

Patient safety incident response plan

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Introduction

This patient safety incident response plan sets out how **B&NES Enhanced Medical Services (BEMS)** 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.

PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

These aims align with BEMS agreed visions and values, created by BEMS staff, and encompassing the way of working within BEMS:

- Trusted and respected leadership
- Responsiveness
- Quality
- Efficiency
- Clear purpose
- Local focus
- Openness and Transparency
- Being a good partner

This framework will see BEMS move away from the Serious Incident Framework (SIF), to a new approach to incident management, one which enables examination of a wider range of patient safety incidents “in the spirit of reflection and learning” rather than as part of a “framework of accountability”.

The introduction of PSIRF forms part of our commitment to developing a just and learning culture, building openness and transparency, ensuring everyone is treated fairly and that we learn from any errors. Our clinical governance team are currently working hard to make sure we are ready to implement the new framework, by strengthening our incident reporting processes to identify patient safety incidents, so that they can be escalated and investigated appropriately.

Our services

BEMS provides the following patient services:

B&NES, Swindon & Wiltshire (BSW) wide;

- Covid Medicines Delivery Unit (CMDU)

B&NES-wide;

- Fracture and soft tissue injury clinic
- Urgent Treatment Centre GPs (UTC)
- Community Dermatology
- Deep Vein Thrombosis (DVT)

Selected Practices;

- GP Practice Enhanced Access
- Home visiting
- Rapid Diagnostic Service (RDS)

Defining our patient safety incident profile

This profile has been discussed and agreed in collaboration with BEMS' Patient representative Board member, the BEMS Clinical Governance Committee, the BEMS Management Executive Committee (MEC), which is made up of the BEMS Directors, and BaNES, Swindon and Wiltshire Integrated Care Board.

Patient safety is defined as the avoidance of unintended or unexpected harm to people during the provision of health care. Standard NHS patient safety categories that are considered pertinent to the services that BEMS' provide are:

- Access, Admission, transfer, discharge
- Clinical assessment (including diagnosis, scans, tests, assessments)
- Consent, communication, confidentiality
- Disruptive, aggressive behaviour
- Documentation (including electronic and paper records, identification and charts)
- Implementation of care and ongoing monitoring / review
- Infection control incident
- Infrastructure (including staffing, facilities, environment)
- Medical device / equipment
- Medication
- Patient accident
- Self-harming behaviour
- Treatment, procedure

Clinical Governance (Appendix 1 and Appendix 2)

Quarterly clinical governance meetings are held for every BEMS service. These are chaired either by the BEMS Clinical Governance Director or the Service Clinical Governance Lead GP. At each meeting the following are discussed, and actions agreed:

- Activity
- Key Performance Indicators
- Incidents, complaints and compliments
- Audits including patient feedback, record keeping, infection control
- Operational issues
- Safeguarding
- Risks
- New policies and any training needs

BEMS also has an overarching quarterly clinical governance committee that is chaired by the Clinical Governance Director. Attendees are the BEMS Business Director, Operations Manager, Project Manager, Nurse Project Manager and any service clinical governance lead GPs who wish to attend. The agenda items reflect the service clinical governance meetings, but this provides BEMS with an opportunity to review trends in incidents, complaints, compliments, audits and quality reports and suggest actions.

To support promotion and compliance, BEMS has developed relevant policies and procedures that relate to patient safety (Appendix 3):

All BEMS' staff, including permanent and temporary staff, are required to complete and keep up to date, statutory training which includes:

- Fire Safety
- Health & Safety
- Infection Control
- Cardio-Pulmonary Resuscitation (CPR)
- Safeguarding Children
- Safeguarding Adults

- Deprivation of Liberty (DOL)
- Prevent
- Information Governance
- Confidentiality
- Mental Health Awareness
- Disability Awareness
- Autism awareness

Patient safety incident data from historical reporting, which was used to identify the organisational patient safety incident profile, is presented in the table below:

