Patient safety incident response plan

Effective date: September 2023

Estimated refresh date: September 2025

	NAME	TITLE	DATE
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Reviewer	**Clinical Assurance Group**		**5 July 2023**
Authoriser	**Quality Committee**		**16 September 2023**

Foreword

The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them. “

Aidan Fowler, National Director of Patient Safety, NHS England

PSIRF is a different and exciting approach to how we respond to patient safety incidents. This is not a change which involves us doing the same thing but calling it something different but a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again. Our challenge is to shift the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and towards an emphasis on the outcomes of patient safety incident responses that support learning and improvement to prevent recurrence.

Where previously, we have had set timescales and external organisations to approve what we do – PSIRF gives us a set of principles that we will work to and although this could seem scary, we welcome the opportunity to take accountability for the management of our learning responses to patient safety incidents with the aim of learning and improvement. We know that we investigate incidents to learn but we acknowledge that we have been distracted by the previous emphasis on the production of a report, as that is how we have been measured, rather than on showing how we have made meaningful changes to what we do to keep our patients safe.

We need to engage meaningfully with our patients, families, and carers to ensure that their voice is the golden thread in any of our patient safety investigations. PSIRF sets out best principles for this engagement and our move to appointing patient safety partners will ensure that the patient voice is involved at all stages of our patient safety processes.

Our recent work in moving towards a restorative and just culture underpins how we will approach our incident responses. We have fostered a culture in which people feel they can highlight incidents knowing they will be psychologically safe. PSIRF asks that we have conversations where people have been affected by a patient safety incident, no matter how difficult that is, and we will continue work to how we can equip and support those affected to best hear the voice of those involved. The process of reviewing an incident can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure these are part of our PSIRF core objectives.

As we move into adopting this new way of managing our patient safety learning reviews, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to. In this we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change. Most importantly though, PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our patients, their families and carers whilst also protecting the well-being of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead.

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Introduction

This patient safety incident response plan sets out how Wirral Community Health and Care Foundation Trust intends to respond to patient safety incidents over a period of 12-18 months. The plan is not a permanent rule that cannot be changed, we will continue to monitor all incidents for themes, trends and when necessary, these will be escalated to the Clinical Risk Management Group where decisions will be made for appropriate steps to undertake to maximise patient safety. This will enable us to remain flexible in our approach 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 Trust 'Incident Management policy GP08' available to all staff via Staff Zone. WCHC is developing a PSIRF policy in 2023, this incident management policy will be updated and aligned to avoid duplication but to provide further clarity for staff on pathways for escalation, methods of review, safety action development, safety improvement plans and monitoring improvement.

A glossary of terms used can be found at Appendix A

Our services

Our expert teams provide a diverse range of community health care services, seeing and treating people right through their lives both at home and close to home, ensuring essential care continues to be delivered, and preventing a visit to hospital.

We employ over 1,500 members of staff, nearly 90% of whom are directly supporting our patients. Our services are local and community-based, provided from over 50 sites across Wirral, including our main clinical bases, St Catherine's Health Centre in Birkenhead, and Victoria Central Health Centre in Wallasey.

We also provide the Community Integrated Care Centre on the Clatterbridge site providing 71 beds across 3 wards offering reablement care and support to the local community.

We provide integrated 0-19 services in Cheshire East comprising health visiting, school nursing, family nurse partnership and breastfeeding support services from a number of bases including medical centres and children's centres. In September 2021 we started delivering the 0-19 health and wellbeing service in St Helens and in February 2022 we launched a new 0-25 service in Knowsley. It is important to note that due to changes within the commissioned contract for social care from July 2023, we have excluded them from this profile and data sets,

although we will continue with our strong working relationship to provide the safest and high-quality care working cross organisationally.

We have over 1500 members of staff, and nearly 90% of which are patient facing.

We have seven operational localities:

Birkenhead Locality

South Wirral Locality

West Wirral Locality

Wallasey Locality

Wirral System 1

Wirral System 2

Wirral and Regional System

This structure will help us to sustain and grow our services in line with our strategic and transformation plans. It will also allow us to respond to local and national priorities including Patient Safety Incident Response Framework. We will also align our work with key trust strategies such as

- Organisational Strategy
- Quality Strategy
- Inclusion and Health Inequalities Strategy
- The People Strategy
- Digital Strategy

This will enable us to embed the Patient Safety Incident Response Framework by utilising all these resources to further embed a psychological safe culture for our staff and working in partnership with Patients and Families

Defining our patient safety incident profile

Defining our patient safety profile at Wirral Community Health and Care Foundation Trust we reviewed the following data sets taking into consideration the national profile of applicable areas for the trust.

