Patient Safety Incident Response Plan 2023-2025

	NAME	TITLE	DATE
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Authorising Committee	**Clinical Governance Committee**	**Sub Committee of Board**	**21st March 2024**

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Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how Connect Health intends to respond to patient safety incidents over the next of 12 to 18 months. The plan is a fluid document that may change depending on emerging themes and trends. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. We will continue to learn from the patient safety incidents reported by colleagues, patients, and their families as part of our work thereby continually improving the quality and the safety of the care we provide.

This plan will help us measurably improve the efficiency of our local patient safety incident investigations (PSIIs) by:

- refocusing PSIIs towards a systems approach in line with PSIRF (Patient Safety Incident Response Framework) and the identification of connected causatory factors and systems issues.
- focusing on addressing these factors to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- transferring the emphasis so we have high quality PSIIs such that it increases our stakeholders' (patients, families, and colleagues) confidence in the improvement of patient safety through learning from incidents.
- demonstrating the added value from the above approach.
- ensuring our policy reflects the needs and actions required within the national framework.

This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed.

We will continue to develop the planning aspects of this PSIRP with the assistance and approval of our local commissioner(s).

The aim of this approach is to continually improve. As such this document will be reviewed annually and endorsed by the Senior Leadership Team at Connect Health and ratified by the Integrated Quality, Audit and Compliance Committee. This will be done in tandem with the review of the Patient Safety Incident Response Framework (PSIRF) policy.

Connect Health has a low volume of high impact Patient Safety Incidents. This is due to the organisation primarily managing care in the community, in a non-emergency setting. We have already established a robust process for triaging incoming referrals and diagnostics. This thereby reduces the likelihood of patients with significant diagnoses remaining within the service. The key themes of our Patient Safety Incidents are described in detail within this document.

Connect Health has, for the last 12 months, had an existing process for the Thematic Review of Incidents and this has formed the basis of the Patient Safety Incident Response Plan.

Our Services

Connect Health has provided community services in partnership with the NHS since 1993. We have forged strong links with Emergency Care providers, secondary care, primary care and voluntary sectors, maximising estates, innovating the use of systems and technology, personalising patient tools whilst mastering data collection and use to improve quality. Services we provide include:

• Physiotherapy (Tier 1)

• Tier-2 MSK (musculoskeletal services) CATS (Clinical Assessment and Triage Service) (musculoskeletal)

• Mental Health (IAPT (Increasing Access to Psychological Therapies))

• Chronic pain management

• First Contact Practitioners (FCP)

• Rheumatology

• Functional disorder/long Covid

• Rehabilitation

We have 800 colleagues across the business, with approximately 500 Clinical Staff and 300 Support (administrative) colleagues, 150+ premises and two mobile clinics, we see per year circa 375k NHS patients, across 22 NHS Integrated Care Boards (ICB).

Connect Health has a proven partnership model which utilises a tried and tested mobilisation and transformation methodology alongside its operational platform and digital tools (operational and clinical dashboards, Business Intelligence(BI), and Learning Academy etc) which further provide platforms on which to optimise clinical and operational performance and decision making.

Internal Stakeholders

The list of internal stakeholders for the complex elements of Connect Health would include representatives from different clinical and non-clinical staff (e.g., Senior Leadership Team, Integrated Governance, Safeguarding, People Team, Health and Safety, and operational management teams).

External Stakeholders

Depending on the incident to be investigated, the external stakeholders may vary depending on their subject matter expertise.

This may include patient groups and patient and public representative organisations:

- Local Healthwatch,

- Local Authority Safeguarding,
- Integrated Care Board Leads,
- NHS England Commissioning Leads e.g., Health and Justice,
- NHS Resolution,
- Members of the Multi-Disciplinary Team,
- Police,
- Professional Body Representatives e.g., Nursing and Midwifery Council (NMC) Health and Care Professions Council (HCPC)
- Care Quality Commission (CQC).

Defining Our Patient Safety Incident Profile

Aim of a Patient Safety Incident Investigation (PSII)

PSIIs are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected factors that may appear to contribute towards patient safety incidents.

These factors must then be targeted with effective system improvements to either prevent or continuously and measurably reduce repeated incidents.

There is no remit in PSII to apportion blame or determine liability, preventability, or cause of death.

There are several other types of investigation which, unlike PSIIs, may be undertaken. Examples include Complaints, Human Resource, Professional Regulation, Regulatory or Criminal investigations. As the aims of each of these investigations differ, they need to continue to be conducted by the subject matter experts as separate entities to be effective in meeting their specific intended purposes.

