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Patient safety incident response plan

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Introduction

This patient safety incident response plan sets out how DHU Health Care CIC intends to respond to patient safety incidents between 01/09/2023 to 31/12/2024. 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.

This plan should be read alongside the Patient Safety Incident Response Framework (PSIRF) 2022 and the DHU Incident Reporting and Investigation procedure in the Business Management section on Teamnet (DHU Intranet).

Our services

DHU Health Care are a 'not-for-profit' community interest company which delivers a diverse range of services to the NHS frontline, including urgent and emergency care, primary care, out of hours services and the NHS 111 service. Operating 365 days a year, 24 hours a day we cover a population of almost ten million people.

We deliver services in Derbyshire; Northamptonshire; Nottinghamshire; Leicester, Leicestershire & Rutland; Lincolnshire, Milton Keynes and the West Midlands. Working in collaboration with partners and colleagues across NHS systems, GP federations and other private provider companies, we offer innovative, integrated solutions that ensure all our patients and communities can access the right care, in the right place, at the right time.

As part of the NHS frontline, we lead urgent care within Emergency Departments, Urgent Treatment Centres, GP and Primary Care Surgeries and out in our communities. We offer a full range of both 'in and out of hours' clinical specialist services, provided by a diverse workforce made up of medical, nursing, allied health and support teams.

Our business offer includes community nursing, urgent treatment, primary care streaming, urgent on-day primary care, GP home visiting, phlebotomy, community hospital medical cover, telephone consultation support, weekend palliative care home visiting. Other services to support urgent care include Emergency Department (ED) validation, virtual wards and winter hubs. We've supported the national COVID-19 incident response by operating testing and vaccination programmes, as well as delivering home oximetry monitoring for patients receiving out of hospital treatment for COVID-19. We have also been providing nMAB services which are community access to Neutralising Monoclonal Antibodies and Oral Antivirals for Covid-19 Treatment.

We are equally at the heart of the national NHS111 first service – responding to 2.4 million calls a year (2021/22) from centres in Derby, Chesterfield, Leicester and most recently Oldbury. We also continue to support the London Ambulance Service with non-urgent calls. To support this provision across a large geographical area, DHU 111 employs: Health Advisers, Clinical Advisers, Pharmacists, Paramedics and Dental Nurses.

Defining our patient safety incident profile

A review of patient safety incidents (PSIs) reported between 01/07/2020 and 31/01/2023 have been analysed to identify learning themes. It is important to note this data includes patient safety incidents identified via several sources including formal patient complaints, clinical negligence claims and health care professional feedback.

Incident categories were ranked by total PSIs and number of PSIs where the harm was moderate or above. These rankings were combined to identify the top 10 patient safety incidents categories, and these are summarized below.

Incident Type	Specific categories (where applicable)
Delayed care of patients presenting with sepsis	• Delayed referral to emergency department • Missed opportunities for an ambulance response
Delayed care / missed diagnosis when patients present with abdominal pain	• Delayed referral to acute services - emergency department / surgical assessment unit • Missed opportunities for an ambulance response

Delayed care / missed diagnosis of pregnancy related conditions	• Delayed treatment / onward referral for –
	  ○ Ectopic pregnancies
	  ○ Miscarriages
	  ○ Pre/ postnatal infections
	  ○ Pre-eclampsia

Delayed care / missed diagnosis of cardiac condition when patients present with atypical chest pain	• Delayed referral to emergency department • Missed opportunities for an ambulance response
Delayed care / missed diagnosis when patients present with stroke symptoms	• Delayed referral to emergency department • Missed opportunities for an ambulance response
Delays in patient care	• Delays in clinical call backs • Delayed access to urgent care services – home visits, urgent care centres

Incorrect patient outcomes resulting in potential clinical negligence claims	• Inappropriate patient outcomes in relation to the symptoms the patient was presenting with at the time • Referral to inappropriate services in relation to the symptoms the patient was presenting with at the time
Communication issues resulting in a delay in patient care	• Inappropriate patient outcomes due to communication breakdowns / misinterpretation • Booking errors as a result of human error / issues with the Directory of services
IT issues	• Potential delayed care due to IT and telephone issues
Information Governance potential breach of data protection and GDPR regulations	• Emails containing patient information sent to non secure email addresses • Referrals sent to the incorrect services • Patient Demographic Searches (PDS) not being completed correctly resulting in patient records being sent to the wrong GP practices

