Spectrum Community Care CiC

Patient Safety Incident Response Plan

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Foreword

Ensuring the safety and well-being of every patient and service user is the basis of any healthcare system, and it is with pleasure that I present this Patient Safety Incident Response Plan.

In today's rapidly advancing healthcare landscape, our commitment to patient safety remains consistent. This is driven by the collective efforts of compassionate professionals to provide healthcare services to people in vulnerable circumstances.

This Patient Safety Incident Response Plan reflects the expectation of our healthcare organisation to continuously improve our practices, prevent harm, and enhance patient outcomes. Our Plan recognises that safety is not a solitary endeavour, but a collective responsibility shared by every member of our staff which supports our ambition to deliver excellence in care.

Through a comprehensive review of patient/user experiences, we have developed an understanding of our patient safety profile and areas of good practice that requires enhancing and areas that we need to improve. We recognise that to improve outcomes for those impacted by patient safety incidents, we need to provide our staff with the environment, skills, and confidence to identify and implement areas of learning.

At Spectrum, we are passionate about the services we provide and strive to provide quality healthcare that makes a difference to people’s lives. We recognise that to improve outcomes for patients and families, there is a need to focus on collaboration, involvement, openness, and transparency with those affected by patient safety incidents. This is a priority for the first year of the response planning process.

This document outlines how we will respond proportionately to patient safety incidents and ensure our resources are used in the best way possible, enabling the focus to be on the delivery of change.

I would like to thank every member of staff whose commitment and dedication support the wellbeing and delivery of safe care to those patients we provide services to.

Angela Star

Executive Director of Nursing and Quality

Introduction

This patient safety incident response plan sets out how Spectrum Community Health CiC 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 circumstance in which patient safety issues and incidents occurred and the needs of those affected.

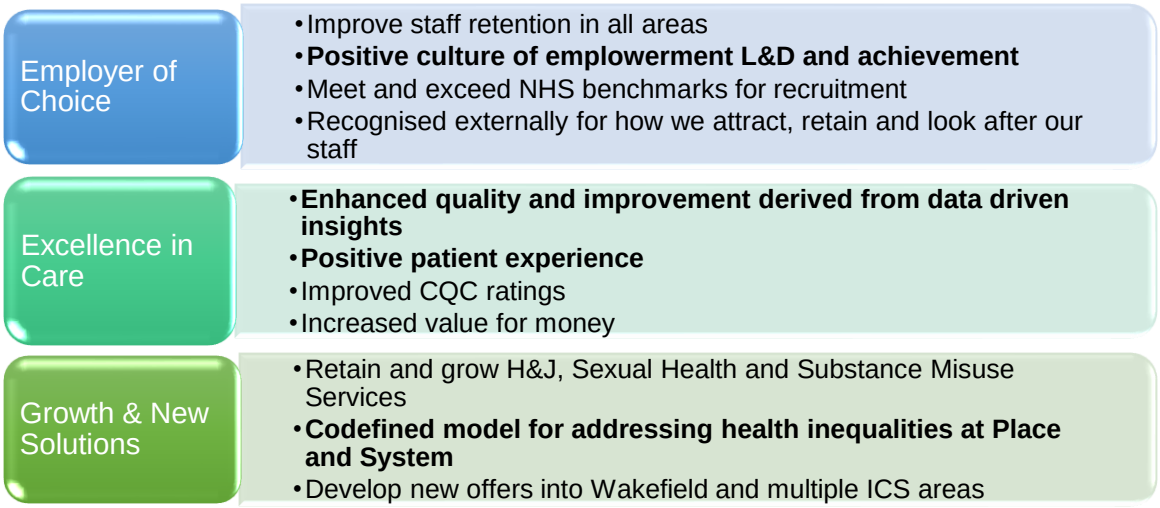
The plan sets out how Spectrum Community Health CiC will seek to learn from patient safety incidents reported by staff, patients, patient's families and carers and our partners to ensure we continually learn and improve the quality and safety of care we provide.