Service	2020/21					2021/22					2022/23				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Fracture Clinic	0	2	0	2	4	2	1	2	1	6	0	0	0	0	0
Home visiting	3	3	1	0	7	1	2	0	1	4	2	1	2	0	5
Dermatology	2	0	2	5	9	2	3	2	0	7	0	0	0	1	1
DVT	3	3	0	0	6	0	0	0	0	0	1	0	0	0	1
Improving Access	1	0	0	0	1	0	0	1	2	3	1	0	1	0	2
RDS	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
TOTALS	9	8	3	7	27	5	6	5	4	20	4	1	4	1	10

Complaints

2020/21 – 4 complaints

Two Fracture and Soft Tissue Injury Service complaints. One clinical complaint related to delays to treatment and diagnostics due to impact of Covid-19. One clinical complaint related to delays to treatment and diagnostics due to impact of Covid-19, issues referring on to clinical teams in the RUH, and issues accessing the full patient record. All learning implemented, and no repeat incidents or complaints regarding these issues.

One Referral Support Service complaints. Complaint related to communication issues with national letters sent by eReferrals. BEMS resolved the issue for the patient once made aware.

One Covid-19 Vaccination Hub complaint. Complaint related to communication issues, wait time at the clinic and concerns regarding vaccination technique of clinician. All learning implemented, and no repeat incidents or complaints regarding these issues.

2021/22 – 3 complaints

One Covid-19 Hot Hub complaint. Clinical complaint regarding assessment and outcome of appointment. GP fed back reflections and learning, and no repeat incidents or complaints regarding these issues.

One Fracture and Soft Tissue Injury Service complaint. Complaint relating to attitude of GP. BEMS met with GP to discuss and there have been no repeat incidents or complaints regarding these issues. Patient feedback collated and reviewed quarterly to support this.

One Community Dermatology Service complaint. Clinical complaint regarding diagnosis following appointment. GP fed back reflections and learning, and no repeat incidents or complaints regarding these issues.

2022/23 – 0 complaints

Feedback

2020/21

- Dermatology Service 100% would recommend the service to a family member or friend.
- DVT Service 100% would recommend the service to a family member or friend.
- Fracture and Soft Tissue Injury Clinic 100% would recommend the service to a family member or friend.
- Vasectomy Service 100% would recommend the service to a family member or friend.
- Covid-19 Hot Hub Service 96% patients were satisfied with their visit.

2021/22

- Covid-19 Hot Hub Service 96% patients were satisfied or very satisfied with their visit.
- Dermatology Service 98% would recommend the service to a family member or friend.
- DVT Service 99% would recommend the service to a family member or friend.
- Fracture and Soft Tissue Injury Clinic 97% would recommend the service to a family member or friend.
- Paediatric Urgent Service Hub 100% would recommend the service to a family member or friend.
- Vasectomy Service 100% would recommend the service to a family member or friend.

2022/23

- Dermatology Service 100% would recommend the service to a family member or friend.
- DVT Service 99% would recommend the service to a family member or friend.
- Enhanced Access Service 97% would recommend the service to a family member or friend.
- Fracture and Soft Tissue Injury Clinic 97% would recommend the service to a family member or friend.
- Paediatric Urgent Service Hub 100% would recommend the service to a family member or friend.
- Vasectomy Service 100% would recommend the service to a family member or friend.

Themes

2020/21

- Surgical safety checklist implemented for Dermatology, and shared with our Vasectomy Service as well.
- The need to discharge patients as soon as possible, as discharges include actions for referring GPs. Reminders set-up on the administration team system, to ensure patients are discharged promptly and regularly for all services. Team members made aware it is better to over communicate that under communicate and we can utilise SystemOne tasks, emails and phonecalls depending on urgency of action required by referring GP.
- Staff needing to know where emergency equipment is at host sites. Applicable learning for all staff and all sites. BEMS complete annual site visits, but this is only a single point in time. Ask sites to attend our Clinical Governance meetings so they can make us aware of relevant changes, such as emergency equipment being moved to a different location.
- Frequent sharing of latest infection control guidance to all services, in light of impact of Covid-19. Also key learning to keep all sites informed, and ask them to make us aware of any local processes we need to follow, specific to their site.

2021/22

- Repeat incidents relating to Non-Emergency Patient Transport for our DVT service. Number of issues required involvement of commissioner to help resolve and improve the

service offered to BEMS patients, who can use this service if required for the DVT service. DVT transport.

