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NHS
Providing NHS Services

Patient safety incident response plan

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Website: **www.chec.uk**

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Introduction

This patient safety incident response plan sets out how Community Health and Eyecare Limited's (CHEC) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected

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Our Services

Community Health and Eyecare Limited's (CHEC) is proud to be a leading provider of NHS community-based Ophthalmology and Endoscopy services, enabling patients to receive timely care and treatment locally.

As a national provider of community Ophthalmology and Endoscopy we have continued to expand our services to 25 treatment centres across England and Wales. Our increasing footprint is supported by several NHS community Ophthalmology and Endoscopy contracts in dedicated outpatient facilities, optometry practices and CHEC's hospital hubs. We partner with over 1,400 Optometrist Practices to offer patients equitable access to eyecare services closer to home.

Our Vision – To make eyecare and endoscopy services more readily available and accessible in local communities, by offering patients greater choice, flexibility, and reduced waiting times. Caring- For the health of the people in our local communities, treating the patient as we would want our dearest relative. Caring for our patients/ families, colleagues, and communities. Making life better.

Passionate- About what we do, providing high quality and safe care for our patients and families. Sharing our strengths, recognising team engagement, and being willing with our time, knowledge, and skills. A willingness to give our best.

Togetherness- Recognising the diversity, individuality of our patients, treating patients and ourselves with respect and dignity. One inclusive team, all different, united behind a shared vision of an inclusive culture, and delivering strong-patient centred services. Celebrating what brings us together every day.

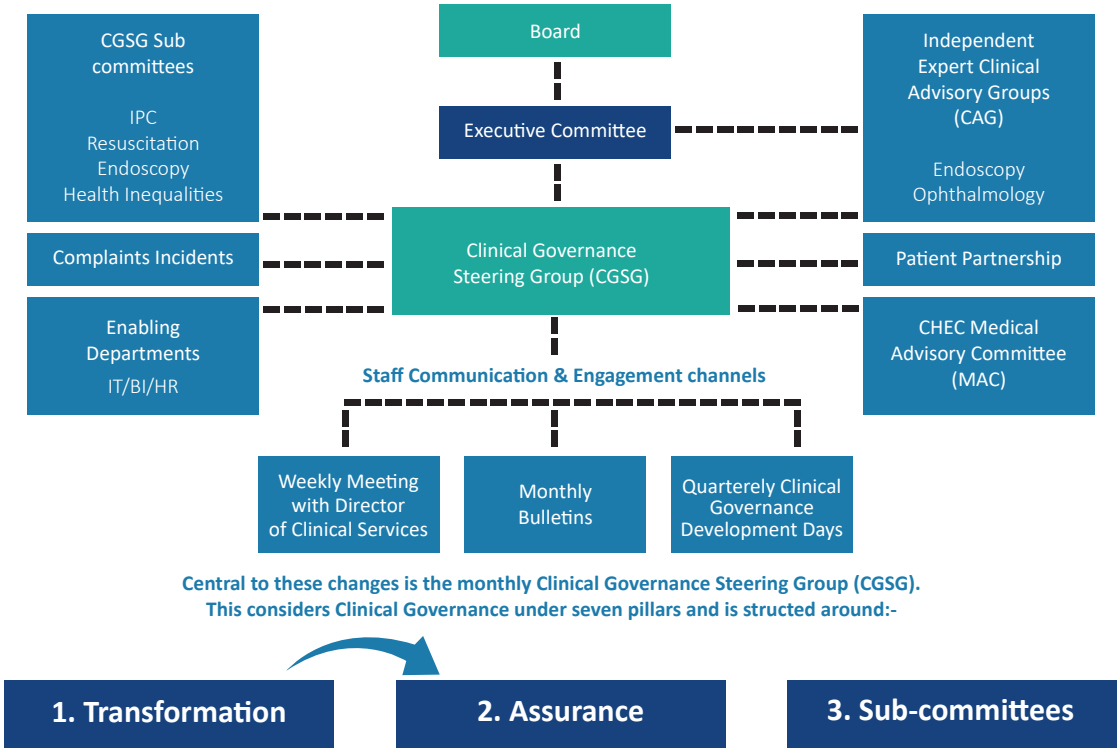
Listening- To our patients and team members, showing compassion, empathy honesty, and integrity. Taking ownership, responsibility and committing to the promises we make to patients and each other. Being the best, we can be.

