Physiological Measurements Ltd.

Patient Safety Incident Response Plan

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29/07/2024	Tracey Jones Derek Taylor	V1	I1	New document	29/07/2025

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1.0 Introduction

Our Patient Safety Incident Response Plan (PSIRP) is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 months or as and when required to ensure our focus remains up to date; with ongoing improvement work, our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

Updated plans will be published on our website, replacing any previous versions.

There are four main incident responses that can be considered under the Patient Safety Incident Response Framework (PSIRF) when patient safety incidents occur:

- An **After Action Review** is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.
- **Swarm-based huddles** are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.
- A **patient safety incident investigation (PSII)** is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.
- The **multidisciplinary team (MDT) review** supports health and social care teams to: identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.

Physiological Measurements Ltd (PML) are committed to improving patient safety through the adoption of PSIRF, supporting a systematic, compassionate and proficient response to patient safety incidents, embedded in the principles of "just culture" (openness, honesty and fair accountability), shared learning and continuous improvement.

In line with the NHS Patient Safety Strategy (2019), patient safety is about maximising the things that go right and minimising the things that go wrong. While patient safety incidents at PML are rare, under the new PSIRF framework we will prioritise compassionate engagement with patients, family and any staff affected. This provides vital insight into how to improve care, ultimately making services safer for our patients and residents.

PML will also utilise RADAR, our overarching digital quality and compliance system, to allow for a whole system overview of incidents, to facilitate ease of incident reporting and analysing and allow the sharing of relevant information across all company staff.

2.0 Our Services

Established in 2005, PML is committed to delivering high quality community healthcare diagnostic services, specialising in Non-Obstetric Ultrasound (NOUS) and Cardiology. As the landscape of the National Health Service (NHS) has evolved, so too has PML, aligning its growth and practices with the modernisation objectives of the NHS. With a focus on enhancing quality and devolving power to locally led clinical services, PML has consistently supported this initiative, maintaining a steadfast commitment to delivering high-quality ultrasound and cardiology services.

PML's central operations, including its head offices, patient management centre (PMC), human resources, and senior management, are headquartered in Oswestry, Shropshire. With a dedicated and proficient team, PML receives over 15,000 referrals monthly from various locations across England.

PML are committed to deploying technology as an enabler, utilising systems such as CIMAR, our bespoke picture archiving and communications system (PACS) which is hosted securely on the Health and Social Care Network (HSCN) to allow immediate sharing of patient images for clinical peer review, and IPMC2 our bespoke patient administration system.

Community Ultrasound Services

PML's operational framework provides NHS patients with increased accessibility and choice in receiving high quality diagnostic services, facilitated by cutting-edge technology and supported closely by an experienced clinical and operational team. Our ultrasound investigations span a range of specialties, ensuring patients receive specialised care tailored to their needs. Furthermore, access to advice from Consultant Radiologists or our Superintendent Sonographer Team ensures clinical appropriateness and expertise across various specialist interests. Our staff from across our ultrasound and cardiology teams also attend a whole day in-person meeting on a quarterly basis which allows clinical and administration teams to come together in order to share experiences and promote best practise.

Community Cardiology Services

In collaboration with local general practitioners (GPs) and commissioners, PML has developed a comprehensive patient pathway for community cardiology, transcending mere diagnostics. With a multidisciplinary team comprising cardiologists, cardiac physiologists, heart failure nurses, and cardiac rehabilitation staff, our service has experienced substantial growth and garnered national recognition through esteemed awards. Adhering rigorously to clinical governance standards, including agreed escalation protocols for urgent care provision, ensures uncompromised patient safety and quality of service.

PML offers an array of diagnostic tests in cardiology, supported by state-of-the-art equipment and experienced staff, covering a broad spectrum of cardiac health assessments. Additionally, our partnership with the Sport and Exercise Department of the Football Association (FA) underscores our commitment to providing specialised cardiology screening services for sports clubs and athletes, both through mobile units and fixed-site facilities.

Additionally, our sports diagnostic services extend to county cricket sides, professional cycling, rugby union, and rugby league, ensuring accessibility and compliance with screening requirements, even at short notice.

Through our dedication to innovation, collaboration, and excellence, PML remains steadfast in its mission to provide unparalleled community healthcare diagnostic services, enriching the lives and well-being of individuals across England.

3.0 Defining our Patient Safety Incident Profile

Fair and Just Culture is at the heart of all of PML's governance processes. This promotes an open and transparent culture to identify and understand patient safety incidents and a desire to learn from and improve the quality and safety of services.

In the event of a patient safety incident, supervisors will contact staff members involved to discuss details of the incident, gather statements, and provide support. Incidents are discussed at weekly Governance Team meetings and weekly Senior Management Team meetings to review learning, opportunities for improvement, risks and key safety issues. In addition, we hold quarterly clinical meetings to discuss quality improvement, clinical cases, patient experience, and share lessons learned from practice. All of these collectively underpin PML's quality strategy.

PSIRF sets the national requirements listed within the plan, see Table 1. The remainder of the plan is data driven, covering the last 5 years for serious incidents and 2 years for all other data which has provided an insight into the key patient safety incident themes, patterns and trends, and the greatest opportunities for learning to improve patient safety outcomes.

As a small organisation with defined services, the risks of serious incidents occurring are smaller than a large NHS Acute Trust. Thus, the number of incidents occurring each year that either met the criteria for reporting as a serious incident or investigating in more detail as an internal Root Cause Analysis (RCA) were relatively small.

