Patient Safety Incident Response Plan

Contents

Introduction

This patient safety incident response plan sets out how Baywater Healthcare intends to respond to patient safety incidents in accordance with the Patient Safety Incident Response Framework (PSIRF). The plan is not rigid and can be adapted if necessary. Baywater Healthcare will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Baywater Healthcare is committed to improving patient safety by adopting the Patient Safety Incident Response Framework, which supports a systematic, compassionate, and proficient response to patient safety incidents anchored in the principles of openness, fair accountability, learning, and continuous improvement. The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents to learn and improve patient safety.

In line with the NHS Patient Safety Strategy (2019), patient safety is about maximising what goes right and minimising what goes wrong. Whilst patient safety incidents are rare, Baywater Healthcare prioritises compassionate engagement with patients, family and staff affected by incidents. This provides vital insight into how to improve care, ultimately making services safer for patients. The focus is on understanding how incidents happen, including their contributing factors.

Baywater Healthcare will review patient safety information regularly through governance and safety meetings, providing updates to the workstreams within the plan. The plan will be reviewed annually to ensure the workstreams fully reflect the patient safety issues with the greatest potential for learning and improvement. Reviews of the plan will involve stakeholder engagement, and agreement will be sought regarding proposed updates to the plan. Updates will be published as a new version of the plan.

Baywater Healthcare Services

Baywater Healthcare (headquartered in Crewe, Cheshire) provides respiratory services for the National Health Service (NHS). The organisation provides national clinical services and healthcare therapy equipment contracts, including home oxygen assessment, pulmonary rehabilitation, and continuous positive airway pressure (CPAP) triage and assessment. Most services provided are domiciliary, but some are within NHS clinics or hospital locations.

A Chief Executive Officer and a Board of Directors govern the organisation. The Board is responsible for the organisation's strategy, activity, decision making and integrity. Day-to-day running of clinical and non-clinical services is delegated to Senior Managers.

Clinical services, including Pulmonary Rehabilitation, Home Oxygen Assessment and Review and CPAP triage and assessment, are managed by practising clinician managers, supported by the Clinical Services Manager and a Clinical Director, registered healthcare professionals. The practising clinician managers are responsible for the day-to-day running of the clinical services and compliance with clinical policies and procedures. The Clinical Services Manager maintains and updates policies and procedures according to best practices, manages risks, compliance with

regulations and ensures accreditation. The corporate structure can be viewed within Baywater Healthcare's Electronic Quality Management System (EQMS).
Safety and Governance within the organisation are embedded within the corporate structure. Within the Clinical Governance Structure, the Commercial and Clinical Director, Clinical Services Manager, and Quality and Safety Manager support the Chief Executive Officer for patient safety and clinical effectiveness. Clinical Governance and a safety team are within the organisational structure, which are responsible for the processes and management of risks and incidents described in detail in the PSIRF policy.

Defining Baywater Healthcare Patient Safety Incident Profile

A key part of developing the PSIRF Plan is understanding the key issues that lead to risks for patient safety within Baywater Healthcare, known as the Patient Safety Profile. A wide source of information about patient risks is reviewed and evaluated to understand the patient safety incident profile. The process of developing the patient safety incident profile is described below.
Within the National contracts that Baywater Healthcare serves, 3442 incidents were recorded in a two-year period, 0.05% of which were reported as serious incidents.
The patient safety incident risks for this organisation have been profiled using organisational data, including:
• Incident Reports: Two years of data have been reviewed, and a thematic analysis has been undertaken. Further deep dives into specific reporting categories were undertaken
• Risk Register: The Risk Register was reviewed, with a focus on risks related to patient safety, and this was triangulated with incidents and complaint themes
• Complaints: Themes of complaints were reviewed, and a thematic analysis was undertaken and triangulated with other data sources.
• Getting it Right First Time (GIRFT) outcomes and recommendations were reviewed, and the emerging themes were triangulated with other data.
• Clinical and quality audit outcomes and recommendations were reviewed, and the themes were triangulated with other data.
The defined priorities identified throughout this analysis validated what had been seen throughout patient safety incidents reporting for many years, and these will be our focus for Year 1, with reviews in future years to revise these, addressing any emergent themes. Leads will meet each quarter to review our data, triangulate this, and identify any new or merging themes that require improvement. From this, future PSIRF priorities will be identified and shared annually with the Board. Revised PSIRF priorities will go to the Quality Committee for consideration and approval. Improvement work will be delivered by Specialist Steering Groups, with monitoring led by the Patient Safety Group, which will report to the Quality Group. Where possible, improvement work will be underpinned by the model for improvement. Where an area of focus is also a quality priority, this will be led by existing governance arrangements.

Stakeholder Engagement

The Baywater Healthcare patient safety incident profile, which has informed the PSIRF plan, has been developed in collaboration with stakeholders from across the organisation, patient representatives, and relevant external organisations. Key stakeholders were identified and invited to form the membership of the PSIRF steering group. These include:
• Health and Safety Manager
• Clinical Services Manager
• Head of Clinical Governance
• PSIRF Implementation Project Leads
• Safety Champions
• Commercial and Clinical Director
• Patient Experience and Engagement Lead
• Quality Team Lead
• Quality Manager
• Communication Lead

• Clinical Information Officer (CIO)
• Clinical Governance Lead
• A patient representative/Patient Safety Partner

Defining Our Patient Safety Improvement Profile

Baywater Healthcare has a comprehensive programme for patient safety improvement and an active quality improvement programme. The clinical governance framework enables a robust assurance process, ensuring improvements are made, embedded and sustained. Baywater Healthcare collaborates with our colleagues across the Trafford Integrated Care Board to improve patient safety. The Quality Improvement Programme and Priorities for Baywater Healthcare are:

• Getting It Right First Time
• Quality Improvement
• Falls prevention
• Fire Prevention
• Infection Prevention and Control

These key priorities are discussed, and assurance is given of progress through the following groups and committees

•Safeguarding Committee
• Infection Control Group
• Quality and Patient Safety Group
• Clinical Governance Group
• Information Governance Group
• Patient Experience Team

Priority	Required Response	Anticipated Improvement Route
Incidents Meeting the Never Events Criteria	• Patient Safety Incident Investigation	• Cases to be reviewed by the Quality and Patient Safety Group
Safeguarding Incidents	• Patients harmed or at risk of harm	• As defined by Safeguarding Committee requirements
Notification of Infectious Disease	• Patient Safety Incident Investigation	• Infection Control Group
Information Governance	• Follow National Reporting Guidelines	• Information Governance Group
Patient Fire	• Patient Safety Incident Investigation	• Quality and Patient Safety Group • Patient Experience Team
Patient falls	• Patient Safety Incident Investigation	• Quality and Patient Safety Group • Patient Experience Team
Delays in service delivery resulting in moderate to severe harm or a near miss where there is potential for systems learning	• Patient Safety Incident Investigation • Rapid Evaluation of Care • Duty of Candour	• Quality and Patient Safety Group • Clinical Governance Group

	• After Action Review (AAR)	
Deterioration of a patient due to faulty equipment provision	• Patient Safety Incident Investigation • Rapid Evaluation of Care • Duty of Candour • After Action Review (AAR)	• Quality and Patient Safety Group • Clinical Governance Group • Patient Experiences Group
Other incidents which have resulted in moderate to severe harm or a near miss where there is potential for wider learning	• Patient Safety Incident Investigation • Rapid Evaluation of Care • Duty of Candour • After Action Review (AAR)	• Quality and Patient Safety Group • Clinical Governance Group • Patient Experiences Group