Stakeholder Engagement

Consultation on the DHU's Patient Safety Incident Response Plan (PSIRP) has been undertaken internally via the Clinical Governance framework. The PSIRP has been disseminated and discussed within the DHU 111 and Urgent & Emergency Care (UEC) Clinical Governance and Risk Committee which is chaired by the Clinical Directors. It has also been discussed at the Clinical Quality and Patient Safety meeting chaired by the Medical Directors. These clinical governance meetings feed into the DHU Clinical Governance Oversight Committee (CGOC). The CGOC, reports into the Board and the PSIRP therefore will have final approval from the Board of Directors. The PSIRP has also been discussed within the Clinical Leaders forum.

External consultation has also been undertaken with the Integrated Care Board (ICB) Quality Leads for Derbyshire, Leicestershire, Northamptonshire, Nottinghamshire and Lincolnshire in January 2023.

The Corporate Head of Clinical Governance is also a member of the LLR & Derbyshire PSIRF Operational Groups. She has also attended the Milton Keynes

Patient engagement has been sought through DHU's Patient & Public Involvement (PPI) committee.

An annual programme of Patient Safety Walkrounds is in place to ask the frontline staff, to identify any concerns and improvements required for patient safety. Frontline staff are encouraged at these walk rounds to report patient safety concerns.

A measure of patient safety culture is also taken through the annual DHU People (staff) Survey. In 2021, DHU adopted the version used by the NHS - one of the largest workforce surveys in the world, which has been conducted every year since 2003. It enables organisations to compare results, seek out good practice and set out improvement actions.

Taking these into account DHU are able to assess if it is developing a positive safety culture that works across individuals, teams, patients, families, carers, and partners – and ensures safe care is enabled by continuous learning and reducing safety risks.

A staff communication plan will be put into place between April 2023 and September 2023 to ensure their understanding of the patient safety incident response plan.

Defining our patient safety improvement profile

DHU has a number of patient safety related improvement delivery plans currently being implemented. These are listed below.

- Piloting of a innovative software solution that has been shown to improve productivity, patient safety and improved patient experience (planned for mid 2023)
- Review of skill mix in clinical service delivery
- Improved education and training programme for telephone triage for nurses / clinicians
- Patient Safety Walkrounds - An annual programme of walkrounds to DHU sites is in place. This will follow a set format, asking the frontline staff, to identify any concerns and improvements required for patient safety. Action plans following Patient Safety walk rounds will be discussed at the bimonthly Clinical Quality & Patient Safety and the DHU 111 and UEC Clinical Governance committees.
- The Infection Prevention and Control (IPC) Strategy.
- Sepsis programme of work, monitored through monthly meetings, that ensures a standardised approach across the organisation to review sepsis pathways, latest evidence, training and development sessions for staff, incidents/complaints and ways to promoted awareness of sepsis
- Using a number of different patient experience solutions not previously used to gather more patient feedback which will help improve the understanding of patient satisfaction and safety concerns.

Quality and Continuous improvement is monitored through the audit process.

DHU has an annual audit programme which includes:

- Royal College of GP (RCGP) audits - Clinician consultations (telephone and face to face) are reviewed against set criteria. Feedback is given to the the clinicians and they receive copies of their audit results, which are discussed in their annual appraisal.
- NHS Pathways audits – All staff are audited using the standard audit tool that marks calls as an overall percentage; the audit pass mark is 86%. The calls are marked on 8 separate criteria.
- Health & Safety Audits and site visits
- Infection Prevention - compliance with hand hygiene standards; assess the environment against infection control standards; assess kitchen area against infection control standards; assess disposal of waste against guidance; assess spillages; assess use of personal protective equipment (PPE); assess prevention of sharps injuries or injuries from bodily fluids; assess decontamination processes
- Antimicrobial audits – to monitor prescribing in accordance the antimicrobial guidelines and prescribing of of broad spectrum antibiotics, determining whether there is a deviation from these set guidelines
- Safeguarding
- Information governance audits
- Internal Organisation for Standardisation (ISO) – to ensure the standardisation of systems and processes for which we have achieved accreditation for 9001 (quality) and 27001 (IG) an 22301 (Business continuity)
- Training plans and changes to processes in response to incident investigations
- Patient Satisfaction surveys to obtain feedback from patients on their experience to provide opportunities for improvement

