Patient safety incident response plan (*gtd healthcare*)

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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.

This patient safety incident response plan sets out how *gtd healthcare* 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.

The patient safety incident response plan is underpinned by the patient safety incident response policy. The patient safety incident response policy describes our overall approach to responding to and learning from patient safety incidents. The policy outlines how those affected by a patient safety incident are engaged, what governance processes for oversight are in place and how learning responses are translated into improvement and integrated into wider improvement work across the organisation.

Our services

gtd healthcare is a not-for-profit healthcare service provider. We are often the first contact a person has with the healthcare system when they have a health problem or issue that is not an emergency. This includes both remote and face-to-face clinical triage, and urgent and scheduled care services across parts of Greater Manchester, Cheshire, Merseyside, Lancashire and Derbyshire. *gtd healthcare* provides and manages a variety of services including but not exclusively:

- Primary care.
- Out-of-hours.
- Urgent care centres.

This plan is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all *gtd healthcare* services.

Defining our patient safety incident profile

A key aim of the PSIRF is to undertake considered and proportionate responses to patient safety incidents.

An understanding of the local patient safety profile and ongoing improvement work is required to enable proportionate responses that balance learning and improvement.

As part of *gtd healthcare's* PSIRF planning process, the governance team undertook a detailed analysis of data from the previous three years including:

- Patient Safety Incident Investigation reports.
- Patient safety incidents.
- Safeguarding incidents.
- Complaints.
- Patient surveys.
- Staff surveys.
- Freedom to speak up enquiries.
- Requests for information.

The review involved a quantitative analysis of the numbers reported e.g., by type/category and a qualitative analysis of the themes identified (including any improvement work undertaken or underway).

The data was discussed at *gtd healthcare's* Patient Safety Incident Response Framework Implementation Group (PSIRFIG) to collate the themes across the organisation.

As part of *gtd healthcare's* stakeholder engagement, two staff surveys were created to help identify:

- Staff opinion on current incident management processes (including staff that have been involved in an incident and staff who have investigated incidents); and,
- Where staff feel *gtd healthcare's* largest opportunity for learning and improvement is.

Following the detailed quantitative and qualitative analysis of our data, staff were provided with the opportunity to comment on the patient safety priorities identified.

Patient surveys were a key source of data during the curation and understanding of *gtd healthcare's* patient safety priorities. In addition, the head of risk and safety attended

Patient Participation Groups to discuss patient safety priorities for *gtd healthcare* patients. The engagement was useful to help understand patient safety issues from a patient and service user point of view.

As a result, *gtd healthcare* has identified four key themes that form our patient safety profile:

1. Processing of letters and information at GP practices including referrals, blood, and other test results.
2. Recording of clinical documentation following treatment and review of patients.
3. Triage and transfer of patients into and out of the urgent care centres resulting in patients not being seen/treated by the most appropriate services.
4. Missed opportunities to make safeguarding referrals for high-risk individuals.

Developing a patient safety profile has enabled *gtd healthcare* to identify key patient safety risks that it will address through the patient safety incident response plan.

gtd healthcare is an organisation that is continually growing and evolving across primary care, urgent care, and a wide range of out-of-hours services. *gtd healthcare's* Patient Safety Incident Response Plan is designed to cover all *gtd healthcare* services.

Defining our patient safety improvement profile

The detailed quantitative and qualitative analysis of our data included reviewing local improvement work underway to address the patient safety priorities identified.

Processing of letters and information at GP practices including referrals, blood, and other test results

At our GP practices, the incorrect processing of letters and information can lead to several outcomes (failed referrals, missed test results, etc). The incoming correspondence is either not being processed promptly or the information is being filed without taking the necessary action.

Initial improvement work is underway to address the issues that have been highlighted through incident investigations. The operational and clinical teams are working together to explore the creation of processes that can be shared and adopted by all *gtd healthcare* GP practices to improve standardisation. *gtd healthcare* is also exploring the feasibility of

creating a central administrative team that will be able to perform administrative duties for all *gtd healthcare* GP practices, this is currently being piloted at two GP practices.

Investigating incidents relating to the processing of letters and information at GP practices will enhance our understanding of the underlying issues with the systems in place and put the organisation in a position to address them.

Recording of clinical documentation following treatment and review of patients

Incidents relating to the standard of clinical documentation following treatment and review of patients is a theme that has been identified across all types of incidents and all *gtd healthcare* services.

The analysis has highlighted that although the standard of clinical documentation might not be the primary cause of patient safety incidents, it is a theme that is present in most patient safety incidents.

The standard of documentation across all *gtd healthcare* services was discussed at *gtd healthcare's* learning and development forum. The learning and development forum discusses and agrees on learning priorities for *gtd healthcare*. The director of nursing and allied health professionals with the medical director for *gtd healthcare* is overseeing a project that is being co-ordinated by the *gtd* academy Manager, which will standardise a learning package that will be shared across *gtd healthcare* services.

