Patient Safety Incident Response Plan (PSIRP)

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Introduction

The Patient Safety Incident Response Framework (PSIRF) (2022) replaces the Serious Incident Framework (2015) and significantly changes the way in which the National Health Service (NHS) manages patient safety.

PSIRF is not considered to be an investigation framework, rather it looks to:

- Provide a coordinated and data-driven response to incidents with compassionate engagement to those affected by them (staff, patients, and patient families).
- Place incident response in the wider context of the systematic improvement of Local Care Direct (LCD), the wider NHS and other third-party organisations.

Each organisation is required to look at its resource, incident profiles (the type of incidents/ complaints and claims that they have) and current safety actions to develop a plan (Patient Safety Incident Response Plan (PSIRP)), outlining how it will respond when a specific type of patient safety event occurs.

Some stipulations do remain, for example all Never Events[1] require a full investigation.

LCD commenced a preliminary data evaluation at an early stage of this process and hence gained a good knowledge of existing issues. Preliminary information was shared with the Quality Improvement Group (QIG) during 2022. This was updated and shared as part of the diagnostics and discovery stage of the PSIRF implementation.

The QIG ultimately transitioned to become LCD's Patient Safety Group (PSG) in May 2023 and PSIRF readiness continues as an integral part of the agenda.

This PSIRP sets out how Local Care Direct 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.

It is important to note that this plan covers patient safety incident responses conducted for the purpose of learning and improvement only. We may become aware of a patient safety incident from a variety of different routes, e.g. from an incident report on the Datix reporting system, within feedback from a patient or their family or carer, feedback from another service provider or from clinical audit activity.

[1] https://bit.ly/NeverEventsList

All incident reviews conducted for reasons other than for the purpose of learning and improvement, fall outside the scope of this plan. The following list covers a few examples:

- Complaints management
- Professional Standards investigations
- Human Resources investigations
- Reviews and inquests undertaken by a Coroner
- Criminal investigation

Oversight and Monitoring:

It is the responsibility of LCD's multi-disciplinary Patient Safety Group to give first stage endorsement of this PSIRP, the Executive Team second approval, and LCD's Board final approval.

This process provides effective internal oversight, Governance, and document control.

The NHS West Yorkshire Integrated Care Board provide objective, external oversight and approved the internally approved PSIRP prior to issue. This helps to ensure consistency of approach across the healthcare network from the outset and ongoing collaboration and shared learning as the framework evolves and embeds into practice.

Our services

LCD care for people 24 hours a day, 7 days a week, and 365 days a year.

As a general overview of our facilities LCD operates:

- A Central Contact Centre.
- Two Urgent Treatment Centres (UTC).
- A Walk-in Centre.
- A Dental Clinical Assessment and Booking Service.
- Twelve Primary Care Centres (PCC).
- Eighteen hybrid vehicles, which our drivers use to take Doctors to patients across West Yorkshire.

Between 1st April 2023 and 31 March 2024, LCD provided 22 services to a population of 5.4 million across Yorkshire and the Humber, and 726,093 patient cases came through to our teams. Here is a short description of some of our key services:

- The Dental Clinical Assessment & Booking Service (DCABS) is an Urgent/Unplanned Dental Care Service for the Yorkshire & Humber area. It is designed for those aged over 5yrs experiencing an urgent dental issue in the Yorkshire & Humber area. We give specialist clinical advice and support, and then depending on patient need, our consultation will result in self-care, direct booking into an urgent dental appointment with one of our partners, or, signposting to external support.
- Emergency Department Streaming: We provide on-site support to Emergency Departments (ED) in Airedale, Calderdale, and Huddersfield to help them with patients who attend with a primary care need. Leeds Emergency Departments can also refer people into our Urgent Treatment Centres.

- Clinical Assessment Service: We provide advanced remote clinical assessment as part of our urgent primary care services to support Yorkshire Ambulance service, NHS111, General Practice and Emergency Departments.
- GP/Clinicians Out of Hours: If patients need to see a clinician in the evening, at weekends or on a Bank Holidays arrangements can be made for them to be seen by one of our clinicians at a Primary Care Centre, or if appropriate, one of the clinicians may visit the patient at home. All services are accessed via NHS 111. In many cases, one of our clinical colleagues may offer support over the telephone with advice or referral to another more appropriate service according to individual needs.
- Routine Primary Care: We help patients access routine primary care by working with colleagues in General Practices. We do this by helping them by providing daytime cover during emergencies and training.
- Urgent Community Response (UCR): The Urgent Community Response (UCR) hub works with the visiting teams to provide a 0-2hour response to patients in their usual place of residence who are experiencing a medical and/or social crisis and are at risk of hospital admission. The Kirklees UCR service is an alliance of different organisations (including Curo Health, Local Authority, Locala, and Local Care Direct).

