Patient Safety Incident Response Plan

1 April 2024 to 31 March 2025

Start Date	1 April 2024	**End Date**	31 March 2025
Approved by:	ICB Stakeholder Panel Clinical Quality and Effectiveness Group	**Responsible Executive**	Jon Ota, Director of Quality and People and Chief nurse
Ratified by:	Quality Committee	**Version**	2

Contents

Safety Starts with Me is about everyone's responsibility to learn from safety incidents and improve the safety of First Community for everyone that works here or uses our services.

Safety Starts with Me aligns with the National Patient Safety Strategy recognising the importance of improving safety across the whole system and giving *everyone* the skills and opportunity to improve patient safety.

Our Vision, the purple thread and speaking up… A letter from Emma Marcroft and Anita Lamb, Freedom to Speak up Guardians.

Dear Colleagues and members of our community

It is with great pleasure we introduce First Community's Patient Safety Incident Response Plan. As First Community's Freedom to Speak Up Guardians we are incredibly optimistic by this significant shift in how the NHS as a whole think about and responds to patient safety incidents. This plan sets out how we, at First Community, will learn from and respond to patient safety incidents reported by staff and people who use our services.

Rather than describing when and how we will investigate incidents, the focus is on learning, improvement and involvement of all of you. We will be flexible in our approach, consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected, therefore this plan can and may change as we learn and improve this approach.

Freedom to Speak Up is about a culture where people feel they can speak up about anything that gets in the way of good care and their voices will be heard, their suggestions acted upon. We know culture is complex and we continue to ensure speaking up is the norm, something we all do as routine to learn and improve. We strive to continue to develop and foster a restorative just culture in which everyone feels psychologically safe and a learning approach to incidents, which focuses on learning and not blame. 87% of you who responded to the NHS Staff Survey in 2023 said you felt secure to raise concerns about unsafe practice. This plan helps us continue on that journey to being an organisation that lives and breathes a safe culture in which people feel safe to speak up. It plays to our strengths of being employee owned and empowering clinically led continuous improvement and learning.

The foundations of this plan enable us to achieve our strategic plan and approach. The purple thread is clear as you can see on the next page.

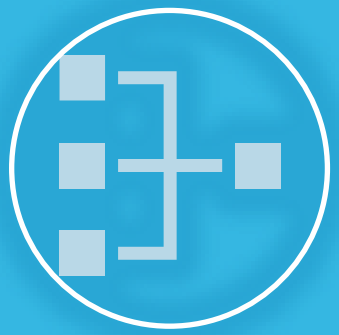
We are looking forward to the journey ahead with all of you.

Anita and Emma

Vision: To work in partnership with people living and working in our community to deliver outstanding lifelong local NHS healthcare, supporting everyone to achieve their potential

People

First Community will be a great place to work where people are psychologically safe to speak up and empowered to learn and improve. Everyones voice is heard and respected.



Performance

Our incident reporting system is fit for this plan's purpose and will help us to report on our progress. It enables self service for interrogation and analysis at team level.

Improvement and learning will deliver efficiencies.

Partnerships

Involvement of staff and people who use our services is at the heart of this approach.

Planet

We will learn and improve and include sustainability impact in our thinking and approach.

1. Our Services

Long Term Condition Services

- Community Neurological Rehabilitation
- Community Physiotherapy
- Falls Prevention
- Heart Failure Team
- Motor Neurone Disease (MND) and Rare Neurology Specialist Practitioner Service
- Multiple Sclerosis Nursing Service
- Parkinson's Specialist Practitioner
- Respiratory Service
- Early Supported Discharge and Neuro Rehab
- Continence Service

Primary Care Networks

- Care Home Advisors
- Community Matrons
- District Nursing
- Night Nursing
- Mental Health Nurse Advisors
- Tissue Viability Service
- End of Life Advisor

Children and Family Health Services

- 0-19 Health Visiting
- School Nursing
- Children's Physiotherapy
- Children's Occupational Therapy
- Children's Speech and Language Therapy
- Advice Line
- Speech and Language Therapy
- Immunisations
- Inclusion Health Team

Direct Access Therapies

- Audiology
- Dietetics
- Integrated Care and Assessment Treatment Service (ICATS)
- Orthotics
- Outpatient Physiotherapy
- Podiatry

