Patient Safety Incident Response Framework Plan 2024/2025

Dorking Healthcare

Contents

Introduction 3
Patient Safety Incident Response Framework (PSIRF) 3
Aims and objectives 3
Focus on Improvement and Learning 5
Defining our patient safety incident profile 6
Defining our patient safety improvement profile 6
Defining our incident profile 6
Stakeholder Engagement 6
Data Sources 7
Our patient safety incident response plan: 10
Selection of Patient Safety Incident - Local focus 10
Appendix 1 - PSIRF Training 15
Appendix 2 - Selection of techniques for incidents review 20

Introduction

DHC (Dorking Healthcare Ltd) has grown out of a collaboration of Dorking GP practices to become an NHS provider organisation serving the Surrey population. Our services cover primary care, community health, outpatient services (including diagnostics and procedures), and mental health (Talking Therapies).

Patient Safety Incident Response Framework (PSIRF)

This Patient Safety Incident Response Plan (PSIRP) sets out how DHC intends to respond to patient safety incidents (PSIs) reported by staff, patients and their carers over 12 to 18 months. It identifies how we will seek to learn from these events to continually improve our care quality and safety. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents have occurred and the needs of all those affected.

Aims and objectives

The DHC PSIRP (Patient Safety Incident Response Plan) is based upon the key aims of PSIRF (Patient Safety Incident Response Framework) that support developing and maintaining an effective patient safety incident response system.

OVERARCHING AIMS	SPECIFIC OBJECTIVES
Improve the safety and experience of the care that we provide to our patients	• Develop a climate that supports a just culture[1] and an effective learning response to patient safety incidents • Respond to PSIs from a patient safety perspective • Consider the safety issues that contribute to similar types of issues
Continually improve the quality and efficiency of our care systems	• Consider the safety issues that contribute to similar types of incidents • Develop systems-based improvement plans in response to the incident(s) • Measure the improvement initiatives based on the learning from incident responses
Improve the experience of patients, their families and carers when a patient safety incident is identified, and a PSII is carried out	• Act on feedback from patients, families, carers and staff about their concerns • Support and involve patients, families and carers during the incident response to elicit a better understanding of the issues and contributory factors involved and promote Duty of Candour[2]
Improve the working environment for staff regarding their experience with PSIs.	• Act on feedback from staff about their concerns • Support and involve staff in the PSI response to elicit a better understanding of the issues and contributory factors involved • Engage staff in the development of improvement initiatives
Improve the use of resources.	• Reduce the number of duplicate PSIIs in the same type of incident to reduce waste and enable more resources to focus on an investigation, leading to a more rigorous investigation that will identify systemic contributory factors.

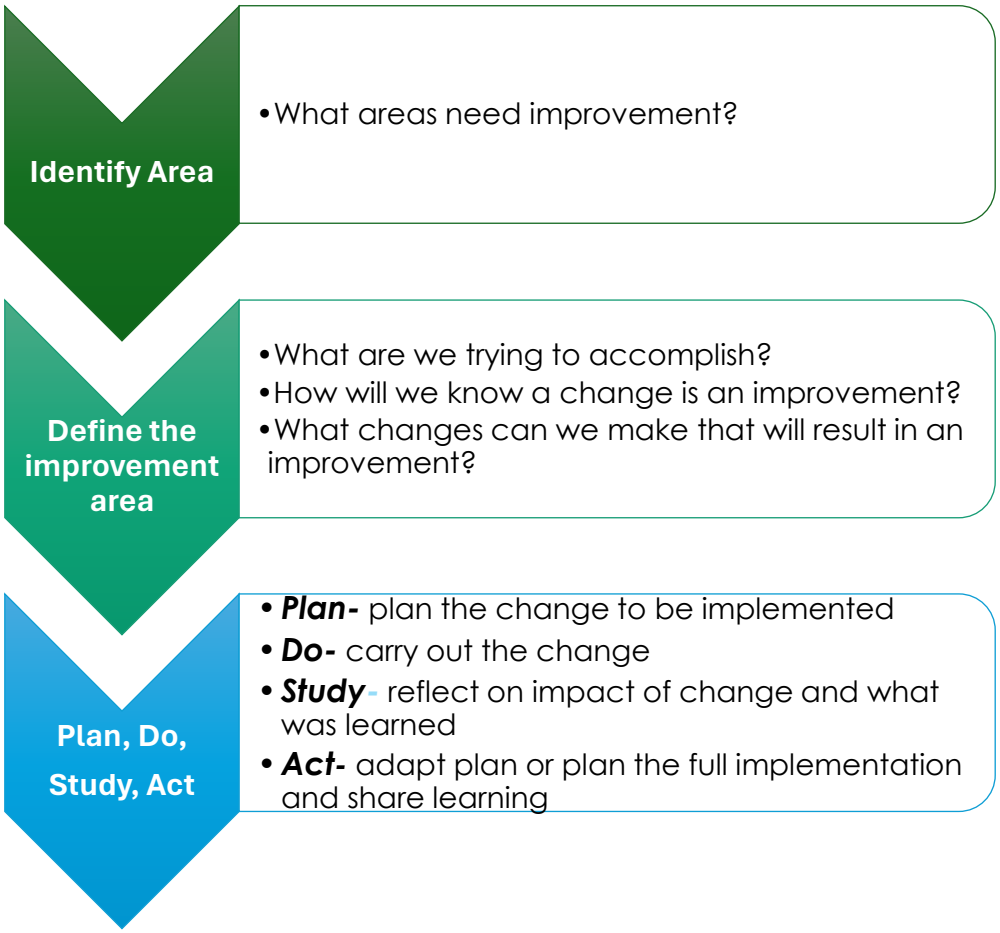
1 **The fair treatment of staff supports a culture of fairness, openness and learning by making staff feel confident to speak up when things go wrong rather than fearing blame**