- More learning on how best to communicate actions to Practices upon discharge. Changing templates on SystemOne, so our administrative teams can easily tell the urgency of an action, and which form of communication is most appropriate, to make the referring GP aware.

2022/23

- Transport issues in DVT continued after complaint made to commissioners. Commissioners assisted in arranging a meeting that resulted in BEMS accessing an improved online system, that gives us greater control and oversight of transport we have booked. Learning that we can escalate to the ICB if needed, when issues occur with other providers.
- Access to emergency equipment. Incident whereby a same-day acute clinic was placed far away from the on-site emergency equipment. In future to consider where an acute clinic should be held within a host site, and ensure close proximity to emergency equipment.

Defining our patient safety improvement profile

The following section details BEMS proposed patient improvement and service transformation initiatives. These have been discussed and agreed in collaboration with BEMS' Patient representative Board member, the BEMS Clinical Governance Committee and the MEC.

- Engage with Integrated Care System level, Patient Safety Improvement Networks to support delivery of the priorities within the NHS Patient Safety Strategy.
- Link with local patient safety collaboratives to establish a local network for sharing learning
- Include questions regarding awareness of PSIRF in BEMS' annual staff survey
- Support the national adoption and implementation of the Patient Safety Incident Response Framework (PSIRF).
- Engage, where appropriate, with the National Patient Safety Alert process and the Learn From Patient Safety Events (LFPSE) service
- Appoint a dedicated Central Alerting System (CAS) officer and Patient Safety Specialist
- Support training and utilisation of relevant clinical management tools and approaches (e.g. NEWS, Personalised Care etc.) in relation to the services it provides.
- Continue to promote safe and appropriate prescribing in the services that it provides
- Update BEMS' Incident Reporting Policy and process/procedure to ensure it encompasses PSIRF principles, e.g. engaging with patients, families, carers, national and local reporting requirements etc..
- Ensure that all regular reviews of Policies and procedures consider patient safety elements, e.g. notification and reporting
- Respond to incidents in a considered and proportionate way that maximises learning and improvement.
- Investigate patient safety incidents relevant to their context and the populations they serve.
- Identify other local providers and services to collaborate in benchmarking and shared learning
- Sharing learning, and aspects of best practice arising from incidents, patient & staff feedback, audits etc.

Our patient safety incident response plan: national requirements

National patient safety incident type	Required response	Anticipated improvement route
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Report via BEMS' Incident Reporting Policy	Review BEMS' incident reporting policy to ensure appropriate response relating to investigation and reporting of deaths resulting from problems in care
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 meeting the learning from deaths criteria)	Report via BEMS' Incident Reporting Policy	Review BEMS' incident reporting policy to ensure appropriate response relating to deaths of patient detained under the Mental Health Act/Mental Capacity Act.
Incidents meeting the Never Events criteria 2018, or its replacement.	Report via BEMS' Incident Reporting Policy	Respond in accordance with the relevant BEMS' policy Identify learning and/or system changes to mitigate recurrence Refer to relevant body/organisation as required
Mental health-related homicides	Report via BEMS' Incident Reporting Policy	Respond in accordance with the relevant BEMS' policy Identify learning and/or system changes to mitigate recurrence Refer to NHS England Regional Independent Investigation Team (RIIT)
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Report via BEMS' Incident Reporting Policy	Review BEMS' incident reporting policy to ensure appropriate response relating to maternity and/or neonatal incidents
Child deaths	Report via BEMS' Incident Reporting Policy	Respond in accordance with the relevant BEMS' policy Identify learning and/or system changes to mitigate recurrence Refer for Child Death Overview Panel review
Deaths of persons with learning disabilities	Report via BEMS' Incident Reporting Policy	Respond in accordance with the relevant BEMS' policy Refer for Learning Disability Mortality Review (LeDeR)