The Patient Safety Incident Response Framework (PSIRF) outlines how organisations should respond to patient safety incidents for the purpose of learning and improvement. PSIRF is centred around compassionate involvement and engagement with those affected by an incident by using a systems-based approach. This supports the identification of areas of learning and improvement with an emphasis on having a just learning culture to promote continuous improvement.

The underpinning principles of PSIRF are to:

- recognise a proportionate approach to responding when incidents occur,
- utilise a data-driven approach which prioritises engagement with those affected,
- to embed a system view of learning that considers every aspect of how healthcare services are delivered when incidents are identified.

Our Patient Safety Response Plan is one element of delivering the overall vision for Spectrum Community Health CiC by delivering quality healthcare that makes a difference to people lives, regardless of circumstances. This plan aligns to our strategic ambitions of:



Our Services

We work in partnership to provide primary care, substance misuse, sexual health services in the community and in secure environments including prisons, hospitals and immigration services.

Health and Justice Services

We provide healthcare services in a range of settings which come together as Health and Justice Services (H&J). We make sure everyone has access to the healthcare they need, in any circumstances, as they would in the community.

This includes secure environments (prisons, secure hospital units and immigration removal centres), as well as supporting people in police custody. Our H&J services also include a highly regarded, independent Death in Custody Review Service which supports His Majesty's Prison and Probation Service (HMPPS) to meet the statutory requirements to investigate every death in custody which takes place within prisons. The service undertakes the clinical review part of the investigation which is directly commissioned by NHS England.

Across our secure environments, we work in partnership to provide comprehensive primary care services, including nursing and GPs, sexual health, substance misuse, pharmacy, podiatry, physiotherapy, optometry, and mental health. We look after our patients physical and mental health, providing on-site healthcare wherever possible, and arranging for external healthcare when required. We also support our patients to continue accessing the right healthcare services when they return to the community.

Community Services including:

Primary Care

Primary Care is an important element of our Spectrum service portfolio. Many of our service users need support in the community with a range of health and social issues. A number of our service users come within the NHS Core20PLUS5, a national NHS framework which identifies those who need the most support in order to reduce healthcare inequalities. Working in community based Primary Care is an important part of our service framework and fits perfectly with our vision and mission.