2 **A professional responsibility to be honest with patients* when things go wrong.**

Focus on Improvement and Learning

DHC will bring together safety learning responses and quality improvement tools to enable continuous learning and improvement.
Improvement and learning from patient safety incidents will focus on but not be restricted to:

- Appropriate measures to test the effectiveness of any planned actions will be identified.
- Implemented actions will be reviewed using these measures to evaluate their impact on the patient safety incident issue and determine whether they should be adopted, adopted or abandoned.
- It is important that others can learn from our improvement work to support more widespread learning and change. Learning from improvement will be shared as defined in our patient safety incident policy, affiliated organisations, network and commissioning partners.



Defining our patient safety incident profile

Defining our patient safety improvement profile

We have identified and agreed to our PSIP by examining historical data regarding incidents, complaints, and feedback from service users and staff members. We looked at the reoccurrence rate, considered those that had the most significant impact on stakeholders, and recognised that there was significant scope for learning.

Defining our incident profile

Stakeholder Engagement

The patient safety incident profile has been developed through participation with key stakeholders. The key holders are:

- Board members
- Executive team
- Nurse leads
- IPC link nurse
- Service Managers from each service
- Governance and Compliance lead (PSIRF Implementation Lead)

DHC has also worked with Surrey Heartlands Integrated Care Board to identify and refine potential improvement areas that would benefit from a locally focused patient incident response plan. The incidents data is regularly shared and discussed with the Surrey Heartlands Quality lead on a monthly basis as a part of the Quality report.

To effectively engage both internal and external stakeholders within a patient safety incident response framework, various strategies were adapted:

Group	**Communication Method**	**Involvement**
All Staff	DHC All Staff meeting/ Governance bulletins/ Emails	Educational videos on PSIRF (source NHS England), New Training requirements, Q and A sessions, Discussion around barriers to incident reporting
Board members	Meetings to update on the	Progress on PSIRF / Board

	Governance priorities including the PSIRF plan progress	roles and responsibilities and training requirements.
Executive Team	Emails/weekly and monthly catch-ups/Quarterly Organisational Governance meetings. Review and analysis of the DHC patient safety profiles	All above and continues involvement in defining the PSIRF safety profile and Improvement plan
Service Managers	Emails/weekly and monthly service level Governance meetings / Quarterly Organisational Governance meetings. Review and analysis of the DHC patient safety profiles	All of the above and continue to be involved in defining the PSIRF safety profile and improvement plan.

Data Sources

The patient safety incident profile has been compiled using organisational data.

- **Incident Reports:** A data review of the DHC Incident management systems was conducted for incidents reported between April 2021 and March 2023 to establish the number and level of investigations. One High-Level Incident was reported. Zero Never Events were recorded. Zero SIs were reported. The remaining PSIs are shown in Figures 1 and 2 below.
- **Complaints:** Complaints made between April 2021 and March 2023 were reviewed, and a thematic analysis was undertaken, which was linked to corresponding incident themes, as shown in Figures 1 and 2 below.