<p>Safeguarding incidents in which:</p> <p>babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence</p> <p>adults (over 18 years old) are in receipt of care and support needs from their local authority</p> <p>the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence</p>	<p>Report via BEMS' Incident Reporting Policy</p>	<p>Respond in accordance with the relevant BEMS' policy</p> <p>BEMS must contribute towards safeguarding enquiries and reviews as required by the Local Safeguarding Partnership / Adults Board</p> <p>Identify learning and/or system changes to mitigate recurrence</p> <p>Refer to local authority safeguarding lead</p>
<p>Incidents in NHS screening programmes</p>	<p>Not applicable as BEMS does not provide screening services</p>	<p>Review BEMS' incident reporting policy to ensure appropriate response relating to screening programme incidents</p>
<p>Deaths in custody (e.g. police custody, in prison, etc) where health provision is delivered by the NHS</p>	<p>Not applicable as BEMS does not provide these services</p>	<p>Review BEMS' incident reporting policy to ensure appropriate response relating to deaths in custody</p>
<p>Domestic homicide</p>	<p>Report via BEMS' Incident Reporting Policy</p>	<p>Respond in accordance with the relevant BEMS' policy</p> <p>Identify learning and/or system changes to mitigate recurrence</p> <p>Report to local Police for investigation</p>

Our patient safety incident response plan: local focus

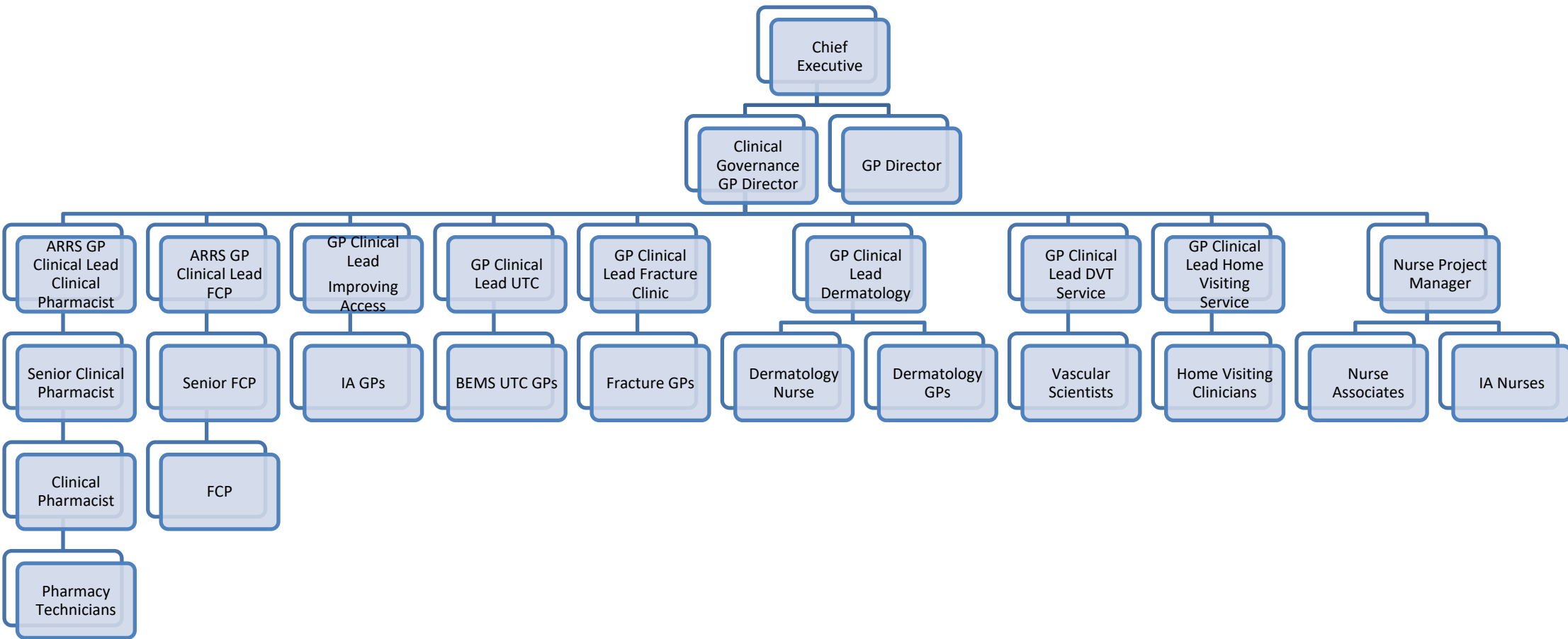
The mapping of historical incident reporting, complaints and patient feedback data for BEMS' services has informed the development of the following objectives for each topic area.