Selection of Patient Safety Incidents for PSII

In view of the above, the selection of incidents for PSII is based on the:

- actual and potential impact of the incident's outcome (harm to people, service quality, public confidence, products, funds, etc.)
- likelihood of recurrence (including scale, scope and spread)
- potential for new learning in terms of:
    - enhanced knowledge and understanding of the underlying factors,
    - improved efficiency and effectiveness,
    - opportunity to influence wider system improvement.

Timescales for Patient Safety PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified.

PSIIs should ordinarily be completed within 30 to 60 days of their start date. Timescales are dependent on the intensity of the action and the amount of work required.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between Connect Health and the patient/family/carer.

No local PSII should take longer than six months. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether latest information indicates the need for further investigative activity.

Nationally Defined Incidents Requiring Local PSII

Nationally defined incidents for local PSII are set by the PSIRF and other national initiatives for the period 2020 to 2021. These are:

- incidents that meet the criteria set in the Never Events list 2018.
- incidents that meet the 'Learning from Deaths' criteria (March 2017); that is, deaths clinically assessed as more likely than not due to problems in care.

Locally Defined Incidents Requiring Local PSII

Based on a local analysis and review of the local incident reporting profile, local priorities for PSII have been set by Connect Health for the next 18 months.

To do this we reviewed our Patient Safety Incident Data for the period of April 2022 to April 2023 as well as continuing to monitor our Patient Safety data up to the end of September 2023. The profile has been developed based on the Thematic Analysis of this data and a full review of our existing thematic incident reviews. As a primarily Community Provider of services our Patient Safety Incident profile has an overall lower risk than many other healthcare organisations who offer emergency or urgent care.

Our biggest potential exposure to risk is in identifying and acting on significant diagnoses and ensuring that patients are dealt with by the appropriate urgent service, as soon as possible. Thematically this is related to patients who may be referred inappropriately to us by General Practitioners or via the patient self-referral process. Our Patient Safety Incident Risk profile demonstrates that we have robust identification processes with very few 'harm' incidents within the organisation. Any incidents identified allow us to have focussed attention on improving processes.

From our reviews we have identified the following key types of incidents:

1. **Timely Management of Onward Referrals (diagnostics).**

   We have identified a handful of incidents where onward referrals were not completed in a timely manner. These relate primarily to incidental findings on a

requested diagnostic e.g., MRI, that were not escalated within agreed timeframes stipulated within individual contracts. None of these have resulted in serious harm but have been significant near misses. There were multiple factors in each incident and all related to a combination of both Clinical and Administrative issues. As a result of these incidents changes have been made in the prioritisation of 'tasks' within our Electronic Patient Record (SystmOne) and in respect of the colleagues who administer these tasks. Through sustained corrective actions relating to these incidents, we have seen a significant decrease in this type of incident occurring over the last 18 months. Nevertheless, our aim should be to continue to reduce these leading to a complete eradication of this type of incident. as this is one of our largest patient safety risks. This will be monitored through the Patient Safety Incident Response Plan (PSIRP).

2. Timely identification of Significant Diagnoses

Much improvement work has been undertaken by Connect Health in the early identification of Significant Diagnoses. The most predominant of these is within our Musculoskeletal Services. This relates to the timely identification of Cauda Equina Syndrome (CES) and is due to the condition often presenting as back pain, which has several less serious causes and is likely to be progressive. Due to the urgency with which CES must be actioned, often by Surgical teams in secondary care, we have established a robust policy for identifying, escalating, and managing potential CES cases. Specific training is in place for all clinical colleagues at induction and throughout their tenures at Connect Health. Adherence to this policy is monitored through a regular Serious Diagnosis and Referral to ED Audit which is undertaken on an annual basis. Any incidents within this theme will be considered for further investigation as part of this PSIRP.

The organisation already has a robust framework for reducing the likelihood of high-risk patients entering the service. Our assessment and treatment of patients in this risk group is not appropriate as we are a community provider and as such not here to manage urgent or emergency conditions. All referrals are triaged by a senior clinician within 24-48 hours of receipt, depending on the service line. All self-referral MSK patients are taken through our online platform, which incorporates risk stratification, called PhysioNow. This will advise the patient to contact 111 if there are urgent concerns that would not be appropriate to be seen within our service.

3. Ensuring Clinical Notes Are Added to Patient Records in A Timely Manner.

We have identified an emerging theme in that, on occasions, patient notes following a consultation are sometimes not being documented in a timely enough fashion. While unlikely, this may have an impact on Patient Safety, if the clinical notes indicate an onward referral or action from a patient's GP this could delay this being undertaken. Connect Health, by policy, requires that clinicians ensure

that notes are added within 24 hours of a patient appointment but in most cases during the appointment itself.