Figure 1

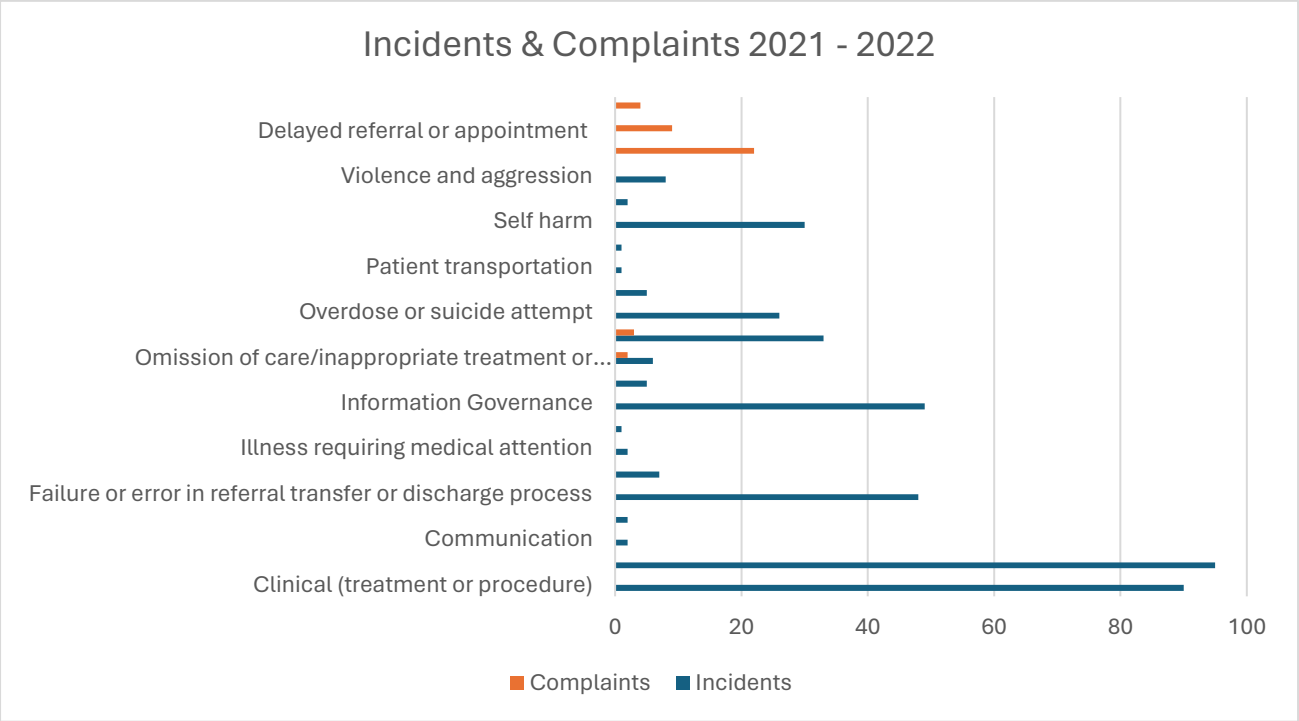
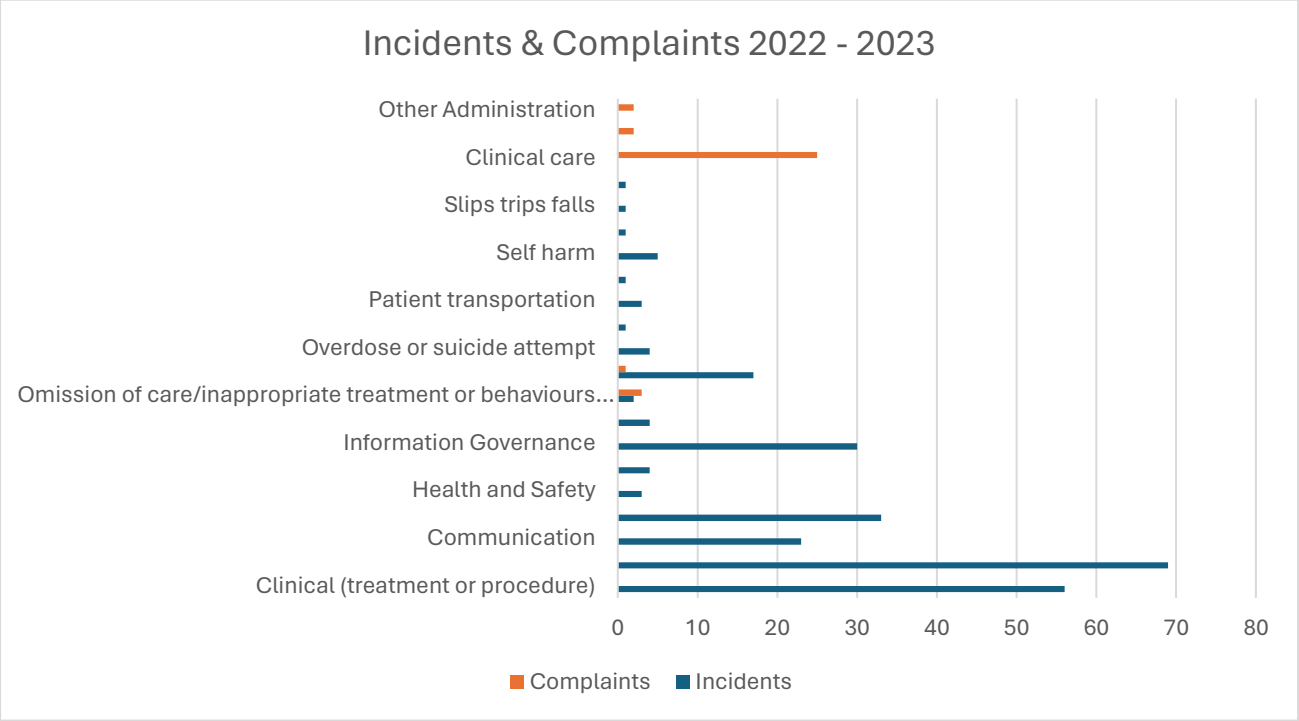


