / carer experience Safe, embedded processes (and associated audits)
3	Maintaining Safety in the Clinical Call-Back Queues in Times of High Demand	PSII PSA AAR MDTR PDSA TM SEIPS	Improved patient safety Improved patient journey, clinical safety, pathway, and experience NHS England Pathways disposition times and breaches manged within defined timescales Clinical management of waiting lists- with prioritisation as clinically indicated During times of extreme activity / pressures- consistent and robust ‘Comfort calling’ processes,

	Patient safety incident type or issue	Planned response(s)	Anticipated improvement
			with associated audits and wider surge and escalation measures
4	Quality and documentation standards relating to history of presenting complaint	PSII TM SEIPS PSA AAR MDTR	Improved patient journey, clinical safety, pathway, and experience Safe, embedded processes (and associated audits)

Where an incident occurs that does not fall into the criteria listed above, we will undertake an initial review (except a PSII) to establish if there is anything new to be learned and/or new issues identified which require further investigation.

Where the organisation has identified specific issues, such as complaints, professional standards investigations, coroners, requests, other types or responses are in place to deal with these as the aims of these responses fall out of scope of this plan. These will be referred to:

- Human Resources and Workforce
  - Professional conduct/competence
- Legal Teams
  - Negligence claims
- Medical Examiners
  - Issues relating to cause of death
- Police
  - Concerns about criminal activity

8. Glossary

After Action Review (AAR)
A structured, facilitated discussion of an event, the outcome of which gives the 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 those involved.

CAS
Clinical Assessment Service

HUC
Herts Urgent Care Ltd

ICB
Integrated Care Board

Multidisciplinary Team Review (MDTR)
The multidisciplinary team review supports health and social care teams to identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.

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 a national level and have been implemented by healthcare providers. The definition of what constitutes a Never Event is determined by NHS England.
2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)

Patient Safety Incident Investigation (PSII)
A PSII is an in-depth review of a single patient safety incident or cluster of events to understand what happened, how, and why. PSIIs are conducted to identify underlying system factors that contributed to an incident and to identify areas for improvement. The organisation then agrees improvement plans to address those system factors and help deliver safer care for our patients effectively and sustainably

PSA
Patient Safety Audit

Patient Safety Incident Response Framework (PSIRF)
This is a national framework applicable to all NHS organisations

Patient Safety Incident Response Framework Policy (PSIRFP)
An organisation's PSIRF Policy should describe its overall approach to responding to and learning from patient safety incidents for improvement and identify the systems and processes in place to integrate the four key aims of PSIRF. It should describe how those affected by a patient safety incident will be engaged, what governance processes for

System Engineering Initiative for Patient Safety (SEIPS)
A framework for understanding outcomes within complex socio-technical systems. SEIPS can be used as a general problem-solving tool (e.g., to guide how we learn and improve following a patient safety incident, to conduct a horizon scan, and to inform system design).

Patient Safety Incident Response Plan (PSIRP)
An organisation's PSIRF Plan should specify the methods it intends to use to maximise learning and improvement and how these will be applied to different patient safety incidents. It should be based on a thorough understanding of the organisation's patient safety incident profile, ongoing improvement priorities, available resources, and the priorities of stakeholders including patients.

Thematic Analysis (TA)
The thematic analysis tool is used to identify patterns that show links or identify issues. Thematic reviews can be used for multiple purposes and can use both qualitative and quantitative data. They are commonly used as a learning response tool to aggregate findings from multiple incidents to identify interlinked contributory factors to inform/direct improvement efforts. It can also be used to identify themes across areas for improvement as well as assessing the impact of safety improvement plans.

Plan-Do-Study-Act (PDSA) cycle
Plan, Do Study Act cycle is a method of evaluation that allows you to test the impact of an initiative and continuously learn from your experiences, whilst improving your approach.

Timeline Mapping (TM)
Timelines linearly document observable actions over time to help make sense of a patient safety incident; they support the narrative and deeper understanding of a patient safety incident and aid the identification of missed opportunities in the delivery of care.