The medical lead at Preston and Chorley is providing support and guidance to staff at the Preston and Chorley urgent care centres regarding clinical documentation.

Investigating incidents relating to the recording of clinical documentation following treatment and review of patients will be useful to understand:

- If we are giving more thorough care than the documentation suggests.
  OR
- Whether the documentation in fact reflects the standard of care delivered.

Triage and transfer of patients in the urgent care centres resulting in patients not being seen/treated by the most appropriate services

This theme relates to the division of patients between the *gtd healthcare* urgent care centres and the Lancashire Teaching Hospitals NHS Foundation Trust emergency department at Royal Preston Hospital and Chorley and South Ribble Hospital.

Disagreements regarding the most appropriate service for patients can result in delays in delivering treatment. The reasons appear to be multifactorial including the wrong outcome from triage, possible lack of understanding of the role and skills and the lack of a 24/7 emergency department in Chorley and South Ribble Hospital.

A joint governance meeting between *gtd healthcare* and Lancashire Teaching Hospitals NHS Foundation Trust takes place quarterly to discuss incident themes. A wider joint review of processes is taking place to address the issues relating to the triage and transfer of patients.

Investigating incidents that relate to the triage and transfer of patients in the urgent care centres will aim to improve the quality of care a patient receives when they present to Royal Preston Hospital and Chorley and South Ribble Hospital. Learning from incidents will enable processes to continually improve and increase patient safety.

Missed opportunities to make safeguarding referrals for high-risk individuals

gtd healthcare reports a high volume of safeguarding incidents across all services, this reflects our open culture regarding safeguarding reporting. *gtd healthcare* has an operational safeguarding manager who reviews all incidents reported and participates in wider safeguarding reviews with other organisations.

A rolling programme of safeguarding training sessions has been organised by the heads of nursing and allied health professionals and the operational safeguarding manager for *gtd healthcare* staff members.

From the analysis of our data, a key theme was potential missed opportunities to make safeguarding referrals for high-risk individuals. Investigating these types of incidents will enable the organisation to gain a deeper understanding of the reasons why opportunities are missed and will enable system improvements to address any gaps identified.

National patient safety priorities and improvement work

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

gtd healthcare commits to completing a Patient Safety Incident Investigation for national priorities.

Our patient safety incident response plan: National requirements

The table below outlines the patient safety incident types that must be responded to according to national requirements with the expected local response from *gtd healthcare*.

Patient safety incident type	**Required response**	**Anticipated improvement route**
Deaths are thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for Patient Safety Incident Investigation).	Locally led Patient Safety Incident Investigation.[1]	Create local organisational actions and feed these into the *gtd healthcare* safety improvement plan.
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 Patient Safety Incident Investigation.	Create local organisational actions and feed these into the *gtd healthcare* safety improvement plan.
Incidents meeting the Never Events criteria 2018, or its replacement.	Locally led Patient Safety Incident Investigation.	Create local organisational actions and feed these into *gtd healthcare's* safety improvement plan.
Mental health-related homicides.	Referred to the NHS England Regional Independent Investigation Team (RIIT) for	Create local organisational actions and feed these into

[1] PSIIs are in-depth reviews of a single patient safety incident or a cluster of incidents to understand what happened and how

	consideration for an independent Patient Safety Incident Investigation. Locally led Patient Safety Incident Investigation may be required.	*gtd healthcare's* safety improvement plan.
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch criteria or Special Healthcare Authority criteria when in place	Refer to the Healthcare Safety Investigation Branch or Special Healthcare Authority for independent Patient Safety Incident Investigation.	Create local organisational actions and feed these into *gtd healthcare's* safety improvement plan.
Child deaths.	Refer to the Child Death Overview Panel review Locally-led Patient Safety Incident Investigation (or other response) may be required alongside the panel review – *gtd healthcare* should liaise with the panel.	Create local organisational actions and feed these into *gtd healthcare's* safety improvement plan.
Deaths of persons with learning disabilities.	Refer to Learning Disability Mortality Review Locally led Patient Safety Incident Investigation (or other response) may be required alongside the Learning Disability Mortality Review.	Create local organisational actions and feed these into *gtd healthcare's* safety improvement plan.
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.	Refer to the local authority safeguarding lead. *gtd healthcare* must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic	Create local organisational actions and feed these into *gtd healthcare's* safety improvement plan.