Figure 2


Incidents & Complaints 2022 - 2023
Other Administration
Clinical care
Slips trips falls
Self harm
Patient transportation
Overdose or suicide attempt
Omission of care/inappropriate treatment or behaviours...
Information Governance
Health and Safety
Communication
Clinical (treatment or procedure)
0
10
20
30
40
50
60
70
80
Complaints
Incidents

Our patient safety incident response plan:
Selection of Patient Safety Incident - Local focus

The criteria for defining local incident response are on;

A. Potential for new learning in terms of:

- Enhanced knowledge and understanding of the underlying factors
- Improved efficiency and effectiveness (control potential)
- Opportunity to influence wider system improvement.

B. Likelihood of recurrence (including scale, scope and spread)

Self-harm while on the waiting list for Talking Therapies.	• AAR [3] • Duty of Candour • PSR • PSII	Improvement plan • Improving wait times • Encouraging shorter wait options such as group therapy
Diagnostic tests/reports lost or delayed for urgent referrals. (Outpatients department)	• AAR • Duty of Candour • PSR • PSII	• Identify areas for improvement relating to pathway management and discharge procedure • Introduce processes such as who to report third-party findings to, assurance they are taking it seriously, should we expect a response, timeframe to raise Shared learning
Medication errors related to prescribing/issue/administration. (Pond Tail)	• AAR • Duty of Candour • PSR • PSII	• Identify areas of improvement relating to the 'Medicine management system. • Identify training needs • Share Learning

Other incidents which have resulted in moderate to severe harm or a near miss where there is potential for wider learning. (organisational wide)	• AAR • Duty of Candour • PSR • PSII	• Create local safety improvement actions and feed this into the Incident Review Group • Inform ongoing improvement efforts • Where relevant, reviewing the clinical systems and identifying plans for the improvement.

3 An AAR is a short discussion that can be held at any time and enables the individuals involved to learn for themselves what happened, what went well, what needs improvement and what lessons can be learned from the experienc

National priorities requiring a response

National priorities are set by the PSIRF and other national initiatives which require a PSII to be conducted by the organisation:

There are other events that have a recommended response (mental health related homicide, maternity and neonatal incidents, child deaths, deaths in NHS screening programs, death in custody and domestic custody). These have not been separately stated in this PSIRP as they are unlikely to occur due to the nature of care offered by Dorking Healthcare Limited. Should such an event occur, the recommended action set out by NHS England will be followed.

NATIONAL PRIORITY	INCIDENT TYPE	SPECIALITY	Required Response	Anticipated improvement route
Never event	All	All	PSII	Incident Review Group
Learning from deaths	Where a patient's death is thought more likely than not to be due to problems in care	All	PSII	Incident Review Group
Safeguarding Incidents	All	All	Refer to local authority safeguarding lead	Incident Review Group and Safeguarding Leads
Deaths of persons with learning disabilities	All	All	Refer to Learning Disability Mortality Review (LeDeR) Locally-led PSII may be required alongside the LeDeR	Incident Review Group and Safeguarding Leads

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 have occurred and the needs of all those affected.