Patient safety incident type	Required response	Anticipated improvement route
Patient death	Report via BEMS' Incident Reporting Policy	<p>Identify learning and/or system changes to mitigate recurrence</p> <p>Initiate policy to determine appropriate level and route for investigation, reporting and action.</p> <p>To be discussed and agreed at Director Level. Special meeting would be convened due to severity of incident and rarity of incident. No patient death has occurred ever within a BEMS service.</p> <p>Report via national system/s, as required</p>
Safeguarding incidents	Report via BEMS' Incident Reporting Policy	<p>Respond in accordance with the relevant BEMS' policy, e.g. Children and/or Vulnerable Adults</p> <p>Identify learning and/or system changes to mitigate recurrence. Discussed at Service Clinical Governance meeting. Ad hoc meeting to be arranged if required due to length of time until scheduled meeting.</p> <p>Refer to relevant body/organisation as required.</p> <p>Liaise with relevant local and national agencies to support investigation of incidents and to implement any agreed changes/actions.</p> <p>To be discussed and agreed at Director Level (Clinical Governance Committee and/or MEC).</p>
Confidentiality and/or data breaches	Report via BEMS' Incident Reporting Policy	<p>Respond in accordance with the relevant BEMS' policy, e.g. GDPR, Data Protection</p> <p>Identify learning and/or system changes to mitigate recurrence</p> <p>Refer to relevant body/organisation as required.</p> <p>Liaise with appropriate local and national agencies, patients/carers etc. to ensure learning is embedded as required. Would</p>

		<p>involve BEMS DPO and BEMS Caldicott Guardian.</p> <p>To be discussed and agreed at Director Level (Clinical Governance Committee and/or MEC). Ad hoc meeting to be arranged if required due to length of time until scheduled meeting.</p>
Clinical incidents	Report via BEMS' Incident Reporting Policy	<p>Identify learning and/or system changes to mitigate recurrence. Discussed at Service Clinical Governance meeting. Ad hoc meeting to be arranged if required due to length of time until scheduled meeting.</p> <p>Refer to relevant body/organisation as required</p> <p>Liaise with appropriate local and national agencies, patients/carers etc. to ensure learning is embedded as required</p> <p>To be discussed and agreed at Director Level (Clinical Governance Committee and/or MEC). Ad hoc meeting to be arranged if required due to length of time until scheduled meeting.</p>
Health & Safety incidents	Report via BEMS' Incident Reporting Policy	<p>Respond in accordance with the relevant BEMS' policy, e.g. Health & Safety, Needlestick Injury, Infection Control etc.</p> <p>Identify learning and/or system changes to mitigate recurrence</p> <p>Refer to relevant body/organisation as required, e.g. HSE, Riddor reporting etc.</p> <p>Liaise with appropriate local and national agencies, patients/carers etc. to ensure learning is embedded as required</p> <p>To be discussed and agreed at Director Level (Clinical Governance Committee and/or MEC). Ad hoc meeting to be arranged if required due to length of time until scheduled meeting.</p>
Prescribing errors	Report via BEMS' Incident Reporting Policy	<p>Respond in accordance with the relevant BEMS' policy, e.g. Medicines Management.</p> <p>Identify learning and/or system changes to mitigate recurrence</p> <p>Refer to relevant body/organisation as required</p> <p>Liaise with appropriate local and national agencies, patients/carers etc. to ensure learning is embedded as required</p>