Our patient safety incident response plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
Unexpected deaths thought to be due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)	PSII	Develop any immediate safety actions and monitor delivery via the clinical governance process. PSII action plans to be reviewed within the DHU 111 and Urgent Care Clinical Governance and Risk Committee. Any concerns will be escalated to the Clinical Governance oversight committee.
Child deaths	Refer for Child Death Overview Panel review PSII (or other response) may be required alongside the panel review	Liaise with the Child Death Overview Panel review PSII action plans to be reviewed within the DHU 111 and Urgent Care Clinical Governance and Risk Committee
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	Refer to local authority safeguarding lead PSII (or other response) contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required	Liaise with the local safeguarding partnership (for children) and local safeguarding adults boards PSII action plans to be reviewed within the DHU 111 and Urgent Care Clinical Governance and Risk Committee

Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) PSII (or other response) may be required alongside the LeDeR	Liaise with the Learning Disability Mortality review PSII action plans to be reviewed within the DHU 111 and Urgent Care Clinical Governance and Risk Committee
Domestic homicide	Identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case PSII (or other response) as required	Liaise with the community safety partnership (CSP) PSII action plans to be reviewed within the DHU 111 and Urgent Care Clinical Governance and Risk Committee
Incidents meeting the Never Events criteria 2018, or its replacement.	PSII	It is unlikely that DHU will be involved in a Never Event. Refer to the DHU Incident Reporting and Investigation procedure

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Delayed care of patients presenting with sepsis	Learning response- Patient Safety Incident Investigation (PSII) A minimum of 3 PSIIs will be undertaken followed by a thematic review	Develop local safety actions following investigation. Learning to be shared via ; staff newsletters / memos, 'hot topics' and educational evenings / events social media platforms Patient feedback website Learning to be shared and monitored via DHU 111 and Urgent Care Clinical Governance and Risk Committees. Thematic analysis to be shared with NHS Pathways for future development and improvements to be considered. ISO 9001 audit - review adherence to process Audits against Sepsis tool within Adastra (electronic patient record system) will show an increased level of compliance
Delayed care / missed diagnosis when patients present with abdominal pain	Learning response- Patient Safety Incident Investigation (PSII) A minimum of 3 PSIIs will be undertaken followed by a thematic review	Develop local safety actions following investigation. Learning to be shared via ; staff newsletters / memos, 'hot topics' and educational evenings / events social media platforms Patient feedback website Learning to be shared and monitored via DHU 111 and Urgent Care Clinical Governance and Risk Committees. Thematic analysis to be shared with NHS Pathways for future

		development and improvements to be considered. ISO 9001 audit - review adherence to process
Delayed care / missed diagnosis of pregnancy related conditions	<u>Learning response</u>- Patient Safety Incident Investigation (PSII) A minimum of 3 PSIIs will be undertaken followed by a thematic review	Develop local safety actions following investigation. Learning to be shared via ; staff newsletters / memos, 'hot topics' and educational evenings / events Develop patient pathways for managing pregnancy related conditions in line with hospital Trust policies Learning to be shared and monitored via DHU 111 and Urgent Care Clinical Governance and Risk Committees. Thematic analysis to be shared with NHS Pathways for future development and improvements to be considered. ISO 9001 audit - review adherence to process
Delayed care / missed diagnosis of cardiac condition when patients present with atypical chest pain	Plan for 5 clinical reviews to determine and describe how the care provided compared with accepted standards and identify key common factors	Develop local safety actions following investigation. Learning to be shared via ; staff newsletters / memos, internal comms, 'hot topics' and educational evenings / events, social media platforms Patient feedback website Learning to be shared and monitored via DHU 111 and Urgent Care Clinical Governance and Risk Committees. ISO 9001 audit - review adherence to process
Delayed care / missed diagnosis when patients present with stroke symptoms	Plan for 5 clinical reviews to determine and describe how the care provided compared	Develop local safety actions following investigation.