PML's patient safety incident profile has been developed by analysing data from the following sources:

- Incidents reported between 01/01/2022 – 31/12/2023 (2 years)
- Serious incidents reported between 01/01/2019 – 31/12/2023 (5 years)
- Root Cause Analysis (RCA) reports between 01/01/2019 – 31/12/2023 (5 years)
- Safeguarding incidents recorded between 01/01/2022 – 31/12/2023 (2 years)
- Complaints investigated between 01/01/2022 – 31/12/2023 (2 years)

Consultation on PML's prioritisation plan has been undertaken internally via regular meetings with the Governance Team and the Senior Management Team, and externally with PML's commissioners via meetings with ICB PSIRF leads.

Local patient safety risks have been defined as the list of risks identified through the stakeholder approach and the patient safety data analysis described above. These local identified risks represent

opportunities for learning and improvement across PML. Table 2 lists our local patient safety priorities.

The criteria PML has used for defining the local patient safety risks is as follows:

Potential for harm:

- People: physical, psychological, loss of trust (patients, family, caregivers)
- Service delivery: impact on quality and delivery of healthcare services; impact on capacity and patient flow

Likelihood for occurrence:

- Persistence of risk/recurrence
- Frequency
- Potential to escalate

Potential for new learning and improvement

- Enhanced knowledge and understanding of the underlying factors.
- Improved efficiency and effectiveness (control potential)
- Opportunity to influence wider system improvement

There are many ways to respond to a patient safety incident. This plan covers responses conducted solely for the purpose of system learning and improvement. There is no remit within this plan or PSIRF to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

Historically, it has been necessary to investigate each incident report that meets a certain outcome threshold or 'trigger list'. It has since been learnt that, focusing most patient safety investigation efforts on incidents with the most severe outcome does not necessarily provide the most effective route to 'organisational learning'. There has also been found to be no clear need to investigate every incident report to identify the common contributory causes and improvement actions required to reduce the risk of similar incidents occurring.

The move to decide which incidents to investigate from a learning and improvement perspective increases the opportunity for continuous improvement by:

a. improving the quality of future patient safety incident investigations (PSIIs)
b. conducting PSIIs purely from a patient safety perspective
c. reducing the number of PSIIs into the same type of incident
d. aggregating and confirming the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents

This approach will allow healthcare organisations to consider the safety issues that are common to similar types of incidents and, on the basis of the risk and learning opportunities they present, demonstrate that these are:

a. being explored and addressed as a priority in current PSII work, or

b. the subject of current improvement work that can be shown to result in progress, or
c. listed for PSII work to be scheduled in the future. In some cases where a PSII for system learning is not indicated, another response may be required

Options that meet the needs of the situation more appropriately should be considered.

4.0 Defining our Patient Safety Improvement Profile

PML has developed strong governance processes across the clinical divisions and throughout the business and continues to review its governance processes to ensure that they remain fit for purpose, ensure that patient safety is the focus and that there remains an ongoing process of effective learning and continuous improvement within a fair and just culture.

PML will also continue to embrace national and regional guidance and support from NHS organisations, Regulators and Commissioners. PML's Governance Team and Senior Management Team will retain oversight of quality improvement measures and safety improvement plans to ensure that they remain of the highest standard, as well as ensuring that the clinical and corporate divisions provide robust assurance to learning and safety improvement plans, ensuring that the process of embedded learning from PSIRF continues.

The Governance Team will ensure that the clinical and corporate divisions provide robust assurance to quality improvement, in accordance with PML's Quality Strategy. PML will continue to ensure that quality and safety of services is paramount to the investigations that it undertakes in accordance with National and Local Priorities and that its' approach remains flexible to new risk and significant opportunities for learning.

5.0 Our Patient Safety Incident Response Plan: National Requirements

The following table identifies the incident types that could potentially occur at PML and their response methods, based on national guidance:

Table 1

Patient Safety Incident Type	Required Response	Lead Body for Response
Deaths thought more likely than not due to problems in care (incidents meeting **the learning from deaths criteria** for PSII)	Locally led PSII	The organisation in which the event occurred
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)	Locally led PSII	The organisation in which the event occurred
Incidents meeting the Never Events criteria 2018, or its replacement.	Locally led PSII	The organisation in which the event occurred
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	As decided by the RIIT
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSIB or SpHA for independent PSII.	HSIB (or SpHA)
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	Child Death Overview Panel

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	LeDeR programme
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	Notify internal safeguarding lead and refer to internal safeguarding policy. Refer to local authority safeguarding lead. Healthcare organisations must 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	Refer to your local designated professionals for child and adult safeguarding
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: **Guidance for managing incidents in NHS screening programmes**	The organisation in which the event occurred
Deaths in custody (e.g. 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.	PPO or IOPC

	Healthcare organisations must fully support these investigations where required to do so	
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, 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	CSP

6.0 Our Patient Safety Incident Response Plan: Local Focus

The following table sets out other types of incidents that could potentially occur within PML and their potential response methods based on the results of our incident profile. All incidents will be discussed internally to decide on the most appropriate method and therefore Table 2 should be used as a guide only.

Table 2

	Incident Management Method			
Incident Type	**Local Review** **Radar (Quality management System)**	**After Action Review**	**Patient Safety Incident Investigation (PSII)**	**Shared Learning**
No / Low Harm Incident	☑	☑		☑
Moderate / Severe Harm Incident	☑		☑	☑
Missed Diagnosis Leading to Patient Harm	☑		☑	☑
Inaccurate Results Leading to Patient Harm	☑		☑	☑
Delay in Patient Care Leading to Patient Harm	☑		☑	☑
Opportunity for Significant Learning (Regardless of Harm)	☑		☑	☑

Appendix 1: Incident Response Methods