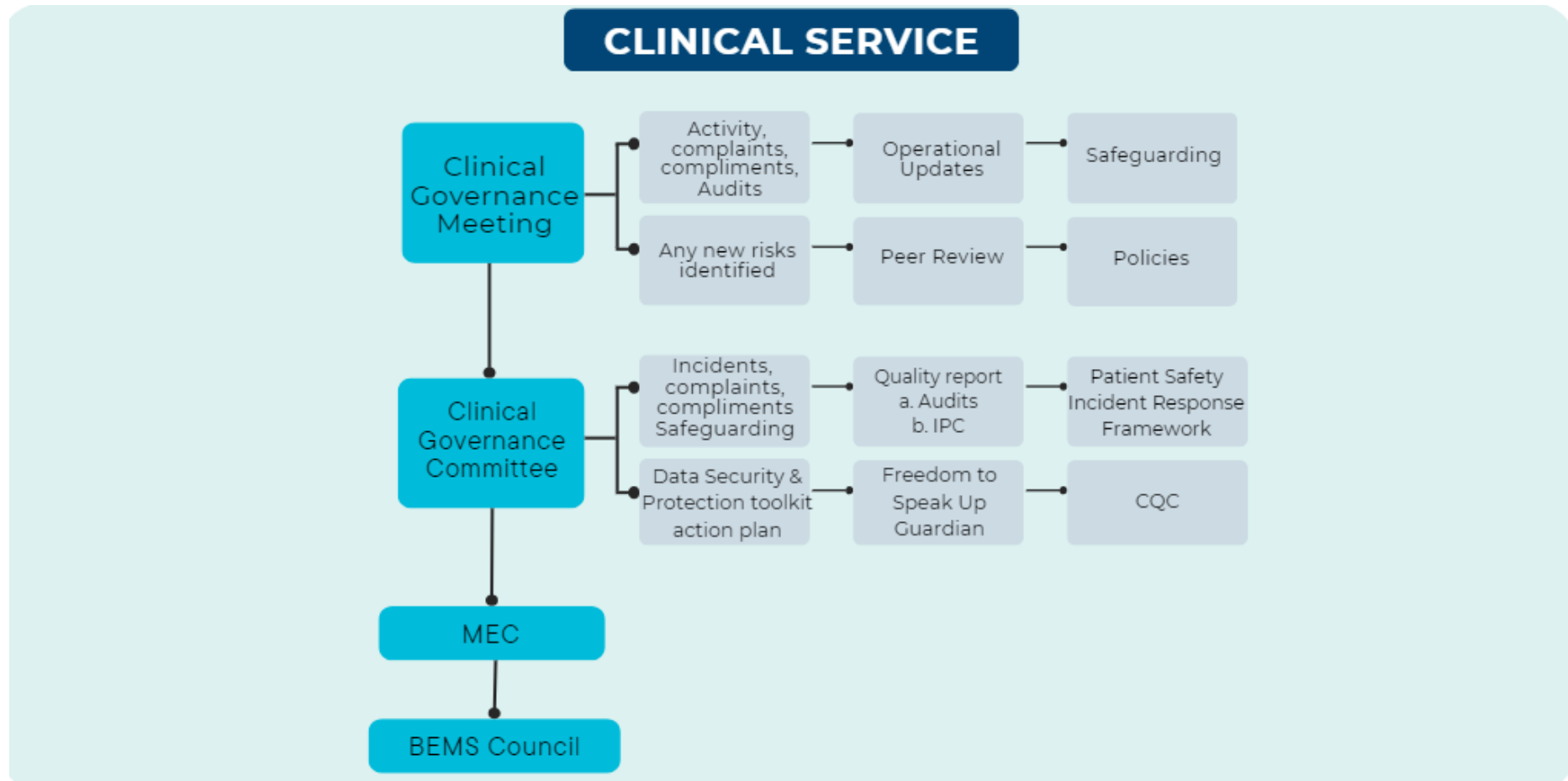
		To be discussed and agreed at Director Level (Clinical Governance Committee and/or MEC). Ad hoc meeting to be arranged if required due to length of time until scheduled meeting.
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Appendix 1: BEMS' Clinical Governance Structure



Patient safety incident response plan

Appendix 2: BEMS Clinical Governance meeting structure



Appendix 3: BEMS' Policies relating to Patient Safety:

- Chaperone Policy
- Data Protection Policy
- Was not Brought Policy
- Domestic Abuse Policy
- Safeguarding Children Policy
- Safeguarding Vulnerable Adults Policy
- Infection Control Policy
- Complaints Policy
- Incident Reporting Policy
- Speaking up (Whistleblowing) Policy
- Risk Management Policy
- Health & Safety Policy
- Freedom of Information Policy
- General Data Protection Regulations Policy
- Clinical Governance Policy
- Subject Access Requests Policy
- Consent to examine or treat Policy
- Medicines Management Policy