Responsive Services

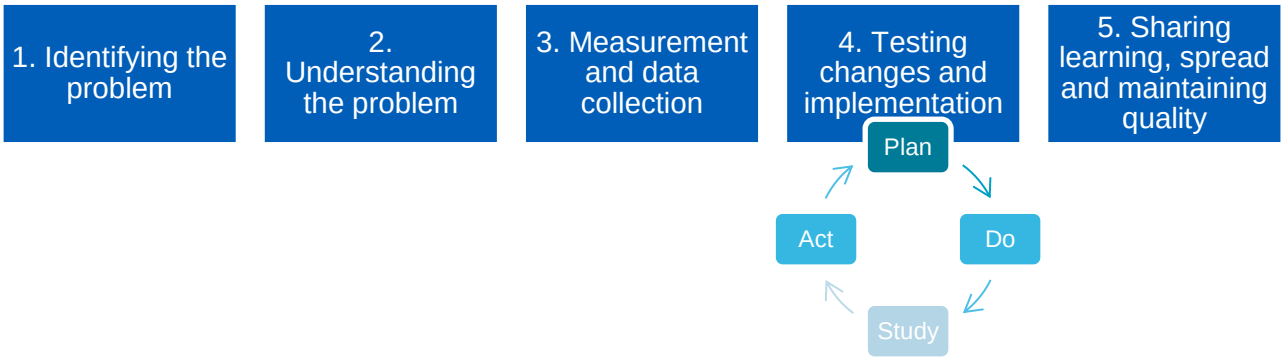
- Intermediate Care Team
- Urgent Community Response Service
- Integrated Discharge Team
- Virtual Ward

Bed Based Care Services

- 28 Community Intermediate care beds
- Minor Injury Unit
- Scheduled Wound Clinic

2. Focus on Improvement and Learning

Improvement and learning from patient safety incidents, including the locally defined priorities in section six, will address the five recognised stages to a Quality Improvement project as stated below.



Defining clusters of patient safety incidents and our patient safety incident profile, as detailed in this plan, has allowed us to identify and begin to understand the problem each patient safety incident issue.

First community will bring together safety learning responses and quality improvement tools to enable continuous learning and improvement. 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 adapted, adopted or abandoned.

It is important that others can learn from these pieces of improvement work to support more wide-spread learning and change. Learning will be shared at First Community's Clinical Quality and Effectiveness Group, through the QI Leaders Network, project reporting posters, storytelling using Sketch notes and First News and at First Community's annual Quality Improvement Day to maximise organisation-wide learning.

2.1 Using our Quality Improvement approach to deliver this plan

DEFINITIONS:

Patient Safety Incident Investigation (PSII): A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.
B1465-PSII-overview-v1-FINAL.pdf (england.nhs.uk)

Learning from Lives and Deaths: People with a Learning Disability and autistic people (LeDeR): A LeDeR review looks at key episodes of health and social care a person has received looking for areas that need improvement and where practice has been good.

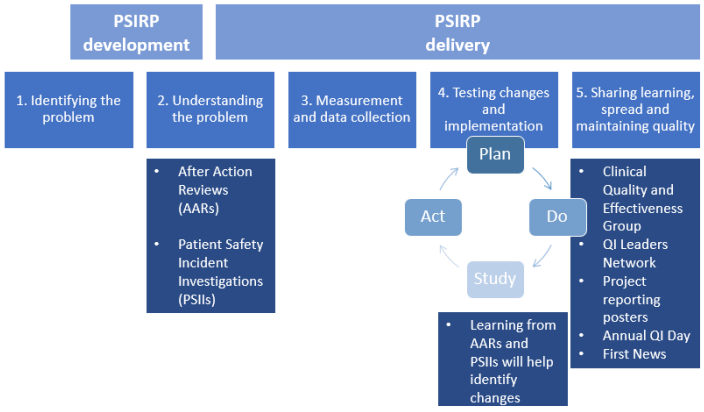
Post Infection Review (PIR): A review into the circumstances surrounding specific infections to find out improvements, learning and share good practice.