Focus- On what we do, how we do it, and what makes a difference to us all. Being accountable, believing in ourselves, and having resilience to meet daily challenges, improve now and in the future. Always striving for a better tomorrow.

Defining our patient safety incident profile

Community Health and Eyecare Limited's (CHEC) has a continuous commitment to learning from patient safety incidents and we have developed our understanding and insights into patient safety matters over a period of years.

CHEC's Clinical Govenance framework reflects the improvements in structure, reporting, analysing and drives improvement to lessions learnt.



Central to these changes is the monthly Clinical Governance Steering Group (CGSG). This considers Clinical Governance under seven pillars and is structed around:-

1. Transformation **2. Assurance** **3. Sub-committees**

The CGSG is responsible for informing the Executive Committee and the Board on Clinical Governance matters. The CGSG is supported by:

- The Endoscopy and Ophthalmology Clinical Advisory Group membership comprises of independent subject experts and supports CHEC staff in providing independent advice and scrutiny of CHECs activities and services.
- The Medical Advisory Committee will be responsible for many of the activities required under the Medical Practitioners Assurance Framework.
- The weekly complaints/incidents meeting and the regular patient partnership meetings feed into the CGSG.
- The CGSG is supported by many enabling departments such as IT/HR etc.
- The sub-committees occupy the last quarter of the CGSG agenda on a rotational basis and deal with other matters not covered under the standard clinical governance agenda. Currently these comprise of:

> IPC
> Endoscopy
> Resuscitation
> Health Inequalities

PSIRF sets no rules or thresholds to determine what needs to be learned from to inform improvement apart from the national requirements listed on p13-14 below. To fully implement the Framework the organisation has completed a review of what types of patient safety incident occur to understand what needs to be learned from to improve

Stakeholder engagement
The clinical governance team has consulted with the ICB patient safety team to fully understand the requirements of PSIRF and to understand the practicalities of planning and implementation. We have met regularly with our chose ICB and participated in there learning forums with other stakeholders, some of which were early adopters, so they have been able to share valuable insight.

We are conscious that PSIRF requires a very different approach to the oversight of patient safety incidents. Internally, the senior management team has been informed of the major differences between PSIRF and the SI framework. A presentation delivered by the ICB patient safety team will be delivered at one of the SMT meetings to fully engage the management team and answer any questions that may arise prior to implementation in January 2024.

We also undertook a resource analysis exercise, details on this are provided in the Patient Safety policy document, but this was invaluable for understanding our current resource and capacity for responding to patient safety incidents. Our data sources and how they were used to define our safety profile is detailed below. We have discussed in our CSCG meeting our approach to other patient safety incidents requiring a response.

Data sources

To define our patient safety response profile, we have reviewed our incident's themes and trends.

We have considered feedback and information from the following sources:

- Patient safety incident investigation reports
- Complaints
- Freedom to Speak Up (Previously Whistleblowing)
- Safeguarding incidents
- Data from quality audit results
- Risk Register

Where possible we have considered what the data tells us about inequalities in patient safety.

Safety issues highlighted by the data.

Having identified the types of incidents being reported we then considered the themes, this identified 5 broad themes as set out below.

Theme	Descriptor
Administration (To encompass cancellations, booking errors and administration related incidents.	All incidents involving administration events. Administration related incidents was identified as a consistent theme over various data sets this included: Patient safety incident investigation reports Complaints Data from quality audit results Risk Register From our engagement workshops further analysis was undertaken with key stakeholders who identified booking errors including our booking app, cancellations, and administration incidents.
Delay in referrals to secondary care	All incidents involving delay in referrals. Delay in referrals to secondary care related incidents was identified as a consistent theme over various data sets this included: Patient safety incident investigation reports Complaints Safeguarding incidents From our engagement workshops further analysis was undertaken with key stakeholders who identified historic delays in referring patients with AMD/ Glaucoma to secondary care in a timely manner.

Theme	Descriptor
Surgical	All incidents involving surgery. Surgical related incidents were identified as a consistent theme over various data sets this included: Patient safety incident investigation reports Complaints Freedom to Speak Up (Previously Whistleblowing) Data from quality audit results From our engagement workshops further analysis was undertaken with key stakeholders who identified surgical errors and near misses particularly throughout the checking process.
Post-operative complications	All incidents involving post-operative complications. Post operative complications related incidents was identified as a consistent theme over various data sets this included: Patient safety incident investigation reports Complaints Freedom to Speak Up (Previously Whistleblowing) Data from quality audit results From our engagement workshops further analysis was undertaken with key stakeholders who identified an increase in reportable incidents specially relating to post-operative complications.
Medicines Management	All incidents involving medication incidents. Medicines related incidents was identified as a consistent theme over various data sets this included: Patient safety incident investigation reports Complaints Freedom to Speak Up (Previously Whistleblowing) Safeguarding incidents Data from quality audit results Risk Register From our engagement workshops we have identified an increase in incidents relating to dispensing and prescribing medication. We have developed a task and finish group to specifically focus on medicines management.