  Our UCR hub also supports the front-end onboarding of Calderdale and Wakefield services. Our UCR hub receives all patient referrals for Kirklees and Calderdale, as well as referrals from the Yorkshire Ambulance Service for the Wakefield area. Following non-clinical onboarding, which rules out red flags and checks against service criteria, patients receive remote holistic clinical triage from one of our advanced UCR hub clinicians. Following triage and the assessment of patients' needs, the patient may be referred to the UCR visiting teams, closed with advice/ prescription in our hub or signposted to an alternative appropriate service.

  The UCR hub operates 8am-8pm, with the last referral time for visits being 5.30pm. After 5.30pm, the UCR hub offers a hear and treat service for care homes, YAS roadside crews and self-referrals from patients (who have been seen by the service in the last 30 days – note this is only for Kirklees UCR).

  Please note that patients are referred into the UCR service via a range of referral sources, which include but is not limited to care homes, GP Practice, Yorkshire Ambulance Service, NHS111 or other Health and social care practitioners.

- Walk-in Services: When GP surgeries are closed, working in partnership with NHS 111, we provide specialist urgen t care services for West Yorkshire and the Craven district of North Yorkshire. Each facility has a specific range of services as outlined below:

  King Street Walk-In Centre: The walk-in service is open for patients (except children under 6 months and pregnancy related issues) who need same-day care and cannot wait to see their own GP. The service is operated by a dedicated team of experienced clinicians who can assess, diagnose, and treat a range of minor illnesses and injuries that do not need an x-ray, including:

  - ear, nose, and throat problems
  - sprains and strains
  - wound infections
  - minor burns and scalds
  - minor head injuries
  - skin conditions
  - minor respiratory conditions
  - mild abdominal pain or discomfort
  - insect and animal bites and stings
  - minor eye problems
  - minor injuries to the back, shoulder, and chest
  - acute wound dressings
  - emergency contraception

- Pontefract Urgent Treatment Centre: The walk-in service is open for anyone with Illness or Injury 24 hours a day. At Local Care Direct we provide the care at the service during 22:00 – 08:00. You can also access this service by pre-booking an appointment via NHS111.
- Wharfedale and St George's Urgent Treatment Centres: The Urgent Treatment Centres (UTC) will see patients with urgent illness (except babies under 6 weeks old or deal with pregnancy related conditions) which cannot wait for you to see your own GP. The service also supports patients with minor injuries including cuts, bites, sprains, bone, muscle, or joint injuries. X-ray facilities are available until 20:30 depending on the nature of the injury; one of our healthcare professionals will advise if an x-ray is required. Both of our UTC's are nurse-led clinics.

LCD is an integral part of the Integrated Care System (ICS) overseen by the West Yorkshire Integrated Care Board (ICB). This enables us to work in partnership with other service providers, all with a shared goal of continuous service improvements to improve experiences and outcomes for our patients, their families, and carers. We will endeavour to do this by taking a systems approach, by working collaboratively and openly sharing our experiences & learning outcomes.

For the purpose of our PSIRP, LCD considered all services collectively rather than individually or by group and, in turn, mapped all data as a collective from across the organisation.

Defining our patient safety incident profile

In line with the national planning process (figure 1), LCD's data was examined to establish an incident profile, this provided a greater understanding of the types of incidents managed by the organisation.

Stakeholder engagement: Work to establish LCD's incident profile was led by LCD's Clinical Governance & Quality Lead & Patient Safety Specialist. The approach was collaborative involving all members of the Quality, Governance, Audit and Risk teams, Operations Leads, Clinical Advisors and colleagues from the West Yorkshire ICB Quality team.

During the investigative and planning stages, LCD had not recruited Patient Safety Partners (PSP's), however as application of the new framework evolves, patient representation will be integral to our patient safety plans and processes. Patient Safety Partner representation from the ICB kindly agreed to review the final draft of this plan and to be a key stakeholder in the sign-off (approval) process.