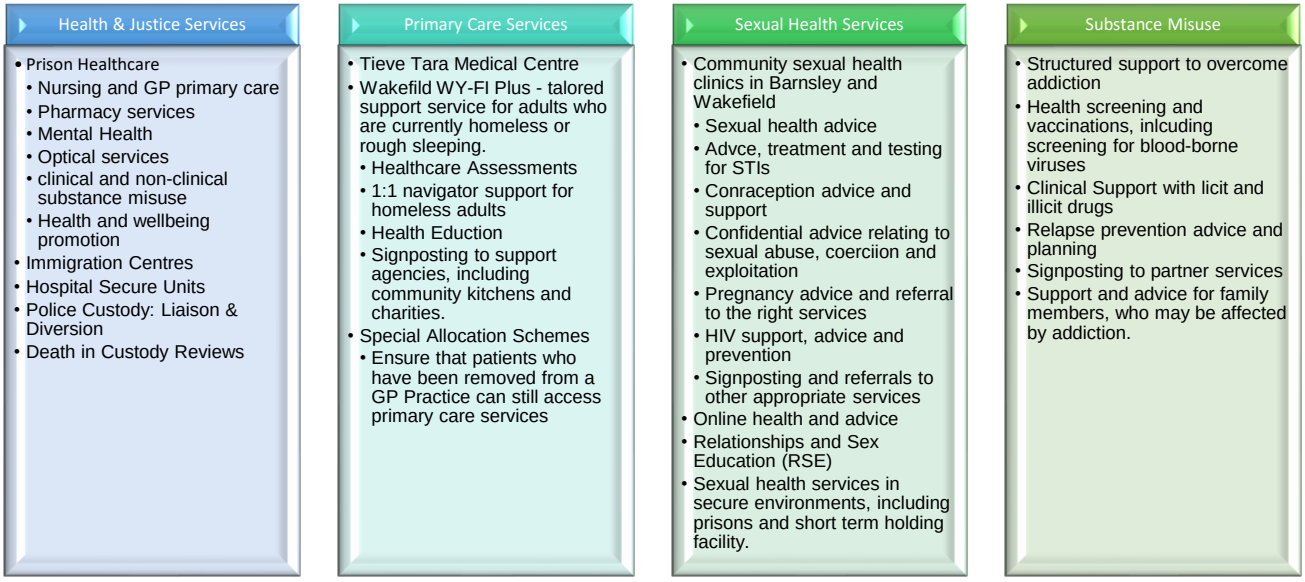
Sexual Health

We provide integrated sexual health services that offer advice, support and treatment on a range of matters, including contraception, pregnancy, sexually transmitted infections (STIs), HIV and more. Our service users reflect our diverse population, including people of all ages, gender, and ethnic backgrounds.

Substance Misuse

Spectrum are sub-contracted to provide the clinical elements of the comprehensive community substance misuse services help to support people to live addiction free lives. We work with each person to develop a personal recovery plan built around their individual circumstances and needs. We also aim to reduce the harm caused by addiction to individuals, families, and communities.

These services are delivered in partnership, with multi-disciplinary teams and other health organisations. We provide clinical expertise, wellbeing focus and outreach provision and have clinics across County Durham, South Tyneside, York and North Yorkshire. We also support patients with substance misuse in secure environments (e.g. prisons).



Core patient safety activities undertaken within Spectrum Community Care CiC include:

- Patient Safety Strategy 2022-2025
- Patient Safety Culture through a robust ward to board clinical governance framework, monitoring of patient safety performance processes and associated data, clinical effectiveness and quality improvement activity.
- Patient Safety Incident Response Framework
- Working with people with lived experience including the inclusion of patient stories as part of the governance and quality improvement agenda.
- Risk management
- Supporting improvement programmes
- Providing a range of patient safety training – mandatory, statutory, and organisational
- Compliance with Duty of Candour (professional and statutory)
- Involving patients and families
- Implementing actions in response to patient safety incidents and monitoring of action completion and evidence through patient safety action group (part of clinical governance framework)
- Implementing actions in response to patient safety alerts
- 10 @ 10 multidisciplinary patient safety event meetings that support the swift identification of reported safety incidents/events and early recognition of trends/themes
- Service level safety huddles.

Other activities within the organisation that provide insights to patient safety include:

- Prison and Probation Ombudsmen reports (learning from deaths)
- Clinical Reviews
- Freedom to Speak Up
- Complaints, Concerns, compliments and other patient, carer or partner feedback.

Defining our patient safety incident profile

The organisation has a commitment to continuous learning from patient safety events and have developed our understanding and insights into patient safety issues over a period of time. We have a monthly organisational Patient Safety Action Group Committee and a monthly executive led Quality Assurance and Patient Safety Committee for additional oversight.

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on p9 below.

To fully implement PSIRF we have completed a review of what types of patient safety incidents occur to understand what needs to be learned from to improve. We examined the patient safety incident records and data for the previous 18-month period from all service areas of the organisation including data relating to:

- Patient safety incident reports
    - Volume of patient safety incident reports
    - Types, categories, and sub-categories of reports
    - Location of incidents e.g. health & justice, sexual health, primary care, or substance misuse services.
- Patient experience including feedback, complaints, and concerns.
- PPO reports
- Clinical Reviews
- Human resource statistics
- Topics referred to within freedom to speak up concerns
- Incident response activity from 2023/24
- Service and organisational risk registers
- Regulatory feedback
- Staff survey results
- Legal claims

The themes from the data sources were considered and discussed leading to the identification of our Local Priorities for a Patient Safety Incident Investigation (PSII) under PSIRF. Where a new risk emerges or learning and improvement can be gained from a PSII into a particular incidents or theme, this will be commissioned.

Stakeholder engagement

The organisation commenced planning for PSIRF in 2022. We have engaged with several organisations in varying stages of their implementation of PSIRF e.g. early adopter prison healthcare provider as part of the national pilot phase, mental health, and ambulance services.

