

Patient Safety Incident Response Plan

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# Introduction

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. 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’ and ‘Serious Incidents’. As such it removes the ‘Serious Incidents’ 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 PSIRF fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate. Instead, it advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents. This provides vital insight into how to improve care, ultimately making services safer for patients. The focus is on understanding how incidents happen and the factors which contribute to them.

This Patient Safety Incident Response Plan (PSIRP) sets out how East Coast Community Healthcare (hereafter referred to as ECCH) intends to respond to patient safety incidents over a period of 12 to 18 months. Essential to this will be fostering a patient safety culture in which people feel safe to talk. In doing so, we will support our core ambition of working in partnership with patients to improve safety.

We may not get it all right at the beginning, but we will monitor the impact and effectiveness of implementing PSIRF, we will talk and respond, and adapt as and when our approach is not achieving what we set out to achieve.

This response plan is underpinned by our PSIRF and Incident Reporting policies and 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.

# A systems approach to learning and improvement

PSIRF is a replacement for the NHS Serious Incident Framework. This document is ECCH’s Patient Safety Incident Response Plan (PSIRP). It describes our journey to the ‘go live’ date for PSIRF.

The Serious Incident Framework provided structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF is best considered as a learning and improvement framework with the **emphasis placed on the system and culture that support continuous improvement** in patient safety through how we respond to patient safety incidents.

One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This plan and associate policies and guidelines will describe how it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation.

Carrying out investigations for the right reasons can and does identify learning. Removal of the serious incident process does not mean “do nothing”, it means respond in the right way depending on the type of incidents and associated factors.

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.

PSIRF recognises the need to ensure we have support structures for staff and patients involved in patient safety incidents. Part of which is the fostering of a psychologically safe culture shown in our leaders, our ECCH-wide strategy and our reporting systems.

We have developed our understanding and insights over the past few months, including regular discussions and engagement through our local and national committees and groups. This plan provides the headlines and description of how PSIRF will be apply in ECCH.

There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of systems-based learning and improvement.

There is no remit within this Plan or PSIRF to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, HR matters, legal claims and inquests.

There are four strategic aims of the Patient Safety Incident Response Framework (PSIRF) upon which this Plan is based. The strategic aims align well to our own ECCH vision statements.



The implementation of PSIRF will see both the strategic aims and organisational visions embodied in our work.

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|  | **Compassion** | **Action** | **Respect** | **Everyone** |
| **ECCH Values** | We listen, we learn, we lead | My responsibility, my accountability | Respect our resources, people, time and money | Work together, achieve together |
| **PSIRF Strategic Aims** | Improve the experience for patients, families, carers wherever a patient safety incident of PSII is identified | Improve the safety of the care I provide to my patients | Improve the use of our valuable resources | Improve the working environment for staff in relation to their experiences of patient safety incidents and investigation |

We are reviewing our local system to understand the people who are involved in patient safety activities across ECCH, as well as the systems and mechanisms that support them. We have an established mechanism in place for Freedom to Speak Up within the organisation which supports this plan. ECCH provides health care in Norfolk and Waveney in several fields of expertise. Our commitment is that each patient is treated with respect and dignity and, most importantly of all, as a person.

ECCH is a complex system with many interrelated components that are crucial to ensuring that everything works. We will be reviewing all patient safety activities and our network of key stakeholders across ECCH who are integral to the Patient Safety agenda.

The Quality Team which includes patient safety, experience and clinical effectiveness works alongside Safeguarding, Risk Management, Medicines Management and Research, Audit and Education within the Quality Directorate.

ECCH provides and/or sub-contracts 31 services for the NHS, public health, and social care.

Core patient safety activities to be undertaken at ECCH include:

* NHS Patient Safety Strategy
* A Just Culture
* Patient Safety Incident Response Framework
* Patient Safety Partners involvement
* Risk Management
* Clinically Challenging Behaviours
* Central Alert System (CAS)
* Supporting improvement programmes
* Learning from Deaths
* Complaints and feedback
* Inquest responses.

The operational ‘work-as-done’ for these patient safety activities is predominantly owned by colleagues on the front-line. This will be teamed with expert support from their respective Quality/Governance colleagues who are supported through strategic, educational, and subject matter expert’s.

This emergent system has been built to fit and respond to the size of organisation we are and the nuances of the teams, services, and structures we work in. This involves key people and teams within ECCH who are integral in facilitating our patient safety system and patient safety culture, on our road to implementing PSIRF. For details on ECCH’s PSIRF governance structure please see [Appendix 1](#_Appendix_1_–).

Defining our patient safety incident profile

The patient safety risk process is a collaborative process. To define the ECCH patient safety risks and responses for 2023/24 the following stakeholders were involved.

* Staff – through the incidents reported on the ECCH quality assurance system.
* Senior leaders across the organisation
* Patients – through a review of the thematic contents of complaints and Patient Advice and Liaison Service (PALS) contacts\*
* Commissioners/ICS partner organisations – through partnership working with the ICS/ ICB patient safety and quality leads.