Data Sources: The data was collated from all relevant sources and from across all LCD's services.

The data sources were as follows:

- Incidents
- Complaints
- Compliments
- Medical record requests
- Service to service issues/events
- Claims

This provided a rich pool of data to work from to inform our patient safety incident response plan (PSIRP).

Figure 1. Patient safety incident response planning process

Data Analysis:

LCD's data relating to incidents, complaints, claims and medical record requests and their investigations have been stored on the Datix database since 2019; Datix is the Risk Management Information System in use at LCD, designed to collect and manage data on adverse events. This enabled access to four years of data to assess our incident profile.

Figure 2 illustrates the over-arching event types dealt with by LCD:

Figure 2: Event types processed:

Event Type:
Incident
Complaints, Compliments, Concerns, and service to service
Medical Records Request
Claims

The data was analysed further, first to identify the most frequently occurring categories, or types, of both incidents and '4-C's' (complaints, compliments, concerns, claims).

The final stage of the analysis involved filtering the most frequently reported patient safety events from all the afore-mentioned categories.

The most frequently reported event types for LCD, when combining reported incidents and '4-C's' together were (listed with highest first):

- Safeguarding (Adults & Children).
- Inappropriate referrals into the service.
- Delays.
- Failure to follow correct procedure.

Reviewing the data from 'all' event types provided a different, more accurate outcome for the organisation's plan than if events were considered separately in the respective incident or complaints modules of Datix.

The data was then considered, applying the 'level of harm' and 'serious incident' categories of the NHS Serious Incident Framework (2015), which remain in place until there is full transition to the Learning from Patient Safety Events (LFPSE) & the Patient Safety Incident Response Framework (PSIRF).

This confirmed that during the four-year period analysed, for every serious incident investigation that LCD led on, there were three led by other organisations to which LCD participated. This quantity and ratio reflected the picture for each calendar year, and it is therefore a reasonable assumption that this will follow in the forthcoming 12-18 months.

Defining our patient safety improvement profile

Once the data analysis was complete and the most commonly occurring incidents confirmed, existing Quality Improvement activity across these areas was considered.

1. **Safeguarding**: Whilst Safeguarding is everybody's responsibility, this area is led by LCD's Safeguarding Lead Nurse and Freedom to Speak Up Guardian and designated Safeguarding Doctor.

   Reporting is good in this area and over the four-year period analysed, volumes of cases were noted to steadily increase. LCD have an Annual Safeguarding Plan, which is presented to the Board and reviewed at six-monthly intervals.

   Staff training in safeguarding is mandatory, the Policy is regularly updated to reflect national guidance and elements are localised as appropriate across the regions to reflect local Safeguarding Board protocols. Information is regularly provided to help our teams help our patients.

2. **Inappropriate referrals into the service**: LCD works very closely with partner organisations to review patient pathways and to determine how pathways are selected for and by individual patients.

Examples of collaborative working to achieve Quality improvements include work undertaken with NHS 111 to review the dental pathways associated with LCD's Dental Clinical Assessment & Booking Service (DCABS) and to clarify the cases that should be put through to LCD's call centre.

Similarly, LCD have completed work with the North of England Commissioning Support Unity (NECS), to ensure the correct option is selected on the Directory of Services (DOS) for referrals via West Yorkshire Urgent Care arrangements (WYUC).

Work is currently ongoing to ensure that repeat prescriptions are sent to the Community Pharmacy Consultation Scheme (CPCS) as these calls contribute to the volume of calls and delays in service provision and are better dealt with elsewhere.

Work to prevent inappropriate referrals from all of LCD's access points is ongoing and will continue, driven by thematic reviews of cases identified in this category.

3. **Delayed response/visits**: This is another category where work is ongoing and will continue, driven by thematic reviews of cases identified in this category.

   Teams at LCD work collaboratively in an attempt to continually reduce both the number and the extent to which patients are affected by delays, reviewing ways of working from both clinical and operational perspectives. A significant piece of work was undertaken in summer 2023 to quantify the risk posed by delay and incorporate this into the OPEL (Operational Escalation Level) procedures.