After Action Review (AAR): A method of evaluation to capture outcomes of an activity or event, aiming to capture learning and promote success for the future. learning-handbook-after-action-review.pdf (england.nhs.uk)
https://www.firstcommunityhealthcare.co.uk/system/files/library/GU_PSQ061a%20AAR%20Conductors%20Pack%20v1%20%28edit%29.pdf
https://www.firstcommunityhealthcare.co.uk/system/files?file=library/GU_PSQ061b%20AAR%20Information%20Pack%20v1%20%28edit%29.pdf

SWARM Huddle: Immediately after an incident, staff 'swarm' to the site to find out what happened, how it happened and decide on actions to reduce the risk of recurrence. B1465-Swarm-huddle-v1-FINAL.pdf (england.nhs.uk)
https://www.firstcommunityhealthcare.co.uk/system/files?file=library/GU_PSQ061e%20Swarm%20Huddle%20Tool%20v1%20%28edit%29.pdf

Multidisciplinary Team Review: An open discussion to identify key factors and gaps in patient safety incidents for which it is more difficult to collect staff recollections of events either because of the passage of time or staff availability or where there are multiple safety incidents. B1465-MDT-review-v1_FINAL.pdf (england.nhs.uk)
https://www.firstcommunityhealthcare.co.uk/system/files?file=library/GU_PSQ061c%20MDT%20Review%20Tool%20v1%20%28edit%29.pdf

The diagram below demonstrates how First Community's Patient Safety Responses and plan will be integrated into our quality improvement approach



3. Defining our Patient Safety incident and improvement profile

The patient safety incident risks for First Community have been profiled. This has been completed both at service level and at an organisational level. During the period 1 April 2021 to 31 March 2023 there have been five serious incidents, four of which were falls on our inpatient ward (one of which was subsequently downgraded) and one infection outbreak. We know that the most frequent reported incidents are falls, pressure ulcers and medicines. However, that does not mean these will provide the most learning and opportunity for improvement. To define our priorities, the patient safety and quality team met with every service to collaboratively review their data. This enabled an open conversation about risk and maximising resources to enable safety improvement and learning.

The following data sources for the previous 12 months has been used at service level and organisational level:

Incidents	Risks	Complaints and feedback	Quality Improvement and Clinical Audit	Involvement
• Data has been reviewed, including serious incident reports and learning. Further deep dives have been undertaken.	• Review of corporate risk register and triangulation with patient safety. • Review of service risk registers • Performance Report	• Themes and trends from formal, informal complaints and other sources of feedback and user involvement	• Outcomes and results triangulated with other data • Planned activity reviewed	• Staff survey results and involvement of staff at service level to analyse the information and have an open conversation about risks to patient safety.

As well as meetings with all clinical services in First Community the following stakeholders were involved:

- Adult Safeguarding Lead
- Accountable Director for Safeguarding Adult and Children
- Quality Improvement Lead
- Patient Safety Partner
- Clinical Governance Manager
- Freedom to Speak up Guardian
- Learning and Development Lead
- Head of People Services
- Lead Nurse for Patient Safety and Infection Prevention and Control
- Head of Medicines Management
- Council of Governors Representative

First Community acknowledges that our patient safety incident and improvement profile may change over time. Therefore, we have implemented processes to ensure that any emerging priorities are identified, at both a service level and an organisational level, to enable safety improvement and learning.

The following data sources will be used at service level and organisational level.

Healthwatch	Service level reviews	Performance reports	Safety huddle
• We will use healthwatch reports to scope patient safety priorities. • This will help to ensure we capture what matters most to those who use our services.	• Services regularly review the data detailed above to identify any emerging safety priorities. • At least every 6 months each service completes a detailed review of their - incidents - complaints and feedback - quality improvement and clinical audit	• Contractual requirements and performance data and intelligence is reviewed monthly and quarterly, • This will be used to inform safety priorities.	• The safety huddle is responsible for identifying any themes and emergent issues in relation to patient safety matters that should be added to our priorities. • These will be taken forward by either quality improvement, safety investigation or included in this plan.

