PATIENT SAFETY INCIDENT RESPONSE PLAN

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INTRODUCTION

The Patient Safety Incident Response Framework (PSIRF) sets out a new approach in the way that the NHS responds to patient safety incidents to increase the effectiveness of the learning we gather and improve patient safety in all of our services.

A PSIRP is a requirement of each provider, group or network of providers delivering NHS funded care. The Patient Safety Incident Response Framework (PSIRF) 2020 sets out the requirement for this plan to be developed.

PSIRF focuses on the learning culture. Historically organisations were required to investigate incidents if they met a certain outcome threshold. The PSIRF advocates a co-ordinated and data driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents. It also embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

PSIRF supports the development and management of an effective safety incident response system that integrates four aims:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.

This Patient Safety Incident Response Plan (PSIRP) sets out how Cumbria Medical Services intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. This plan should be read in conjunction with CMS' Patient Safety Incident Response Policy.

OUR SERVICES

Cumbria Medical Services (CMS) provides NHS specialist services in community dermatology, minor surgery and ophthalmology from various locations throughout Cumbria utilising facilities in community hospitals and GP surgeries detailed below:

- Cockermouth Community Hospital
- Carlisle Healthcare South
- Victoria Cottage Hospital, Maryport
- Mary Hewetson Hospital, Keswick
- Workington Community Hospital

CMS is committed to the principles of the NHS. We are a GPs with Extended Roles (GPwER) which has been developed over many years in order to provide specialist services in the community without the need to go to a hospital setting. Patient experience is paramount. We are committed to the highest quality of healthcare and will always strive to do what is in the patient's best interests. We will listen to and try our best to meet your expectations.

DEFINING OUR PATIENT SAFETY INCIDENT PROFILE

In order to identify CMS' patient safety incident profile, data from the following sources has been reviewed:

- Individual safety events
- Serious incident reports
- Near miss reports
- Complaints
- Risk assessments
- Feedback from patients
- Staff survey results
- Safeguarding
- Quality Assurance reports
- Freedom to Speak Up
- Legal
- National or local audit
- National Patient Safety Improvement Programmes

Consideration was also given to the improvement work currently being undertaken within the services.

The PSIRF response to patient safety incidents focuses on proportionality and improvement, whereby incidents types/events are allocated either:

1. 'Learning to inform improvement' response
2. An 'improvement based on learning' response
3. 'For assessment' to determine the required response

The emphasis is on ongoing improvement work rather than repeat learning responses.

OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: NATIONAL REQUIREMENTS

Some incidents in healthcare require a specific response as set out in national policies or regulations. Incidents meeting the Never Events criteria and deaths thought more likely than not due to problems in care required a locally led PSII. Any incidents requiring a PSII will be reported to the Integrated Care Board.

A patient safety incident investigation (PSII) is undertaken when an incident or near miss indicates significant patient safety risks and potential for new learning. This may include a review by or a referral to another body or team depending on the nature of the event.

Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can.

The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

Patient Safety Incident Type	Required response	Anticipated Improvement Route
Incidents meeting the Never Events criteria (2018)	Locally led PSII	
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	Locally led PSII	
Child Deaths	Refer to Child Death Overview Panel. Locally led PSII may be required alongside panel review.	
Deaths of persons with Learning Disabilities/Autism	Refer for Learning Disability Mortality Review (LeDeR) Locally led PSII (or other LR) may be required alongside the panel review.	
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.	Refer to local authority safeguarding lead. Contribute to independent inquiries and reviews as required do so by local safeguarding partnership for children and local safeguarding adult board.	

• The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.		

OUR PATIENT SAFETY INCIDENT RESPONSE PLAN: LOCAL FOCUS

CMS has identified the following as its local priority:

Local Priority	**Required response**
Infection Control	Locally led PSII
Documentation - Documentation error leading to harm or the potential for harm.	Locally led PSII

Patients or family members/carers will be given a named key contact to help them through the process and assist in accessing any support needed.

The person will be able to share their experiences early on in the process with the named individual who will actively listen to what happened.

Families and carers will be able to contribute to the investigation process and will receive regular, personalised updates.

CMS will remain flexible and consider each patient safety incident considering the specific circumstances in which it occurred and the needs of those affected.

The governance arrangements for reviewing patient safety incidents at CMS will remain unchanged, with investigation reports being reviewed by the Directors at the Practice Meetings.

CMS will investigate when:

- The incident meets national thresholds detailed above.
- The incident is linked to one of CMS' patient safety priorities.
- The incident is an emergent area of concerns

APPENDIX 1 – GLOSSARY OF TERMS

PSIRF - Patient Safety Incident Response Framework

This is a national framework applicable to all NHS commissioned outside of primary care. 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.

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 co-production approach with the divisions and specialist risk leads supported by analysis of local data.

PSII – Patient Safety Incident Investigation

PSIIs are conducted to identifying 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.

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. The benefit of this is to enable learning together and to balance effort between learning and responding to incidents or exploring issues and improvement work.

AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event an 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 both 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 event?
- What is the learning?

Thematic Review

A thematic review may be useful for understanding common links, themes or issues within a cluster of investigations, incidents or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety. The ‘top tips’ document provides guidance on how to approach a thematic review.

Never Event

Patient safety incidents that are considered to be wholly preventable, where guidance or safety recommendations that provide strong systematic protective barriers are available at a national level and have been implemented by healthcare providers.

