Patient safety incident response plan

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	NAME	TITLE	SIGNATURE	DATE
Author	**Catherine Konzon**	**IG Officer**		**19/11/2024**
Reviewer	**Sevim Mustafa**	**Clinical Director**		**21/11/2024**
Authoriser	**Janet Biglari**	**Clinical Director**		**21/11/2024**

Contents

Introduction 3
Our services 4
Defining our patient safety incident profile 5
Defining our patient safety improvement profile 6
Our patient safety incident response plan: national requirements 7
Our patient safety incident response plan: local focus 8

Introduction

This patient safety incident response plan sets out how TBC Healthcare 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.

TBC Healthcare has been providing community-based Tier 3 multi-disciplinary weight management services since 2009. Over that period the responses to patient safety incidents have evolved. This document covers both clinical and non-clinical staff. Patient-centred care is at the core of TBC Healthcare's commitment to providing a gold standard service and to support this, patient safety incidents are analysed, and learning is disseminated across the entire organisation.

Our services

Our service has 4 main areas of clinical input

- Psychological – team of counsellors
- Dietetic – team of dietitians
- Exercise – team of exercise facilitators
- Medical – Bariatric Surgeon and Bariatric Nurse

In support of this, there are the patient care team (patient coordinators), weight check in coordinators, health advisors and the management team, led by the Clinical Directors.

Patients meeting the required criteria are referred by their GP or self-refer. They are assessed and EOSS scored according to their level of need. Patients are provided with appointments with each discipline throughout their time on the service, which can be for various timeframes, depending on area, circumstances and risks. During their treatment, safeguarding oversight is provided by a registered social worker, who supports and advises staff to manage any issues of risk that may arise.

Defining our patient safety incident profile

TBC Healthcare's patient safety incident profile which has informed the PSIRF plan has been developed in collaboration with stakeholders from across the organisation, with patient representatives and with relevant external organisations.

Key stakeholders were identified and invited to form the membership of the PSIRF steering group. These include:

- Clinical Directors
- Operations Manager
- Medical Lead
- Head of Clinical Governance
- PSIRF Implementation Project Lead
- Patient safety Champions
- Line Managers
- Patient Experience & Engagement Lead
- A member of the Clinical Governance team (minute taker)
- A patient representative/Patient Safety Partner
- Other stakeholders have been kept informed via regular communication

TBC Healthcare analysed data about patient safety incidents over the period 2021-2024.

Most of our incidents are related to patients' mental health issues, self-harm or suicidal thoughts.

Defining our patient safety improvement profile

TBC Healthcare has consistently developed and improved responses to patient safety on an internal basis, making reporting incidents easier and responses more comprehensive. We hold regular Clinical Governance meetings which identify any gaps or changes needed and those changes are implemented very quickly.

TBC Healthcare's safety improvement profile is developed by identifying the organisational improvement activity already underway. Patient safety improvement work in progress includes - a Quality Improvement Programme, improving data capture including ethnicity and building partnerships.

Our patient safety incident response plan: national requirements

PSIRF uses new methods to learn from issues and incidents. In brief, there are four main learning responses:

1. Patient Safety Incident Investigation (PSII) – an in-depth system-based investigation that seeks to identify and understand all the factors and issues that contribute to the incident.

2. After Action Review (AAR) i. A meeting with those involved in the incident and local area seeking to understand what happened, what had been expected to happen, why was there a difference and is there any local learning from the event, and whether there may be wider issues requiring further learning responses.

3. Learning MDT Review. a follow up-multidisciplinary meeting to understand the wider organisational issues, including subject matter experts and other relevant stakeholders.

4. Debrief – a meeting to review the event to answer the same questions as for the AAR review and to provide staff support.

5. Local learning – a brief investigation and response by the local manager where local actions may be identified and implemented.

Patient safety incident type	**Required response**	**Anticipated improvement route**
Eg incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
Eg death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into the quality improvement strategy
Eg incident meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required and feed actions into the quality improvement strategy

Patient safety incident type	Required response	Action
Incidents meeting the Never Events Criteria	PSII	Create local organisational actions and share learning through the weekly management meeting, then cascade through the Clinical Governance meeting.
Babies, children or young people are on a child protection plan, looked after plan or are a victim of neglect or domestic abuse/violence Adults over 18 years old are in receipt of care and support 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 team	Create local organisational actions and share learning through the weekly management meeting, then cascade through the Clinical Governance meeting. May require TBC Healthcare to contribute to an inquiry or review.

Our patient safety incident response plan: local focus

Incidents relating to PSIRF Improvement workstreams will be included in the improvement activities being undertaken. Any new incidents or events reported will be included in the workstream for review to understand whether they highlight any new issues that may not have already been identified. By proactively focusing on the four thematic workstreams, resources for investigation are used more efficiently.

The newer learning response methods of After-Action Review and Learning Multi-disciplinary Team Review provides a robust learning response with a more effective use of time, allowing a focus on learning and improvement. It is anticipated that the four thematic PSII workstreams being undertaken depending on risks and issues being identified, may

increase. The table below outlines the initial plans for how to address the issue, and how to respond to new incidents that relate to these themes.

Quality improvement methods will be undertaken to explore the issues in detail, identify the factors contributing to the risks, areas for improvement and recommendations to address these.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Inadequate handovers - including communication and documentation Referral and MDT processes and pathways	Thematic review of completed incident reports (SIRI, Divisionals, PSII, Learning MDT Reviews and AARs) to identify systems-issues contributing to events Quality Improvement methods will be used to understand the contributory factors and systems-based issues contributing to the risks to patient safety from handover, identify potential areas for improvement and actions to address these.	Develop an improvement plan for key areas identified in analysis. Explore each new incident to identify whether any additional learning highlighted. If significant new issues are raised, perform an appropriate learning response. Update improvement plan with any new actions. Share progress, actions and monitor impact via Clinical Governance meeting.
Care of vulnerable people (safeguarding, learning difficulties and disabilities, autism and mental health issues)	Thematic review of completed incident reports (SIRI, Divisionals, PSII, Learning MDT Reviews and AARs) to identify systems-issues contributing to events Quality Improvement methods will be used to understand the contributory factors and systems-based issues contributing to the risks to patient safety from handover, identify potential areas for improvement and actions to address these.	Perform benchmarking exercise using the Learning disability improvement standards self-improvement tool to identify areas for improvement.

	Follow internal safeguarding process. Perform benchmarking exercise using the Learning disability improvement standards self-improvement tool to identify areas for improvement.	
Other reported incidents where significant systemic issues identified. For example, incidents relating to Positive Patient Identification (PPID) or any other clinical issue where a significant need for organisational learning has been identified.	Incidents with the potential for organisational learning due to systemic issues will be identified by reviewing incidents graded moderate and above, by referral from subject matter experts and governance practitioners. A PSII will be considered as the most appropriate learning response.	Development of an improvement plan for key areas identified in analysis. Learning shared through the weekly management meetings and via the Clinical Governance meetings.