The Trust incident reporting platform Datix system including date ranges reported by all staff employed at the trust 2020-2021, 2021-2022, 2022-2023, this enabled us to identify the top ten incidents reported by the trust, further analysis enables themes and trends to be reviewed. Due to the pandemic and the impact following on from this, we believe the 2022-2023 data provides a more accurate picture for the next few years. Furthermore, due to changes within our profile for newly commissioned services, expansion of existing services and also changes relating the ceasing of the social care contract so further analysis was applied to this date range.

The following other data sets were reviewed for themes and trends alongside our top 10 incidents

StEIS reportable incidents including, never events
Mortality reviews
Staff Surveys
Staff suspensions
Patient Safety reports
72-hour reviews- key themes identified in our Quality Improvement Plans
Claims and complaints data
Safeguarding data
Freedom to speak up

These key areas where triangulated to understand common themes in line with the patient safety strategy 2019 and Patient Safety Incident Response Framework 2022
Internal key stakeholders were involved with the process including, Patient Safety Specialists, Patient Safety Partners, Patient Safety Manager, Quality improvement lead. The reports and findings were initial shared with the key stakeholders for comment. The Clinical Assurance Group also reviewed the key themes identified within the presentation, the plan and policy for approval.

The second part of the sign off process is to seek committee's approval prior to the Patient Safety Incident Plan being agreed and signed off by the ICB
Defining our patient safety incident profile. The patient safety risk process is a collaborative process. To define the WCHC patient safety risks and responses for 2022/23 the following stakeholders were involved.

- Staff – through the incidents reported on the WCHC Datix incident system
- Senior leaders across the divisions Via, CAG and PSIRF stake holder group
- Patient groups – through a review of the thematic contents of complaints and Concerns
- Analysis of three years' of Datix incident data 2020-2023
- Detailed thematic analysis of Datix incident data 2022-2023
  Key themes from other data sets as mentioned above
- Themes from the Learning from deaths reviews were undertaken, but it was noted as learning for the trust and not the cause of death 2020-2023
- Themes and trends have been reviewed from complaints/concerns and claims these have been cross referenced to incidents
- Themes from steis reported incidents where cross referenced with themes of incidents of all incidents reported

- HR are leading on the work stream for culture and psychological safety and have reviewed themes and trends from staff survey, reports from freedom to speak up and other processes related to staff conduct. These have been cross referenced and will flow through the People Plan

- Safeguarding S42 reports have been reviewed from 2022-2023 whilst there has been a theme around falls, further analysis will occur over the following year

- 72-hour reviews and SI reports are reviewed for themes and trends and feed into the Quality improvement driver diagrams for our key organisational risks

- incidents Local patient safety risks related to national priorities have been defined as the list of risks covered by national priorities that WCHC anticipates will require a response in the next 12-18 months.

- The top local patient safety risks have been defined as the list of risks identified through the risk stakeholder approach and the data analysis described above. These local identified risks represent opportunities for learning and improvement in the WCHC health system.

Table 2 lists these top local patient safety risks. Potential for harm for patients these have been triangulated with other data sets named above to better understand the level of risk.The criteria WCHC have used for defining the top local patient safety risks is as follows

Category	Descriptor
Pressure Ulcer	All pressure ulcers that have occurred under the trusts care
Slips, trips, falls and collisions	All patients Slips trips falls that have occurred whilst under our care
Delayed delivery of care	All incidents that included where care had been delayed
Communication	All communication incidents including with patient and staff
Moisture Lesion	All Moisture lesions that have occurred whilst under trust care
Medication: Administration or supply of a medicine from a clinical area	All incidents across the elements of the medication process
Information Governance non treatment related	All incidents of breach of IG or relating to issues with recording and storage or management of patient and staff information
KPI breach	All incidents where a KPI breach had occurred
Medical device/equipment	All incidents with equipment including failure or difficulties with supply or use
Access / Admission / Appointment	All incidents relating to the stated stages in the patient journey
Diagnostic Incident	All diagnostic incidents for patients in receipt of care
Treatment, procedure	All care and treatment provided
Implementation of care or ongoing monitoring/review	All patients under the care of WCHC
Clinical assessment	All clinical assessments on patients undertaken within the trust