Patient safety improvement plans and actions

The findings from incident reviews, PSIIs or other related activities must be translated into effective and sustainable action that reduces the risk to patients. For this to happen, DHC will develop the existing safety action plan tracker to include all below;

- where improvements are needed
- what changes need to be made
- how changes will be implemented
- how to determine if those changes have the desired impact (and if they do not, how they could be adapted).

Safety actions can relate to the local context or broader system issues. All safety actions are developed with relevant stakeholders, including those responsible for implementation. The implementation and efficacy of all safety actions are monitored, and they will be reviewed and monitored in the Governance meetings.

Any quality improvement initiatives, audits and projects that arise as a result of these actions will be monitored/ reviewed and implemented on RADAR and reviewed by the responsible department with the relevant leadership team.

Responding to cross-system incidents/issues

Where more than one organisation is involved in a patient safety incident, the organisation that identifies the incident is responsible for alerting relevant stakeholders to commence investigation and action. This should be one investigation if possible. If required, the ICB can help facilitate these discussions. DHC will work collaboratively with the partner organisations that provided care to the patient(s) involved where that care has played a role in the incident being examined.
DHC will work together and cooperate with any learning response that crosses organisational boundaries.

Resources and training to support patient safety incident response

PSIRF training requirements for DHC are identified in line with the PSIRF standards and the services DHC provides.
DHC is using Radar (DHC internal risk management and compliance system) to monitor compliance, effectiveness and report on training.
In order to meet the requirements of the new NHS National Standards for Patient Safety Investigation we will:

- Assign an appropriately trained member of the management board team to oversee delivery of the PSII standards and support the sign-off of all PSIIs. DHC Medical Director will carry out this responsibility.

- Provide the appropriate training for all management board members. ***(See appendix 1- DHC PSIRF Training Plan)***
  Identify an appropriate training provider for training at all levels. ***(See appendix 1- DHC PSIRF Training Plan)***
- Monitor training compliance through Radar
- Provide access to training for current staff who provide the incident investigation oversight function
- Provide access to updated training for existing investigators or investigation teams/staff in specific areas.
- Work with service managers to review the existing tools PSRs to ensure they reflect current practice.

1. Appendix 1 - PSIRF Training

PSIRF Role	Competence and Training Requirements	Role	Courses required by NHSE (patient safety syllabus)	Provider
All staff		Clinical	• Level 1: Essentials for patient safety (e learning) • Level 2: Access to practice (e learning) 1 • Human Factors / Ergonomics (Safety Science) for Patient Safety Level 1 – Understanding	E Learning for Health

All staff		Non-clinical	• Level 1: Essentials for patient safety (e learning) • Level 2: Access to practice (e learning) 1 • Level 2: Patient safety in the management and administrative sector • Human Factors / Ergonomics (Safety Science) for Patient Safety Level 1 – Understanding	E Learning for Health
Engagement & Involvement Leads	• Engagement leads to complete training as defined for 'All Staff' & 'Board and Senior Leadership' sections. In addition: • Engagement and involvement with those affected is led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process. • Engagement leads undertake continuous professional development in engagement and communication skills	These should be people leading on engagement and involvement with those affected by patient safety incidents such as but not limited to: • Services Manager • Deputy Service Manager • Governance Manager	• Involving those affected by a patient safety incident - 6 hours (face to face)	E Learning for Health Procure training from a NHS Training & Procurement Framework In house training can be offered by staff meeting requirements of 5.1 in PSIRF standards *From October 2023 HSIB intend to have a commercial model for all PSIRF and non- PSIRF training where they hope to offer additional training at a charge to the Independent Sector.

	and knowledge, and network with other leads at least annually to build and maintain their expertise. • Engagement leads contribute to a minimum of two learning responses per year			
Learning Response Leads	• Learning Response Leads to complete training as defined for 'All Staff' & 'Board and Senior Leadership' sections **In addition:** • Learning responses are led by those with at least two days' formal training and skills development in learning from patient safety incidents and experience of patient safety incident response. • Learning response leads undertake continuous professional development in incident response skills and knowledge, and network with other leads at least annually to build and maintain their expertise.	**These should be people leading any system-based learning response such as but not limited to:** • Chief Operating Officer • Governance and Compliance Manager • Services Manager	HSIB level 2 – A systems approach to learning from patient safety incidents (Free of charge to Independent Sector)	E Learning for Health HSIB level 2 – A systems approach to learning from patient safety incidents (Free of charge to Independent Sector)