   The next phase of this improvement work involved a system-wide approach, involving all partners, and co-ordinated by the Integrated Care Board (ICB). The project involved the implementation of 'RADAR', a real-time monitoring tool to monitor wait times and pressures across different parts of the system. This enables timely assessment and informed decisions regarding how best to manage waiting patients across the system. This system went live at LCD on 2nd November 2023.

   How and where patients are directed is also under regular review, in conjunction with assessing clinical resource and pressures associated with particular times of the year, days of the week and times of the day.

4. **Failure to follow correct procedure**: The approach promoted in the PSIRF to monitor 'work as expected' versus 'work as done' will modify how we review this category of incidents. Moving away from a 'people first' focus and embracing a 'systems approach' to investigations triggers different questions and investigatory activities.

   We recognise the importance of our policies and protocols being 'real' and wholly workable with the systems we have in place. As a consequence, this highlights the importance of a frontline view when amending existing, or creating new policies and procedures, and to recognise indications for timely reviews when it is recognised content doesn't adequately reflect how work has to be done.

   This category may also highlight indications to improve induction and/or training for individuals and/or staff groups. Thematic reviews are also indicated for this category of incidents to inform plans for continuous improvement.

5. **Lack of anticipatory medicines for palliative care within the community**: This area of work was recognised from incidents reported on to the Datix system, one which met the PSII criteria, and from internal medicines audits. LCD formed a Palliative Care Task & Finish Group to focus on this issue and continue to work collaboratively with the ICB and all related stakeholders thus adopting a system-based approach to improve this aspect of patient care.

6. **Clinical tools and practice protocols to support early recognition of the deteriorating patient and rapid response**: The opportunity for us to introduce improved clinical tools and protocols to aid early recognition of the deteriorating patient and to escalate and activate a rapid response has been acknowledged following a review of an incident, which was reported on the Datix system in conjunction with a review of tools currently available to clinicians.

   A task & finish group is to be established to focus on this area of work with the aim of producing best practice tools and related protocols for the National Early Warning Score (NEWS) for Adults, Paediatric Early Warning Score (PEWS) for children and young people under the age of 18years along with fully updated SEPSIS Guidance. The latter is frequently reviewed and updated by the Sepsis Trust UK and though the Sepsis tools are currently used within LCD practice, we want to ensure we are applying the most current, evidence-based versions.

LCD is responsive to risks and changes in the wider system and has developed culture of continuous review and improvement along with effective working relationships with partner organisations with a shared ethos for effective governance, shared learning, and continuous Quality Improvement.

Our patient safety incident response plan: national requirements

National requirements determine which patient safety incidents must be reported to other agencies in addition to LFPSE e.g. CQC, Police, Coroner, Social Services and where comprehensive investigations must be undertaken. These include all incidents categorised by NHSE as never events, unexpected deaths in both Adults and Children (Sudden Unexpected Death in Childhood (SUDIC)), deaths in people with Learning Disability and Autistic people (LeDer) and incidents where criminality may be indicated.

LCD's incident profile suggests that 1 full Patient Safety Incident Investigation will be undertaken per annum. Based on our data and the fact that LCD works in close partnership with other providers of health care, it is anticipated that we will support or input into at approximately ten investigations being led by other organisations per year.

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII)	Create local organisational actions and feed these into the quality improvement strategy
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into the quality improvement strategy. Work with the Medical Examiners to improve oversight & the potential for new learning within the system.
Patient harm (including injury & death) where criminality may be indicated.	PSII (Support multi-authority investigation)	System based approach to identify any risk factors. Work with other agencies to determine an improvement strategy.
Participation into investigations being led by partners	PSII After Action Reviews	Supporting system-wide approach to learning.

Our patient safety incident response plan: local focus

Based on the findings of our Patient Safety Incident Profile and taking into consideration the Quality Improvement work already in progress, the table below outlines LCD's anticipated response to the Patient Safety Incident types/issues, which are most likely to occur within the organisation. Those highlighted in blue reflect the most commonly occurring patient safety incidents.

LCD plan to review 1 high volume incident category per annum to look at all incidents within that category to establish the underlying themes. It is planned to form a task and finish group with appropriate staff to undertake these works. Where possible, the learning will be fed into existing improvement workstreams. Otherwise, new improvements will be established and implemented by a task and finish group.

Please note that this reflects a generic, anticipated response, however each incident will be assessed on a case-by-case basis to determine the most appropriate learning response.