The following are examples of organisation and stakeholder engagement activities that have been carried out:

- All staff attending the corporate induction day receive information/training regarding PSIRF, Duty of Candour and definitions of harm and feedback given at that time is captured and used to inform the plan
- Engagement with internal colleagues via group meetings and one to one meetings
- Presentations to individual teams, Registered Managers Forum, and senior leadership group

- Feedback from colleagues about an information booklet and other engagement materials
- Engagement with partner organisations to discuss how we can collaborate and agree a pathway that ensures the most appropriate organisation is leading on learning responses
- Engagement with Commissioners who monitor our service delivery against the contract. This includes statutory reporting of incidents and any investigations completed. There are differences in how each commissioning team undertake their monitoring, so we have taken the process to them to share the implementation plan and gain feedback on the proposed tools. The 72 hour report has been re-introduced after feedback from NHSE Commissioners.

Defining our patient safety improvement profile

Over a number of years, the organisation has developed and defined its governance activity and processes to ensure it gains insight from patient safety incidents and this will feed into the quality improvement activity going forward. 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 and define the quality improvement work we need to undertake.

The Clinical Governance Oversight Group will provide assurance that quality improvement measures, including patient safety plans currently in use, or which require development and implementation going forward continue to be of the highest standard. Its subgroup, the Patient Safety Action Group (PSAG) will be responsible for the oversight of all quality improvement work, including the robust use of quality improvement methodology. The Learning Response Approval Group (LRAG) is a subgroup of PSAG, and is responsible for reviewing learning responses, identifying system-based learning and recommendations for actions that will maximise opportunities for learning across the organisation.

The improvement plan is to focus on development of safety improvement plans across our most significant incident types (national or locally defined priorities) but will remain flexible and adaptable to new or emerging risks, trends/themes and patient safety events that are identified by our internal governance systems.

Recommendations from Patient Safety Incident (PSI) learning responses and Patient Safety Incident Investigations (PSII's) must translate into effective improvement plans with a focus on reducing risk. Therefore, all improvement activity must identify:

- What improvement/s are needed.
- What change/s are needed.
- How will any change/s be implemented.
- How we will determine if the change/s have had the desired outcome/s.
- Are there any unintended consequences or improvements.

Spectrum have several quality improvement plans that are in place and progress is being monitored. They have been developed based on patient safety issues identified through internal and external systems.

Title	Area/Site	Monitoring
CQC Readiness Inspection Programme	All Services	Clinical Governance Oversight Group Quality and Patient Safety Committee
Learning from clinical reviews/PPO reports	Health & Justice Sites	Patient Safety Action Group Clinical Governance Oversight Group
Quality Improvement capacity	Organisation wide	Patient Safety Action Group
Site specific quality improvement plans	Site specific	Quality and Patient Safety Committee

Our patient safety incident response plan: national requirements

The organisation has finite resources for patient safety incident response, we intend to use those resources to maximise learning and improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, where new and widespread learning would be limited.

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses include mandatory patient safety incident investigation (PSII) in some circumstances and review by/referral to another body or team, depending on the nature of the event.

The Guide to responding proportionately to patient safety incidents defines this requirement and sets out whether mandated responses needs to be a PSII or some other response type, including referring the event to another organisation to manage.

	Event	Response Required	Anticipated Improvement Route
1	Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	PSII – Locally Led Working with partners to ensure multidisciplinary review	Create local organisational actions and feed these into the quality improvement strategy
2	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents	PSII – Locally Led Working with partners to ensure multidisciplinary review	Create local organisational actions and feed these into the quality improvement strategy or

	Event	Response Required	Anticipated Improvement Route
	meeting the learning from deaths criteria)		Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
3	Incidents meeting the Never Events criteria 2018, or its replacement.	PSII – Locally Led Working with partners to ensure multidisciplinary review	Create local organisational actions and feed these into the quality improvement strategy
4	Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. Locally led PSII may be required	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
5	Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Work with partners to ensure cases are referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
6	Child Deaths	Refer for Child Death Overview Panel review. Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
7	Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
8	Safeguarding incidents in which:	Refer to local authority safeguarding lead. Healthcare organisations must contribute	Respond to recommendations from external referred