	• Learning response leads contribute to a minimum of two learning responses per year			

Oversight	Those with an oversight role on a provider board or leadership team to complete training as defined for 'All Staff' & 'Board and Senior Leadership' sections
	In addition:
	• All patient safety incident response oversight is led/conducted by those with:
	  • at least two days' formal training and skills development in learning from patient safety incidents AND
	  • One day training in oversight of learning from patient safety incidents.
		These should be people leading in system oversight roles as outlined in the NHSE Roles & Responsibilities guide (i.e. provider board PSIRF lead(s)) and must have knowledge of effective oversight and supporting processes, including effective use of data for assurance and patient safety incident response system development such as but not limited to:
		• Chief Operating Officer
		• Governance and Compliance Manager
		• Services Manager
			• HSIB level 2 – A systems approach to learning from patient safety incidents (Free of charge to Independent Sector)
			• Oversight learning from patient safety incidents – 6 hours (face to face)
				E Learning for Health
				HSIB level 2 – A systems approach to learning from patient safety incidents (Free of charge to Independent Sector)
				Oversight learning from patient safety incidents
				• Procure training from a NHS Training & Procurement Framework
				• In house training can be offered by staff meeting requirements of 5.1 in PSIRF standards
				*From October 2023 HSIB intend to have a commercial model for all PSIRF and non- PSIRF training where they hope to offer additional training at a charge to the Independent Sector

	• All individuals in oversight roles in relation to PSIRF undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.			
Board & Senior Leadership			• Level 1: Essentials of patient safety for boards and senior leadership teams (e learning) • Level 2: Access to practice (e learning) 2 • Human Factors / Ergonomics (Safety Science) for Patient Safety Level 1 – Understanding	E Learning for Health

Appendix 2 - Selection of techniques for incidents review

Technique	Method	When?
After Action Review	Incident recovery	An AAR should be used at any point where there has been an unexpected outcome – whether it is positive or negative. It is usually focused on task-based events during a project
'Being open' conversations	Open disclosure	A Being Open Conversation should be used for incidents that are prevented ('near miss') or no harm. Consideration should be given to local circumstances and what is in the best interest of the patient.
Case record/note review	Clinical documentation review	Clinical record reviews are recommended for the following: • Complaints made by the patient and/or their relatives • Specific serious incident(s) and/or aspects organisational care • Concerns raised by colleagues and or members of the wider medical team.
Hot debrief	Debriefing	Hot debriefing is a form of debriefing which takes place 'there and then' following a clinical event. Hot debriefing has the advantage of earlier intervention, improved participation and improved recall of events.
Safety huddle	Briefing	Immediately after an incident, staff visit the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. Safety huddles enable insights and reflections to be quickly sought and generate prompt learning

Technique	Method	When?
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
Thematic review	Team review	Useful in understanding common links, themes or issues within a cluster of investigations or incidents. It will seek to understand key barriers or facilitators to safety using incidents
Link Analysis	Team Review	Link analysis can be used to highlight the frequently used paths taken in an environment and those that are critical for safety. This can inform the design of a healthcare environment by co-locating those items or areas used to complete the most frequent tasks.
Observation	Specialist review	To reduce risk we must understand how work is actually performed, rather than what is documented in training, procedures or equipment operating manuals (work as prescribed), how we imagine work is conducted (work as imagined) or how people tell us work is performed (work as described)
Mortality / MDT review	Specialist Review	Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each death.
Transaction audit	Audit	To check a trail of activity through a department, etc, from input to output. This could include: • Tracking patient pathway from admission to discharge • Tracking a process i.e. receiving medication / stock onto a ward

Technique	Method	When?
		• Tracking receipt and distribution of equipment i.e. oxygen cylinders
Process audit	Audit	To Process audits look at specific processes, activities or functions performed by Ward or Department. i.e. a process audit can be used to look at practice following a medication error or none adherence with a LoCSSIP.
Outcome audit	Audit	Outcomes are the end results of care; the changes in the patients' health status and can be attributed to delivery of health care services. Outcome audits determine what results if any occurred as result of specific intervention. These audits assume the outcome accurately and demonstrate the quality of care that was provided. Example of outcomes traditionally used to measure quality of hospital care include mortality, its morbidity, and length of hospital stay.
Clinical audit	Outcome audit	A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes.
Walkthrough Analysis	Proactive hazard identification and risk analysis	To determine the likelihood of an identified risk and its potential severity (e.g. clinical, safety, business).