Patient safety incident type or issue	Required response	Anticipated improvement route
Safeguarding incident (Adult or Child)	Thematic reviews Case reviews as indicated	Create local safety actions and feed these into the Quality Improvement Strategy.
Inappropriate referral	Thematic reviews Process mapping After action reviews as indicated	Inform ongoing improvement efforts.
Delays within patient pathway	Thematic reviews Process mapping After action reviews as indicated	Inform ongoing improvement efforts.
Failure to follow correct procedure	Potential PSII Walk through Thematic reviews to highlight trends	Create local safety actions and feed into the Quality Improvement Strategy.

Lack of handover between services	After Action Review Thematic reviews Process mapping	Collaborative working to agree learning, safety actions & improvement plan.
Failure to treat	Case review Potential PSII	Agree learning, safety actions & improvement plan.
Lack of anticipatory drug supply in Palliative Care	Thematic reviews	Inform ongoing improvement efforts
Incidents involving controlled drugs	Thematic reviews Case review	Agree learning, safety actions & improvement plan.
Incorrect treatment/ medication	After action review Potential PSII	Agree learning, safety actions & improvement plan.
Inappropriate prescribing	Thematic reviews Case Review Potential PSII	Agree learning, safety actions & improvement plan.

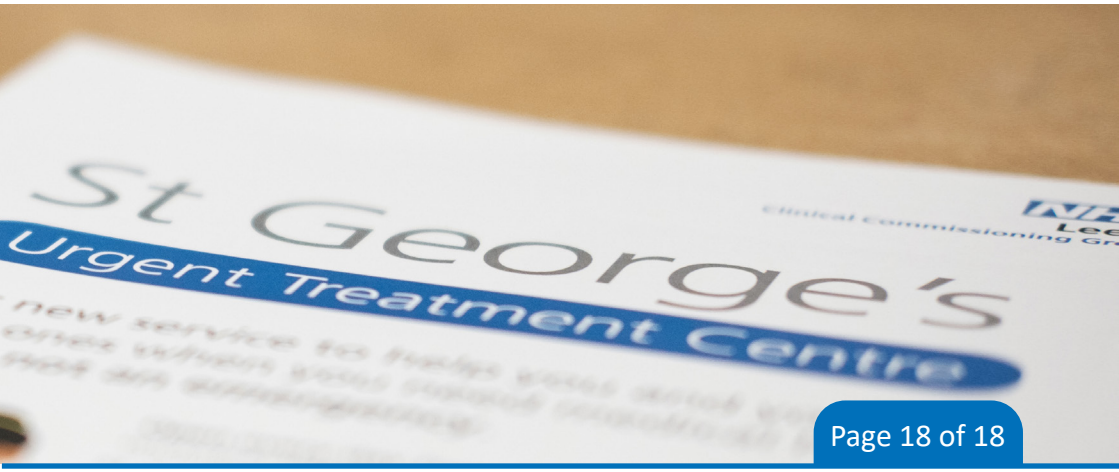
LCD have undertaken a pilot of the proposed processes during 2023-24. Using a Palliative Care incident that met the patient safety incident investigation (PSII) criteria, LCD fed the incident learning into a task and finish group to review the findings alongside other incidents of a similar nature and employ an improvement approach to resolve the wider issues. This approach has been found to be most successful in identifying broad, system-wide issues. LCD has found it necessary to work closely with colleagues at the Integrated Care Board to highlight West Yorkshire/ national wide problems. The initial investigation serving as the start point for the learning, which has extended far beyond the initial incident that occurred.

The success of the pilot allows LCD to have confidence in its planned approach and ensures that the learning from all incidents is maximised to improve patient care.

As the methodology for different types of investigations/learning responses remains new, LCD will continue to review the efficacy of each chosen approach after every investigation/ quality improvement cycle to assess if further amendments are needed to this plan.

The Quality/Governance team at Local Care Direct aim to review this new plan at 3 monthly intervals in the first 12 months from publication. The updates and recommendations from the reviews will be discussed at the Patient Safety Group for oversight and approval, with involvement from colleagues at West Yorkshire ICB.

We aim to continually improve our application of the new methodologies in response to patient safety incidents, to continue to assess the incident profile at LCD to ensure we prioritise our Quality Improvement activities accordingly and to monitor the efficacy of all improvement activity once implemented.



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