Discharge	All discharge related incident managed by Discharge Team or from Community Integrated Care Centre (CICC) to other care in the community
Quality of care concern - another provider	Relates to either patients under our care and in receipt of other services or patients referred in from another provider
Information Technology	Relates to all IT incidents
Unexpected Death	All unexpected deaths of patients who are under the trusts care at time of death
Environmental matters	Relating to trust buildings
Infection control	All Trust infection control incidents
Catheter related incident	All catheter related incidents
Consent	All consent incidents that related to patient care
Moving and handling	All moving and handling incidents related to patient care
Incident relating to package of care	All incidents relating to supply and receipt of a package of care
Security Incident	All security related incidents reported within the trust
Abuse - other	All incidents where violence and aggression has been witnessed or experienced by patients, staff, and others
Safeguarding Adult and Children	All incidents where it has been reported or noted that a patient has required to be safeguarded
Exposure/Contact electricity, hazardous substance, object	All hazardous incidents
Information Governance	All IG related incidents
Property Incident	All community trust property incidents and those that relate to incidents occurring within patient property
Resuscitation Incident	All incidents related to resuscitation
Acute Life -Threatening Episode (ALTE) in Children	All children related incidents related to this area
Fire Incident	All fire incidents with trust premises or patient who are under our care
Abuse etc of patient by another patient	All reports of abuse between patients
Vehicle Incident	Any vehicle incident reported by staff or on trust premises

The Trust has a continuous commitment to learning from patient safety incidents and we have developed our understanding and insights into patient safety matters over a period of years and transitioned away from a Root Cause Analysis (RCA) framework and started using a system-based approach (Serious Incident). We have a weekly safety huddle which reviews incidents for levels of harm moderate and above , these are then presented at CRMG which is chaired by an Executive-led and has Quality and Governance and key divisional leads in attendance. Key themes and trends are shared with the group, following analysis of the Safety Risk and Learning Review Panel. CRMG reviews After Action Reviews, Thematic Analysis and PSI reports, these are cross referenced with Safety Quality Improvement Plans to ensure we are continually improving patient safety.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on page 11. To fully implement the Framework the Trust has completed a review of what types of patient safety incident occur to understand what needs to be learned from to improve.

A small group from the PSIRF key stake holder group including the Patient Safety Partners have reviewed data sets and undertaken a review of data from various sources to arrive at a safety profile. This process has also involved identification and specification of the methods used to maximise learning and improvement. This has led to the development of the local focus for our incident responses listed on page 13.

Defining our patient safety improvement profile

Over a number of years, the Trust has developed its governance processes to ensure it gains insight from patient safety incidents and this feeds into quality improvement activity. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify and define the quality improvement work we need to undertake.

CRMG will provide assurance that quality improvement measures including any safety improvement plans in use currently, or which require development and implementation in the future, continue to be of the highest standard. The Quality and Governance Team will be responsible for the oversight of this quality improvement work including the effective use of quality improvement methodology.

Our clinical and corporate divisions are required to report via SAFE and OPG in order to monitor and measure improvement activity across their divisions. This includes review of progress against key divisional improvement plans. These divisions will also provide assurance during the development of new safety improvement plans following reviews undertaken within PSIRF to ensure they have followed robust processes during development and fulfil SMART Goals requirements and are sufficient to allow the Trust to improve patient safety in future.

We have current improvement plans underway within the Trust these are listed within the local priorities table page 13

We plan to focus our efforts on development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally. We will remain flexible and consider improvement planning as required when a risk or patient safety issue emerges from our own ongoing internal or external insights.

Our patient safety incident response plan: national requirements

National Priority	Trust Response
Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII at WCHC, if applicable work in collaboration with other trusts involved in care
Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII at WCHC, if applicable work in collaboration with other trusts involved in care
Maternity and neonatal incidents meeting HSIB criteria	Not applicable to WCHC as relates to maternity services
Child deaths	Locally led PSII, as appropriate and SUIDIC process

Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally led PSII (or other response) may be required alongside the Mortality Review Group
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.
Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration of locally led learning response. See: Guidance for managing incidents in NHS screening programmes Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk)
Deaths in custody (e.g. police custody, in prison, etc.) where health provision is delivered by the NHS	WCHC as Trust not currently commissioned to provide services to these areas
Mental health related homicides	Locally led PSII by the provider in which the event occurred with WCHC participation if required
Domestic Homicide	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. Locally led PSII by the provider in which the event occurred with WCHC participation if required

In order to utilise trust resources effectively for patient safety incident responses, we intend to take a measured approach which we have indicated within the plan to maximise improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident Investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but the Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed.