	Event	Response Required	Anticipated Improvement Route
	• 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. • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	agency/organisation as required and feed actions into the quality improvement strategy
9	Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for Managing safety incidents in NHS screening programmes	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
10	Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations. Healthcare organisations must fully support these investigations where required to do so.	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy
11	Domestic Homicide	A domestic homicide is 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. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met,	Respond to recommendations from external referred agency/organisation as required and feed actions into the quality improvement strategy

	Event	Response Required	Anticipated Improvement Route
		it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	

From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 7 PSII reviews where national requirements have been met per annum.

Our patient safety incident response plan: local focus

	Event	Response Required	Anticipated Improvement Route
1	Unexpected Deaths	Swarm Huddle Working with partners to ensure multidisciplinary After Action Review. Determine if PSII required	Create organisational actions and feed these into the quality improvement strategy/plan. Create site-based actions and feed the site-based quality improvement strategy/plan
2	Expected Deaths	Swarm Huddle After Action Review Working with partners to ensure multidisciplinary review. Determine if PSII required.	Create organisational actions and feed these into the quality improvement strategy/plan. Create site-based actions and feed the site-based quality improvement strategy/plan
3	Medication Administration Errors	Swarm Huddle After Action Review Determine if further review required.	Create organisational actions and feed these into the organisational quality improvement strategy/plan. Create site-based actions and feed the site-based quality improvement strategy/plan
4	Missing Controlled Drugs related incidents	After Action Review Determine if further review required.	Create organisational actions and feed these into the quality improvement strategy/plan.

			Create site-based actions and feed the site-based quality improvement strategy/plan
5	Patient Falls	Swarm Huddle After Action Review Determine if further review required	Create organisational actions and feed these into the quality improvement strategy/plan. Create site-based actions and feed the site-based quality improvement strategy/plan
6	Responding to a deteriorating patient	Swarm Huddle After Action Review Determine if further review required	Create organisational actions and feed these into the quality improvement strategy/plan. Create site-based actions and feed the site-based quality improvement strategy/plan
7	Mismanagement of patients with diabetes	Swarm Huddle After Action Review Determine if further review required.	Create organisational actions and feed these into the quality improvement strategy/plan. Create site-based actions and feed the site-based quality improvement strategy/plan

Appendix 1

Spectrum CiC Community Care Response Tools

Method	Description
Notifiable Safety Incident Report	These replace the 24 hour report and will include what the expected next steps will be – this will be whichever of the PSIRF tools is best to use or if a full root cause analysis is required.
72 Hour Report	Whilst not a PSIRF tool or methodology to review an incident, these are being completed at the request of NHSE.
Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. The requirement for a PSII may occur in the first instance following a patient safety incident or may follow an initial Early Case Review or After Action Review.
Swarm Huddle	Swarm Huddles offer the opportunity to have a timely discussion a reported patient safety event, to determine if a learning response is required, if any support is required, if internal escalation is required and if a notifiable incident report is required. It is a structured facilitated discussion of the event which adds context to the report/event.
After Action Review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning?
Early Case Review (ECR)	The Early Case Review is designed to be initiated as soon as possible following an event and involves an MDT discussion to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future, provide support for staff and decide whether or not a further review (AAR or PSII) is required.
Thematic Review	Designed to review a cluster of events when a trend or theme needs to be identified. This could include cases

	previously reviewed and/or closed or where no further action has been decided.
Local Learning	A brief investigation and response led by the Head of Service where local actions may be identified and implemented

These tools will continue to be evaluated and reviewed periodically to ensure they remain fit for purpose and support the identification of work system contributory factors and learning.

National Learning Response Tools

Method	Description
Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.
After Action Review	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning?
Swarm Huddle	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
Multidisciplinary team (MDT) review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.