First Community's Quality Committee (Board oversight of Quality) and Clinical Quality and Effectiveness Group (Operational oversight of quality reporting to Quality Committee) delegated authority for the implementation of PSIRF and development of this plan and First Community's Patient Safety Incident Response Policy to a PSIRF Implementation Group that met monthly from February 2023. This group included First Community's Patient Safety Partner as a core member to champion the patient voice in the development of the plan. The membership of this group can be seen in the diagram below:

First Community is committed to clinically led continuous improvement and has embedded annual quality improvement planning which plans improvement activity annually. The governance and reporting framework for quality improvement ensures learning is shared and that improvement is made and sustained. Plans are flexible and are informed by listening and involvement of those who use or services to enable in year modification to respond to arising risks, feedback and incidents.

Planned improvement for the period 1 April 2024 to 31 March 2025 includes the following work that impacts on safety learning and improvement:

Annual Infection Prevention and Control Workplan, with a project to improve hand hygiene

Evaluation of physiotherapist led moving and handling practical sessions on the ward

Reintroduction of volunteers on the ward

Reviewing the impact of integrated clinics between the Integrated Clinical Assessment and Treatment Service (ICATS) and musculoskeletal (MSK) physiotherapy

Work to improve the flu delivery schedule

Audit of the lower limb pathway, contributing to learning and improvement

4. Our patient safety incident response plan: national requirements

Below is a list of patient safety incidents that will be responded to according to national requirements. There will be responses that First Community will lead or be part of involving other partner organisations. Where this is the case First Community will be responsible for the governance around their own actions only. It must be clear in terms of reference or ground rules that each organisation is responsible for implementation and governance of actions. Any actions identified to be enacted by another provider or stakeholder must be discussed with the relevant provider / stakeholder and / or commissioner.

Surrey Heartlands ICB can be involved to maintain oversight depending on the nature of learning and stakeholders involved.

Leading a multi-provider response may be overseen by Surrey Heartlands ICB depending on the nature of learning and stakeholders involved. First Community will alert Surrey Heartlands ICB in the event of a multi-provider learning response, as appropriate.

Patient safety incident type	**Required response**	**Anticipated improvement route**
Incidents meeting the Never Events criteria	PSII	Clinical Quality and Effectiveness Group
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	Mortality Review Group
Death of a person with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS.	PSII LeDeR Review	Mortality Review Group

Incidents with Safeguarding Responsibilities where a concern of abuse or neglect has been identified.	As per safeguarding requirements	Safeguarding Group
Infections Prevention and Control Outbreak Notification of Infectious Disease	PIR PSII AAR	Infection Prevention and Control Group

5. Our patient safety incident response plan: local focus

First Community have determined our local focus based on stakeholder engagement and findings of our local mapping and profiling. Below is a list of patient safety incidents that will be responded to for learning and improvement:

Patient safety incident type or issue	Planned response	Anticipated improvement route
Caterham Dene Ward - Falls Group	AAR Multidisciplinary Team Review	Inform ongoing improvement efforts
Primary Care Networks - Safer administration of insulin	Multidisciplinary Team Review AAR	Build case for improvement plan and then inform ongoing improvement efforts
Other incidents which have resulted in moderate to severe harm, a near miss, or where there is potential for wider learning	Duty of Candour AAR PSII	Create local safety improvement actions and feed this into Clinical Quality and Effectiveness Group
Caterham Dene Ward - Administration of PRN (as required) controlled drugs	Multidisciplinary Team Review AAR	Build case for improvement plan and inform ongoing improvement efforts
Intermediate Care Team – People who fall in their own homes	Multidisciplinary Team Review	Build case for improvement plan and

	AAR	then inform ongoing improvement efforts
Clusters of incidents	Multidisciplinary Team Review	Build case for improvement plan and then inform ongoing improvement efforts
Good or positive care or event	Multidisciplinary Team Review AAR	Build case for improvement plan and inform ongoing improvement efforts
Cross System or multi organisation patient safety incidents	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.	

A detailed explanation of the various learning response methods available to us can be found in Appendix A.