Since this was identified as a theme in 2022, we have made significant improvements in this area and to support this the Clinical Records Documentation Policy has been reviewed to enhance our ability to identify any non-completed notes as early as possible. As previously stated, the main risk of these incidents is around a delay in an onward referral.

As part of risk management process there is mitigation in place which states that the clinician should take direct and immediate action should the outcome be urgent. This means that the action itself has been taken and the notes not being present is an administrative issue. There is a process within the Administration Team to ensure that this policy is followed up by the Clinical Delivery Leads and Operations Managers for each service. This incident type should continue to be monitored through the Patient Safety Incident Response plan. Evidence from all previous incidents we have investigated confirms that the patient safety risk is low. This is due to already implemented actions from previous incidents. Previously identified significant incidents, e.g., where several notes from one clinician have not been completed have not identified any significant patient harm and individual action has been taken with individual clinicians.

Local PSII Process

Connect Health has an existing list of Thematic Review Incidents which encompass key recurring incidents within the organisation. Most of these incidents impact primarily on patient experience rather than patient safety. For example, clinic cancellations, wrong text message information sent etc. We will continue to monitor all incidents and take actions, where appropriate, however given the current trend it is unlikely these will specifically fall into the remit of this framework. It must be remembered that this plan is fluid and will be continuously monitored as Patient Safety Essentials training is rolled out across the organisation.

A PSII will be declared where the criteria (listed above) are met as well as considering any similar PSIIs already being investigated and the area in which the incident occurred. This will ensure that PSII are selected for incidents occurring across the group as well as allowing actions from previous PSIIs to be implemented.

This approach will allow Connect Health to consider the safety issues that are common to similar types of incidents and, based on the risk and learning opportunities they present, demonstrate that these are:

- being explored and addressed as a priority in current PSII work or
- the subject of current improvement work that can be shown to result in progress or
- listed for PSII work to be scheduled in the future.

As part of this approach, incidents requiring other types of investigation and decision-making, which lie outside the scope of this work, will be appropriately referred as follows:

- professional conduct/competence – referred to the Clinical team/ People teams.
- establishing liability/avoidability – referred to claims or legal teams.
- cause of death – referred to the coroner's office.
- criminal - referred to the police.
- safeguarding concerns - raised to the local safeguard board with appropriate registration notifications being made.

In some cases where a PSII for system learning is not indicated, another response may be required. Options that meet the needs of the situation more appropriately should be considered.

Some patient safety incidents will not require PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers, or staff. Different investigation techniques can be adopted, depending on the intended aim, and required outcome. Connect Health will use the following investigation methods.

Technique	Method	Objective
Immediate safety actions	Incident recovery	To take urgent measures to address serious and imminent: ● discomfort, injury, or threat to life ● damage to equipment or the environment
'Duty of Candour/Being open' conversations	Open disclosure	To provide the opportunity for a verbal discussion with the affected patient, family, or carer about the incident (what happened) and to respond to any concerns.
Case recording/note review	Clinical documentation review	To determine whether there were any problems with the care provided to a client by a particular service. To routinely identify the prevalence of issues.
Structured Judgment Review for delays	Clinical documentation review	This approach will be used to assess delays in both thematic reviews and individual cases. It is based upon the principle that trained colleagues use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible. This potential bias needs to be considered when collating the report.
Debrief	Debriefing	To conduct a post-incident review as a team by discussing and answering a series of questions.
Safety huddle/Swarm	Briefing	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: ● improve situational awareness of safety concerns.

		● focus on the patients most at risk. ● Share understanding of the day's focus and priorities agree actions. ● enhance teamwork through communication and collaborative problem-solving. ● celebrate success in reducing harm.
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology.'
After action review	Team review	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses, and areas for improvement by understanding the expectations and perspectives of all those involved thereby capturing learning to share more widely.

Defining Our Patient Safety Improvement Profile

Connect Health has continuously reviewed and enhanced its governance processes to ensure it not only fully adopts but more importantly learns from patient safety incidents.

This feeds into our quality improvement activity and the Clinical Governance Framework. 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, define and refine the quality improvement work we must undertake.

Our Clinical Governance Committee (CGC) 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.

Our Clinical Delivery and Operational teams are required to report any ongoing themes and trends on a monthly/quarterly basis at a national and local level. This is underpinned by our Clinical Governance Framework. The CGC will also provide assurance during the development of new safety improvement plans, following reviews undertaken within the PSIRF, to ensure they are robust during their development and fulfil SMART objectives. Any plans must be sufficient to allow Connect Health to be assured about the improvement of patient safety both now and in the future.