	with accepted standards and identify key common factors	Learning to be shared via ; staff newsletters / memos, 'hot topics' and educational evenings / events Learning to be shared and monitored via DHU 111 and Urgent Care Clinical Governance and Risk Committees. ISO 9001 audit - review adherence to process
Delays in patient care due to system / service pressures	A minimum of 5 Multidisciplinary team reviews to agree the key contributory factors and system gaps that impact on safe patient care.	Learning to be shared and monitored via DHU 111 and Urgent & Emergency Care operational meetings, Clinical Governance and Risk Committees and Clinical Leaders meetings ISO 9001 audit - review adherence to process

Engaging and involving patients, families and staff following a patient safety incident

DHU has adopted processes to align with the Patient Safety Incident Response Framework (PSIRF) expectations and PSII standards. This includes ensuring that patients and / or carers receive an appropriate explanation and apology if they have been harmed or experienced trauma. They are entitled to know what lessons have been learned to avoid a similar incident happening again.

Effective communication with patients begins at the start of their care and must continue throughout their time with DHU. Reporting of Patient Safety Incidents involves apologising to patients and/or their carers (subject to consent if appropriate) who have been harmed as a result of contact with DHU and explaining to them what has happened.

DHU will also follow the NHS England principles on Implementing Duty of Candour. We will contact patients / their family / carers in the event of an incident, resulting in moderate harm, severe harm or death as soon as possible, on becoming aware of the incident, to offer an apology.

Communication will be open and honest and must take place as soon after the incident as possible. However due to the nature of the healthcare provided in the out of hours setting, the harm is most often only identified once the patient has left our care.

Named contacts for patients, families and carers:

The initial duty of candour conversation will take place with the Medical / Clinical Director and the patient / their family / carers, as soon as practical.

An open conversation and apology will be given. The patient / their family / carers will be informed that an investigation will take place and they will have the opportunity to express any concerns or areas they wish to be investigated. The patient / their family will be offered a copy of the investigation report and will be advised of timescales and that the incident may form part of a wider themed analysis.

In the case of an unexpected death, an ethical decision will be made by the Clinical / Medical Director and a judgement on the appropriate time to share information taking into account the effect of the information on the grieving family / carers.

Following the initial discussion, with the Medical / Clinical Director, patient / their family, will be provided with a written apology.

The Corporate Head / Heads of Clinical Governance will be the named contacts, for any further queries or support. She will keep the patient / their family / carers updated on the progress of the investigation.

The comments / complaints leaflet will be provided to the patient / their family / carers so that they are provided with the contact details for the clinical governance department, should the Corporate Head / Head of Clinical Governance be unavailable.

The leaflet will also outline the procedure, should they want to raise a complaint regarding their care. It also details advocacy services and support.

The patient / their family / carers will be informed when the investigation has been completed and the investigation report will be shared with them should they wish to receive a copy. A meeting will be arranged to discuss the report with them, should they require any further explanation or have any queries to address.

Procedures to support staff affected by PSIs

Staff involved in patient safety incidents receive ongoing support from their line managers, throughout the investigation process. The comments and views of staff involved in the incident will be included in the patient safety investigation. All staff have regular 1:1 meetings with their line managers, where incidents are reflected on, including discussions on their wellbeing and whether any additional support can be provided. Staff have access to and are directed to the Westfield Health counselling and support services. Clinical supervision sessions are available to clinical staff and Reflective supervision sessions are available to non-clinical staff. DHU has also provided mental health awareness training and staff have access to Mental Health First aiders amongst their peers.

Should a patient safety incident result in a negligence claim or inquest the clinical governance department will ensure that legal representation is provided, as appropriate.