5. APPENDIX A Learning Response Methods Available

Response Method	Description	When to use	Who can lead this	Who should be involved	Time taken to complete
After Action Review (AAR)	An after-action review (AAR) is a structured approach for reflection and identifying strengths, weaknesses and areas for improvement. It is a facilitated discussion following an event or activity to enable understanding of the expectations and perspectives of all those involved. AAR is recommended as a key tool to bring about learning and improvement in the Patient Safety Incident Response Framework (PSIRF).	First Community have chosen AAR as the main model to learn from incident responses, learning from excellence and other improvement work. An AAR can be used after any activity or event that has been particularly successful or unsuccessful.	Any trained "conductor"	This is identified as part of each AAR. Can be those involved, others involved in the process and multidisciplinary team and service users.	Between 45 and 90 minutes then time to write up the AAR.
Multidisciplinary Team Review (MDT Review)	A multidisciplinary (MDT) review is a structured approach for reflection and identifying learning from multiple patient safety incidents or a safety theme. It is a facilitated discussion to enable insights into 'work as done' from all those involved and contributes to the	An MDT review can be used after when there are multiple, similar incidents or to explore a safety theme, pathway or process e.g. admission or discharge related safety events.	Usually someone who has completed training provided by First Community and / or SEIPS.	The stakeholders whose insights on 'work as done'. This list will depend on the incident or safety theme being explored. It should include clinical and non-clinical staff who work in the care setting or pathway to which you are applying the tool.	Each MDT review is different. Likely to be 2-3 hours and be run as a workshop type event.

Response Method	Description	When to use	Who can lead this	Who should be involved	Time taken to complete
	"understanding the problem" step of Quality Improvement projects. MDT reviews are recommended as a key tool to bring about learning and improvement in the Patient Safety Incident Response Framework (PSIRF). NHS England » Patient safety learning response toolkit				
Patient Safety Incident Investigation (PSII)	A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to	When an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation.	A Learning Response Lead. This is a member of staff who has completed the relevant training and is competent to undertake a PSII. A lead will be nominated by the Safety Huddle.	The investigation team should be formed based on factors including availability, systems-focused safety investigation knowledge and interests.	Up to 80 hours (not all at the same time) and will take a number of weeks to complete.

Response Method	Description	When to use	Who can lead this	Who should be involved	Time taken to complete
	understand why an action and/or decision was deemed appropriate by those involved at the time.				
Swarm huddle	A swarm huddle is a post-incident huddle which explores what happened and how it happened in the context of how care was being delivered in the real world (ie work as done) to allow us to learn and improve. Swarm huddles are recommended as a key tool to bring about learning and improvement in the Patient Safety Incident Response Framework (PSIRF). NHS England » Patient safety learning response toolkit	A swarm huddle takes place as soon as possible after a patient safety incident occurs allowing safety actions to be implemented immediately.	Usually someone who has completed training provided by First Community and / or SEIPS.	Those directly involved in these events. Can also include others involved in the process and multidisciplinary team and service users.	Up to 30 minutes and then time to write up learning.

6. APPENDIX B Version Control Sheet

Version	Date	Author	Status	Comment
0.1	18/07/2023	Emma Marcroft Head of Patient Safety and Quality	DRAFT	Sent for consultation to PSIRF Implementation Group Members and Surrey Heartlands ICB.
0.2	28/07/2023	Emma Marcroft Head of Patient Safety and Quality	DRAFT	Amended from consultation feedback and version sent to Quality Committee.
0.3	10/08/2023	Emma Marcroft Head of Patient Safety and Quality	DRAFT	Minor updates to service list and formatting. Approval given from Quality committee to submit to ICB led Stakeholder panel.
0.4	15/08/2023	Emma Marcroft Head of Patient Safety and Quality	DRAFT	Content page updated to correct section numbers and improvement added to section 3 title.
0.5	08/09/2023	Emma Marcroft Head of Patient Safety and Quality	DRAFT	Changes made following ICB panel
1	12/09/2023	Emma Marcroft Head of Patient Safety and Quality	FINAL	Final version
1.1	10/01/2024	Emma Marcroft Head of Patient Safety and Quality Stephanie Teatherton, Quality Improvement Lead	Draft	Changes made
1.2	29/01/2024	Emma Marcroft Head of Patient Safety and Quality Michelle Barnard Quality Lead Surrey Heartlands ICB		Changes made to section 4 to reflect ICB and governance of multi stakeholder learning responses. Submitted to CQE and Quality Committee for approval and ratification.
2	27/03/2023	Emma Marcroft Head of Patient Safety and Quality Stephanie Teatherton, Quality Improvement Lead		Staff survey results updated for 2023 and quality improvement plans in section 3 amended to reflect work for 2024 / 25