Identification of the above types and themes led to the local focus priorities and will be our priorities for review under PSIRF.

We appreciate that the final list is not fixed, and we will consider additional capacity for ad-hoc patient safety incident investigation, where a new risk emerges or learning, and improvement can be gained from investigation of a particular incident or theme.

Defining our patient safety improvement profile

In recent years Community Health and Eyecare Limited's (CHEC) has developed its governance processes to ensure it gains insight from patient safety incidents and that this feeds into quality improvement activity. Community Health and Eyecare Limited's (CHEC) will continue to draw upon guidance and feedback from national and regional level NHS bodies, regulators, commissioners, providers, and other key stakeholders to identify and define the quality improvement work we need to undertake.

Please see table for National Guidance plus what is happening at a local level. This has been rag rated - green shows practice is embedded; Amber is work being undertaken and Red is work to be commenced.

National guidance	Regional guidance	Local guidance (RAG rated)	Comments on National guidance
Dermatology: Under the Wrong Site surgery category Incorrect skin lesion removals or biopsies are the third most common incident subtype of Never Events. Lessons-Learned-Skin-Cancer-Treatments-Never-Events.pdf (bad.org.uk)		• All Clinicians are required to confirm that they use LocSSIPS and the WHO surgical safety checklist as part of the OPC/ Quality annual audit. • Changes made to the referral service to include supporting photography and body maps. • Changes made to referral system to ensure clear documentation on the referral. • Clinician CV/Qualifications ratified by PCL MD to ensure qualifications are appropriate. • IPC audit performed annually. • Adherence to LLR ARP	• All clinicians must have induction and training on LocSSIPS. • All clinicians can confirm skin lesion site prior to any surgery taking place with a consultant when uncertainty exists. • All clinicians should have the requisite clinical information and be able to confirm the lesion before removal. • Site marking; use of the WHO surgical checklist, body maps and photography. • Clear documentation regarding the lesions to be excised or biopsied.

National guidance	Regional guidance	Local guidance (RAG rated)	Comments on National guidance
Ophthalmology, Cataracts: Cataracts in adults: management (nice.org.uk) Preventing wrong lens implant errors. Endophthalmitis Delay in referrals- Glaucoma Near miss surgical safety incidents Insufficient clinical records Incidents relating to medical devices.		• 3 identifiers are used to ensure correct patient. • Uncertainty with how biometry results are transferred to the patients record. • Patient identity is confirmed in theatre. • Eye is clearly checked and marked. • There is only 1 lens in theatre that matches the patient. • 3 identifiers are used to ensure correct patient. • Uncertainty with how biometry results are transferred to the patients record. • Patient identity is confirmed in theatre. • Eye is clearly checked and marked. • There is only 1 lens in theatre that matches the patient. • Uncertainty around whether 2 members of the surgical team check the accuracy, consistency, and appropriateness of all formulas, calculations, and constants. • Surgeons verifies lens. • WHO surgical checklist is used. • Safety Huddle completed prior to theatre list. • IPC audit completed annually, checklist and safety huddle observed. • Clinician CV/qualifications ratified by PCL MD	Prior to surgery: • 3 identifiers used to ensure correct patient records. • 3 identifiers used on pre-op biometry results. • Ensure biometry results are either electronically transferred o patient record or a printed biometry result has a patient label and is securely fixed to patients record. • Do not transcribe results by hand • In theatre confirm patient identity. • Eye to be operated on is clearly marked and checked. • There is only 1 intraocular lens in theatre that matches the persons selected lens type and prescription. • At least 2 members of the surgical team have checked the appropriateness, consistency and accuracy of all formulas, calculations, and constants. • Surgeon should verify the correct intraocular lens has been selected and is available in theatre.