For clarity, all types of incidents that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods and are detailed in the table below.

From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 5 PSII reviews where national requirements have been met per annum.

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their services and the populations served. Through our analysis of our patient safety insights, based on the review of incidents and sharing the themes and trends analysis we have determined that the Trust requires 10 patient safety priorities as a local focus. We have selected this number due to the breadth of services that the Trust provides. We will undertake a minimum of 1 index case PSII for 5 of the local priorities in each of the types of incidents proposed, the other 5 will have either an AAR or a thematic analysis. This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

We will use the outcomes of PSII to inform our patient safety improvement planning and work.

			Event	Approach	Improvement
Patient Safety Event Occurs	Patient Safety Incident Investigation	Trust Priorities	Medication - priority • Error in administration of critical medications resulting in moderate harm or above	Patient Safety Incident Investigation / AAR	QI Plan in place further learning identified will feed into this
			Delayed Delivery in care - priority • Delay in patient care, treatment, or across care systems resulting in harm or distress, focusing on EOLC patients	Patient Safety Incident Investigation / AAR	Create local organisational recommendations and actions and feed these into the quality improvement
			Slips Trips and falls - priority • Any patient who has been reviewed on the MIFPAT deemed at risk of falling and has a risk factor within bone health/following falls from bed or within the bathroom resulting in moderate harm and above	Patient Safety Incident Investigation / AAR / Thematic Review	QI Plan for Falls Prevention in place further learning identified will feed into this
			Pressure ulcers - priority • Any patients who have developed a category 2 pressure ulcer within the community who are assessed as Low	• Category 2 pressure ulcers thematic review • Category 4 Patient Safety	QI Plan for Wound Care Steering group in place further learning identified will feed into this

			risk • Category 4	Incident Investigation / AAR	
			Discharge incidents -priority • Discharge incidents where patients are discharged with no referral, or equipment to meet their needs	Patient Safety Incident Investigation if a moderate harm and above or AAR / Thematic review	Create local organisational recommendations and actions and feed these into the quality improvement
			Patient Records • Wrong information that has led to harm or near miss where significant harm could have been caused	Thematic Review/AAR	Create local organisational recommendations and actions and feed these into the quality improvement
			Medical device incidents • Unable to provide safe care due to delay / broken equipment	Thematic Review/AAR	Create local organisational recommendations and actions and feed these into the quality improvement
			Moisture Lesions • Any moisture lesion that has developed in the community for patients with continence products	Thematic Review/AAR	Create local organisational recommendations and actions and feed these into the quality improvement
			Access admission and appointments • Delay in patient's appointments that have led to moderate harm or themes in delay per service	Thematic Review/AAR	Create local organisational recommendations and actions and feed these into the quality improvement
			Communication • Monitor themes around communication failure within services • Monitor themes around patients within services • Monitor themes around information giving	Thematic Analysis/AAR	Create local organisational recommendations and actions and feed these into the quality improvement
	Patient safety Review	Local Level	Incident resulting in moderate or severe harm to patient	Statutory duty of candour agreed at CRMG	Inform thematic analysis of ongoing patient safety risks and use to build a case for a new

	Incident response		No/Low/Near miss Harm Patient Safety Incident	Validation of facts at local level – thematic analysis	improvement plan or inform ongoing improvement efforts

For any incident not meeting the PSII criteria, or any other incident, we will use a specific patient safety review tool to enable a learning response. For lesser harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work.

Appendix A

Glossary of terms

CRMG- Clinical Risk Management Group

CAG-Clinical Assurance Group

Safety Huddle- Safety huddles (or safety briefs) are short meetings used for sharing information about potential or existing safety problems. They increase safety awareness among front-line staff, allow for teams to address identified safety issues, and foster a culture of safety

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 coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

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 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.

SWARM - Used within Healthcare in the UK and US, a SWARM approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis and to support those immediately involved.

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. https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

SMART

SMART criteria are used to guide how objectives or goals are set to make sure that they achieve what they intend to achieve. SMART is taken from the first letter of a set of 5 criteria or rules to help for the goal setting as follows

S- Specific – a goal should not be too broad but target a specific area for improvement

M- Measurable – a goal should include some indicator of how progress can be shown to have been made

A- Achievable – a goal should be able to be achieved within the available resources including any potential development needed

R- Relevant – a goal should be relevant to the nature of the issue for improvement

T- Time-related – a goal should specify when a result should be achieved, or targets might slip