Deaths thought more likely than not due to problems in care

Incidents that meet the 'learning from deaths' criteria. Deaths clinically assessed a 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 plan or following reported concerns about care or service delivery.

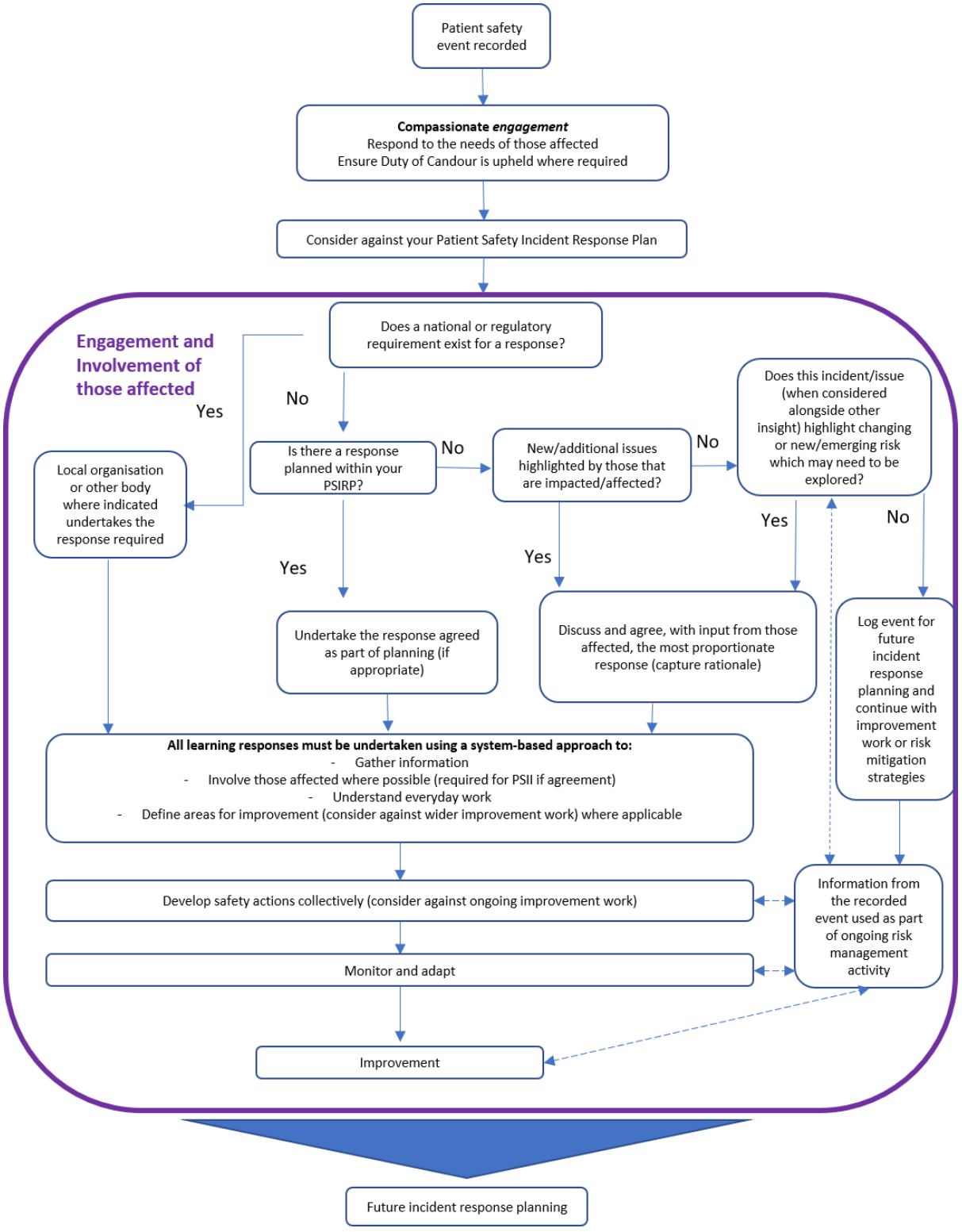
SEIPS – Systems Engineering Initiative for Patient Safety

Systems Engineering Initiative for Patient Safety (SEIPS) helps investigators to consider the full range of contributory factors across a system and to identify important findings. Considering the hierarchy of controls, recommendations should be targeted at system changes which are more likely to prouce sustain safety improvements, rather than at individual behaviours or training, which are less likely to influence future safety. System-based safety investigaitons can positively influence safety culture in organisations.

Safety Improvement Plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues, for example, reviewing output from learning responses undertaken in relation to single incidents collectively when it is felt that there is sufficient understanding of the underlying, interlinked system issues.

Safety Actions

Developing safety actions that respond to underlying system issues starts with identifying and understanding aspects of the work system that need to change to reduce risk and potential for harm (i.e. areas for improvement or system issues). Actions to reduce risk (i.e. safety actions) are then generated in relation to each defined area for improvement. Organisations should seek to reduce duplicative and/or disconnected safety actions, for example, by maintaining a wider safety action log that is referred to when developing safety actions and/or conducting regular reviews of ongoing safety actions as part of patient safety incident response planning.

APPENDIX 2 – INCIDENT RESPONSE DECISION FLOWCHART