ECCH aims to incorporate wider patient perspective into future Patient Safety Incident Response Plans (PSIRP) through the introduction of Patient Safety Partners (PSPs).

ECCH will appoint PSPs alongside our local ICB and Network Partners.

*More information on the national PSP* *programme can be found on the NHS England website* [https://www.england.nhs.uk/patient-safety/framework-for-involving-patientsin-patient-safety/](https://www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/)

ECCH patient safety risks were identified through the following data sources:

* Analysis of three years’ of Datix incident data 2018-2020
* Detailed thematic analysis of Datix incident data 2021.
* Key themes from complaints/PALS/claims/inquests
* Key themes identified from specialist safety & quality committees (e.g., Harm Free Care)
* Output of stakeholder event discussions
* Themes from the learning from deaths reviews undertaken in 2021.
* Pharmacy review of all medication incidents
* HR Grievance and disciplinaries

Local patient safety risks related to national priorities have been defined as the list of risks covered by national priorities that ECCH anticipates will require a response in the next 12 months. [Table 1](#_Table_1) sets out the full list of national priorities that require a response.

The top local patient safety risks have been defined as the risks identified through the risk stakeholder approach and the data mining described above. These locally identified risks represent opportunities for learning and improvement in the ECCH health system.

[Table 3](#_Table_3) lists the top local patient safety risks.

The criteria ECCH have used for defining the top local patient safety risks is as follows:

* + Potential for harm:
		- **People:** physical, psychological, loss of trust (patients, family, caregivers)
		- **Service delivery:** impact on quality and delivery of healthcare services and impact on capacity. Public confidence including political attention and media coverage.
		- **Likelihood of occurrence**: Persistence of the risk, frequency, and potential to escalate.

# Our Patient Safety Incident Response Plan (PSIRP): national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event.

Incidents meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care i.e., incidents meeting the Learning from Deaths criteria for Patient Safety Incident Investigation (PSII) require a locally led PSII.

[Table 1](#_Table_1) below sets out the local or national mandated responses. As ECCH does not directly provide mental health or custodial services it is more likely that the organisation will be a secondary participant rather than a lead for those incident types (6 to 11).

## Table 1

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|   | **National priority**   | **Response**  |
| 1  | Incidents that meet the criteria set in the Never Events list 2018 | Locally led PSII by ECCH  |
| 2  | Deaths clinically assessed as more likely than not due to problems in care  | Locally led PSII by ECCH |
| 3 | Deaths of persons with learning disabilities  | Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII (or other response) may be required alongside the Panel review  |
| 4  | Safeguarding incidents in which: Babies, child and 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 by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.  | Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards.  |
| 5  | Child deaths | Refer for Child Death Overview Panel review. Locally led PSII (or other response) may be required alongside the Panel review |
| 6  | Incidents in screening programmes  | Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: [Guidance for managing incidents in](https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes?msclkid=3ed7eeecbbe011eca69e287393777fd1) [NHS screening programmes](https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes?msclkid=3ed7eeecbbe011eca69e287393777fd1)  |
| 7  | Deaths in custody (e.g., police custody, in prison, etc.) where health provision is delivered by the NHS  | In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. ECCH must fully support these investigations where required to do so.  |
| 8  | Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)  | Locally led PSII by the provider in which the event occurred with ECCH participation if required  |
| 9  | Mental health related homicides  | Referred to the NHS England and NHS Improvement Regional Independent Investigation Team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead and ECCH participation if required  |
| 10 | Domestic Homicide | A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews. |

# Our Patient Safety Incident Response Plan: (PSIRP) local focus

ECCH patient safety risks were identified through the following data sources:

* Analysis of three years’ of Datix incident data 2018-2020
* Detailed thematic analysis of Datix incident data 2021.
* Key themes from complaints/PALS/claims/inquests
* Key themes identified from specialist safety & quality committees (e.g., Harm Free Care)
* Output of stakeholder event discussions
* Themes from the learning from deaths reviews undertaken in 2021.
* Pharmacy review of all medication incidents
* HR Grievance and disciplinaries
* Incident reporting system as listed in [Table 2](#_Table_2_ECCH).

This provided a long list of 9 incident types, set out in [Table 2](#_Table_2_ECCH)**.** From this long list, a short list of 5 incident types was created, set out in [Table 3](#_Table_3).

## Table 2 - ECCH long list of Patient Safety Incident Types

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|  | **Incident type**  | **Description**  | **Response type**  |
| 1  | Transfer of care  | Potential for patient harm as a result of communication with multiple stakeholders for on-going patient care  | PSII  |
| 2  | Discharge  | ‘Failed discharge’ where it has led to an adverse outcome  | PSII  |
| 3  | Medication  | Mis-selection of wrong medication or dose leading to harm or potential for harm | PSII  |
| 4  | Medication  | Opioids management, Diabetes medicines management, Thromboprophylaxis  | PSA programme  |
| 5 | Pressure ulcers  | Pressure ulcers developed in our care category 2 - 4.  | PSA (Cat 2&3) AAR (Cat 4)  |
| 6  | Clinical care & treatment  | Wound care within community services  | AAR  |
| 7  | Falls  | Falls resulting in a bone fracture or haemorrhage  | Debrief and AAR  |
| 8  | Digital systems  | Emerging risks identified as a result of the use of our digital systems  | PSII  |
| 9  | Unexpected PSII  | Identified increase in incidence of subject of theme which has potential for harm  | PSII  |

All incident categories included in [Table 3](#_Table_3) have relevance for all our inpatient and community services. To this end this is an organisation wide PSIRP and there are not separate PSIRPs plans for individual services.