We plan to focus our efforts going forward on the 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 where a risk or patient safety issue emerges from our own ongoing internal or external insights.

In line with the national PSII standards the following resources have been identified to enable delivery of the potential investigation programme, that is:

- national priorities:
    - Never Events
    - ‘Learning from Deaths’-related incidents (these are very unlikely to occur within Connect Health services)
    - unexpected incidents which signify an extreme level of risk for the patients, families and carers, staff, or organisations, and where the potential for learning and improvement is so great (within or across a healthcare service/pathway) that they warrant the use of additional resources to mount a comprehensive PSII response.
- identified local priorities.
- excluding incident types that are already part of an active improvement plan that is being monitored to determine efficacy and for which incremental improvement can be demonstrated.

Investigation Stages

The table below outlines the various stages of the investigation process and the resource required for each PSII. The exact resources required will depend on the specific incident, and therefore the resources stated are estimations. It also provides an indication on the differing resource requirements for the relevant staff groups. This should be reviewed in conjunction with the PSIRF policy.

Investigation Stage	Responsibility
1. Plan the Investigation	
• Appoint investigators who are trained, competent, have secure protected time and sufficient support. • Inform and engage with the patient/family and staff involved in agreeing scope.	• Integrated Governance Team • Clinical Team • Investigation Supervisor and/or Lead
2. Gather and map the information (WHAT Happened)	
• Identify the WHO, WHERE and WHEN of the incident. • Identify WHAT happened. • Map the incident timeline from the patient record, incident report and/or complaint letter. • Add further detail and achieve mutual understanding via meetings/interviews with the patient/family and staff involved	• Lead Investigator/ Investigation Supervisor
3. Identify Problems (HOW it happened and variations from what was expected to happen)	
• Identify and reference good practice requirements (work as imagined) • Identify the key problems arising	• Lead Investigator/ Investigation Supervisor /Subject Matter Expert
4. Analyse contributory and causal factors (WHY these key problems arose)	
• Observe and discuss how work is routinely done (work as done)	• Lead Investigator/ Investigation Supervisor

• Search for contributory and causal factors for each key problem (deep-seated reasons WHY)	
5. Write Investigation Report- with clarity, openness and in full consultation with patient/family and staff	
• Write investigation report	• Lead Investigator/ Investigation Supervisor
6. Develop Recommendations and Action Plan	
• Identify and develop strong systemic improvements (using human factor principles) • Develop an action plan. • Review effectiveness of actions/improvements in reducing or preventing repeat incidents	• Lead Investigator/ Investigation Supervisor • Integrated Governance Team • Clinical and Operations Team

Our Patient Safety Incident Response Plan: National Requirements

Due to the nature of our business currently it is unlikely that Connect Health will be involved in any Patient Safety Incidents as outlined in the national priorities.

Patient safety incident type	**Required response**	**Anticipated improvement route**
Incidents meeting the Never Events criteria	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
Safeguarding incidents in which: Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. Adults over 18 years old are in receipt of care and support needs from their local authority.	Refer to local authority Safeguarding Lead via CH (Connect Health) named Safeguarding Lead. Report to CQC as regulated. CH will contribute to respond and participate in domestic independent inquiries, joint targeted area inspections, child safeguarding practice	Respond to recommendations as required and feed actions into the Clinical Governance Committee

The incident relates to FGM (Female Genital Mutilation), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and the local safeguarding adults boards	

Our Patient Safety Incident Response Plan: Local Focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Delayed Serious Diagnosis	AAR/PSII Duty of Candour (as required)	Create local safety actions and feed these into the quality improvement strategy
Timely management of onward referrals (diagnostics)	AAR/PSII	Create local safety actions and feed these into the quality improvement strategy

Safety Improvement Plans

The type of response to a local PSII would depend on:

- the views of those affected, including clients and their families.
- capacity available to undertake a learning response.
- available resources to share the learning.
- what is known about the factors that lead to the incident(s)
- whether improvement work is underway to address the identified contributory factors
- whether there is evidence that improvement work is having the intended effect/benefit
- if Connect Health and its ICB's are satisfied, risks are being appropriately managed.

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. They can take different forms and may include:

- creating an organisation-wide safety improvement plan summarising improvement work
- creating individual safety improvement plans that focus on a specific service, incident type or situation.

- collectively reviewing output from PSII's of single incidents when it can be evidenced that there are underlying, interlinked system issues
- creating a safety improvement plan to tackle broad areas for improvement (i.e., overarching system issues).

Connect Health will decide upon the best approach to take as an outcome based on the available data following a PSII. This may be to follow a single plan or if complex be a mixture of the above and should be reviewed in conjunction with the PSIRF policy.