• Adults (over 18 years old) receive 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.	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.	
Incidents in NHS screening programmes.	Refer to local screening quality assurance service for consideration of locally-led learning response.	Create local organisational actions and feed these into *gtd healthcare's* safety improvement plan.
Deaths in custody (e.g., police custody, in prison, etc) where health provision is delivered by the NHS.	Any death in prison or police custody will be referred (by *gtd healthcare*) to the Prison and Probation Ombudsman or the Independent Office for Police Conduct to carry out the relevant investigations.	Create local organisational actions and feed these into *gtd healthcare's* safety improvement plan.
Domestic homicide.	A domestic homicide is identified by the police usually in partnership with the community safety partnership with whom the overall responsibility lies for establishing a review of the case.	Create local organisational actions and feed these into *gtd healthcare's* safety improvement plan.

Our patient safety incident response plan: Local focus

The table below outlines the patient safety incident types that will be responded to with the expected local response from *gtd healthcare*.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Processing of letters and information at GP practices including referrals, blood, and other test results.	After Action Review (AAR)[2].	Risks identified will be added to the risk register and supported with subsequent actions to mitigate. Share learning through monthly Clinical Hot Topics bulletin with discussion at relevant committees / leadership meetings. Investigations that identify organisation-wide improvement actions will be added to *gtd healthcare's* safety improvement plan.
Incidents that relate to the standards of clinical documentation following treatment and review of patients.	AAR	Risks identified will be added to the risk register and supported with subsequent actions to mitigate. Share learning through monthly Clinical Hot Topics bulletin with discussion at relevant committees / leadership meetings. Investigations that identify organisation-wide

[2] The AAR investigation tool is a structured facilitated discussion of an event, the outcome of which gives individuals an understanding of why the outcome differed from that expected and will help identify the learning to assist improvement.

		improvement actions will be added to *gtd healthcare's* safety improvement plan.
Triage and transfer of patients into and out of the urgent care centres resulting in patients not being seen/treated by the most appropriate services.	AAR	Risks identified will be added to the risk register and supported with subsequent actions to mitigate. Share learning through monthly Clinical Hot Topics bulletin with discussion at relevant committees / leadership meetings. Investigations that identify organisation-wide improvement actions will be added to *gtd healthcare's* safety improvement plan.
Missed opportunities to make safeguarding referrals for high-risk individuals.	AAR	Risks identified will be added to the risk register and supported with subsequent actions to mitigate. Share learning through monthly Clinical Hot Topics bulletin with discussion at relevant committees / leadership meetings. Investigations that identify organisation-wide improvement actions will be added to *gtd healthcare's* safety improvement plan.
Incidents that result in moderate or severe harm to patients[3] .	AAR	Risks identified will be added to the risk register and supported with

[3] Based on national physical and psychological harm guidance

		subsequent actions to mitigate. Share learning through monthly Clinical Hot Topics bulletin with discussion at relevant committees / leadership meetings. Investigations that identify organisation-wide improvement actions will be added to *gtd healthcare's* safety improvement plan.

Where a safety issue or incident type is well understood (e.g., because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation.

If *gtd healthcare* cannot easily identify where an incident fits the patient safety incident response plan (i.e., whether a learning response is required), we will perform an assessment to determine whether any problems in care require further exploration and potential action.

Appendix one – definitions

Duty of candour

The duty of candour is a critical element of our healthcare system to ensure openness and transparency with patients, families and relevant persons. There is a statutory duty of candour and a professional duty of candour. Both types ensure patients, families and relevant persons are aware when something goes wrong with their treatment or care, or has the potential to cause, harm or distress.

Health inequalities

Health inequalities are unfair and avoidable differences in health across the population and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

Just culture

In a just culture investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However, a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts.

Near miss

A near miss is any incident identified above which has not given rise to actual personal injury, ill-health, harm/major harm, loss, damage or death, but which has the potential to do so.

Patient safety incident

Any unintended or unexpected event (including near misses) which could have, or did, lead to harm for one or more patients receiving healthcare.

Risk

The effect of uncertainty on objectives.

Safety actions

The process starts by identifying and agreeing on those aspects of the work system where

change could reduce risk and potential for harm. Safety actions are then generated about each defined area for improvement. Following these measures to monitor safety actions and the review steps are defined.

Those affected

Those affected include staff and families in the broadest sense; that is: the person or patient (the individual) to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred.

Appendix two – related documents and policies

- Being Open Policy.
- Complaints Policy and Procedure.
- Engaging and Involving Those Affected by Patient Safety Incidents Policy (Including Duty of Candour Procedure).
- *gtd healthcare's* Patient Safety Incident Response Policy.
- Incident Reporting and Management Policy and Procedure.
- Risk Management Policy and Procedure.
- Whistleblowing procedure.

Appendix three – references

- A just culture guide.
- Engaging and involving patients, families and staff following a patient safety incident guidance.
- Framework for involving patients in patient safety.
- Oversight roles and responsibilities specification.