## Table 3

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|   | **Incident type**  | **Description**  | **Response type** *(for clarity of definitions see* [*Annex 1)*](#_Annex_1_-) |
| 1  | Transfer of care and Discharge’s | Potential for patient harm as a result of communication with multiple stakeholders for on-going patient care. Including ‘Failed discharge’ where it has led to an adverse outcome | PSII  |
| 2  | Medication  | Mis-selection of medication; wrong dose, timing, route or patient leading to harm or potential for harm.Opioids management, Diabetes medicines management, Thromboprophylaxis  | PSII PSA  |
| 3 | Clinical care & treatment  | Pressure ulcers developed in our care category 2 - 3. Category 4 pressure ulcers and harm relating to wound care within community services | PSA AAR  |
| 4 | Unexpected PSII | Identified increase in incidence of subject of theme which has potential for harm  | PSII |
|  5 | Other  | Patient safety incidents which meet criteria for harm or potential harm not included in the subjects above or an identified incidence of patient safety theme |  |

Where an incident does not fall into any of the categories 1 – 5; an investigation and/or review method described in[Annex 1](#_Annex_1_-) may be used by the local team **except** PSII (which should not be undertaken by staff who have not received the specialist training required to undertake PSII).

Local methods such as the national SJR tools and/or structured local proformas may be used. The completion of a narrative response on the QUEST incident module is also appropriate.

ECCH will continue to use existing forums for example Harm Free Care where established review of pressure ulcer incidents is completed.

# Appendix 1 – ECCH’s PSIRF Governance Structure

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# Appendix 2 - PSIRF Roles & Responsibilities

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| **PSIRF Roles** | **Roles in ECCH** | **Responsibilities** |
| PSIRF Executive Lead | Executive Director of Quality  | The PSIRF Executive Lead responsibilities include:1. Ensuring the organisation meets national patient safety incident response standards.
2. Ensuring PSIRF is central to overarching safety governance arrangements.
3. Quality assures learning response outputs.
4. Provide direct leadership, advice, and support in complex/high profile cases, and liaise with external bodies as required
 |
| Patient Safety Specialist | Head of Quality and Patient Safety Specialist | The Patient Safety Specialist will work to ensure all national patient safety incident response standards are implemented within the organisation and ensure that patient safety is appropriately prioritised and considered across the organisations.  |
| Patient Safety Partner (PSP) | PSPs can be patients, carers, family members or other lay people (including staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team. | The Patient Safety Partner (PSP) will offer support alongside staff, patients, families/carers to influence and improve safety across our range of services. The main purpose of the role is to be a voice for the patients and community who utilise our services and ensure that patient safety is at the forefront of all that we do. |
| Patient Safety Investigator’s | Staff who have undergone training meeting the national specification for ‘Lot 4a’ A Systems Approach to Learning from Patient Safety Incidents | Patient Safety Investigator’s will undertake Patient Safety Incident Investigations (PSII).  |

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# Appendix 3 - ECCH PSIRF Training Requirements

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| **PSIRF Training**  | **Required to Complete** |
| 000 Patient Safety Level 1 - Essentials for all staff (every 3 years) | All Staff – Mandatory Training  |
| 000 Patient Safety Level 1 - Essentials for Boards and senior leadership teams | Board and Senior Leadership Team |
| 000 Patient Safety Level 2 - Access to Practice | Senior Quality Team Leads & Operational Manager’s |
| A Systems Approach to Learning from Patient Safety Incidents | Staff who undertake investigations  |
| Oversight of learning from patient safety incidents | Deputy Director Of Quality |
| Involving those affected by patient safety incidents in the learning process | Patient Safety Specialist |
| Just and Restorative Learning Culture | HR, Operational and Quality Team Representatives |

# Annex 1 - Glossary

**PSII** - Patient Safety Incident Investigation

PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

**PSIRP** - Patient Safety Incident Response plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

**PSIRF** - Patient Safety Incident Response Framework

Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

**AAR** – After Action Review

A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

**PSA** – Patient Safety Audit

A review of a series of cases (of the same incident type) using clinical audit methodology to identify where there is an opportunity to improve and more consistently achieve the required standards (e.g. in a policy or guideline).

**SJR** - Structured Judgement Review

Developed by the Royal College of Physicians as part of the National quality board national guidance on learning from deaths; the SJR blends traditional, clinical judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.

[nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)](https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf)

**Never Event**

Patient safety incidents that are considered 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. <https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf>

**Deaths thought more likely than not due to problems in care**

Incidents that meet the ‘Learning from Deaths’ criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient’s care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery. [nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)](https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf)

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