National guidance	Regional guidance	Local guidance (RAG rated)	Comments on National guidance
Endoscopy Unexpected findings Appropriate pathways Transfers out following a complication and appropriateness of referral.		• JAG best practise and guidance. • The endoscopy service shall have a defined leadership management and accountability structure to achieve an effective patient-centred service. • The endoscopy service shall have processes in place to identify, respond to and learn from expected and unexpected adverse events. • The endoscopy service shall ensure that it implements and monitors systems to achieve the comfort and respect of patients at all stages of their care. • The endoscopy service shall ensure that it implements and monitors systems for the clinical quality of all procedures. • The endoscopy service shall ensure that it implements and monitors systems for all referrals and procedures to be appropriate and safe. • The endoscopy service shall implement and monitor systems to ensure the clinical and technical quality of the interpretation of test results, and their reporting and communication.	• The endoscopy service shall have policies, protocols, and systems in place to ensure clinically relevant information is received from referrers for all patients. • The endoscopy service shall have systems in place to ensure vetting, justification and prioritisation of referrals and surveillance cases. • The endoscopy service shall have a system in place to ensure that patient reports are produced on the day of the procedure. • The endoscopy service shall have policies and systems in place to ensure effective communication of pathology results to the referrer or for ongoing management.

We plan to focus our efforts on development of safety improvement plans across our most significant incident types, either those within the national priorities or those that we have identified locally. We will remain flexible and consider improvement plans as required where a risk or a patient safety issue emerges from our own or external insights.

Community Health and Eyecare Limited's (CHEC) has limited resources for patient safety incident response, we intend to use those resources to maximise improvement. PSIRF allows us to do this, rather than repeatedly respond to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but Community Health and Eyecare Limited's (CHEC) fully endorses this approach as it fits with our aim to learn and improve within a just and restorative culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed. For clarity, all types of incidents that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods and are detailed in the table below.

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events (2018) criteria or its replacement	Locally led PSII in the organisation in which the event occurred.	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 • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority Safeguarding lead. CHEC will 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 to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	CHEC safeguarding lead will liaise with the ICB safeguarding team and other organisations as required.
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response. See: Managing safety incidents in NHS screening programmes - GOV. UK (www.gov.uk)	Create local organisational actions and feed these into the quality improvement strategy

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety insights, based on the reviews of incidents we have identified the patient safety priorities set out below.

This will allow us to apply a systems-based approach to learning from these incidents and exploring multiple contributory factors.

We will use the outcomes of PSII to inform our patient safety improvement planning and work.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Incident resulting in moderate or severe harm to patient.	Statutory duty or candour and appropriate toolkit item Escalation plan and risk assessments to be carried out by CHEC Quality team	Inform thematic analysis of ongoing patient safety risks and use to build a case for a new improvement plan or inform ongoing improvement efforts.
No/low Harm patient safety incident	Validation of facts at local level – thematic analysis	Inform thematic analysis of ongoing patient safety risks and use to build a case for a new improvement plan or inform ongoing improvement efforts.
Surgical Incidents including Post-Operative Complications.	Statutory duty or candour and appropriate toolkit item if required. Escalation plan and risk assessments to be carried out by CHEC Quality team if required. May require PSII or After-action review, SWARM huddle – response to be agreed locally and discussion with provider.	Inform thematic analysis of ongoing patient safety risks and use to build a case for a new improvement plan or inform ongoing improvement efforts.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Provider staffing levels resulting in reduction or no service.	Review by contract team and quality team as appropriate in conjunction with the provider. Continued monitoring of patient safety incidents to determine any emerging risks/issues.	Inform ongoing improvement efforts
PCLs Service Provider(s) unable to fulfil contract. Possibility of service provider being unable to deliver contract - causes may be illness, premises failure, closure of practice etc.	Review by contract team and quality team as appropriate in conjunction with the provider. Continued monitoring of patient safety incidents to determine any emerging risks/issues.	Inform ongoing improvement efforts
Documentation/IG breach	Review by Clinical governance team. Continued monitoring of patient safety incidents to identify any emerging risks/ issues	Inform ongoing improvement efforts.
Safeguarding	Review by Quality Lead Nurse in conjunction with the ICB safeguarding team to ensure referral and review. Continued monitoring of patient safety incidents to identify any emerging risks/ issues.	Inform ongoing improvement efforts.
Infection Prevention and Control	Review by Infection prevention lead nurse in conjunction with relevant providers and third parties as required. Continue nationally required external reporting for specific infection groups. Continued monitoring of patient safety incidents to identify any emerging risks or issues. May require PSII or After-Action review.	Inform ongoing improvement efforts

All incidents will be reported through LFPSE regardless of level of investigation required.

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