Patient Safety Incident Response Framework

Plan

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Primary Eyecare

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Background

Accountability and Leadership

Primary Eyecare Services is a clinically led (not for profit) organisation with an extensive workforce with the skillset and knowledge to manage patient safety. The Board of Directors and Senior Leadership Team bring in a wide range of leadership, governance, financial, business and clinical skills, together with deep knowledge of NHS eye care services. The Primary Eyecare Services Senior Leadership Team is accountable to the Board, delivers clinical leadership and supports the delivery of services.

Clinical Leadership

Clinical leadership is provided at a regional level through a team of local clinical leads, supported by two Clinical Directors and a Consultant Ophthalmologist. Clinical Leads provide support to staff delivering care in local optometry practices and review performance through data, benchmarking, outlier investigation, complaints, incidents, issues and patient feedback. The Clinical Lead is a qualified optician/optometrist with clinical and service pathway expertise, knowledge of the local area and a strong relationship with the local optometry practices.

Issues, Incidents and Complaints Reporting

Primary Eyecare Services investigates and catalogue all high-level and low-level issues, incidents and complaints. These are used to identify trends and inform service improvements, reducing the likelihood of patient safety incidents occurring. Reporting of issues, incidents and complaints, along with trends analysis, are reported to the board quarterly. All learnings are reviewed and shared, with mitigations put in place to avoid future recurrence or any similar events.

Regulator - Care Quality Commission (CQC)

Primary Eyecare Services has been a registered healthcare provider with the Care Quality Commission (CQC) since 2020. Our commitment to high standards of care and patient safety is demonstrated through our ongoing self-assessment and quality improvement activity, which aligns with CQC's current regulatory framework. This framework focuses on quality statements within the five key domains of safe, effective, caring, responsive and well-led, describing what good care looks like in practice. Primary Eyecare Services uses these quality statements to guide reflection, monitor performance and identify opportunities for improvement, ensuring services are delivered in line with regulatory expectations and patient needs.

Statement of Rationale

This patient safety incident response plan sets out how Primary Eyecare Services intends to respond to patient safety incidents over a period of 12 months. This plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety and incidents occur, the needs of those affected and how we continually evolve our approach to manage patient safety.

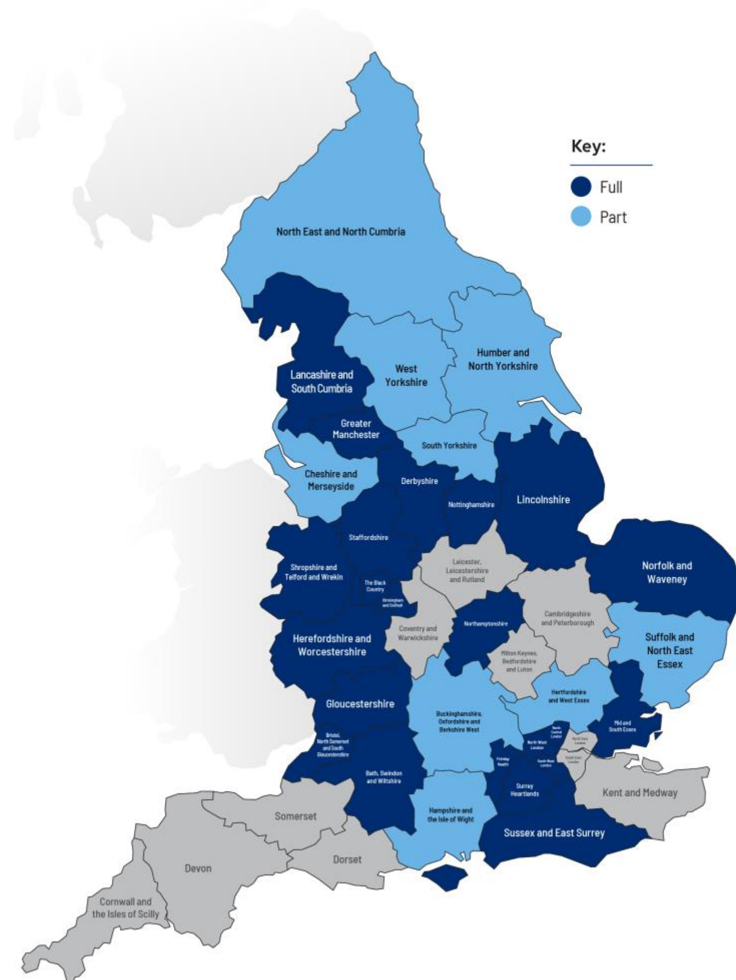
Our Services

Primary Eyecare Services is the leading provider of NHS extended eye care services nationwide, providing services across 30 Integrated Care Boards, in collaboration with 51 Local Optical Committees.

The organisation offers 253 service pathways, providing high-quality, accessible eye care.

These services are delivered across over 2,500 practices with care delivered by more than 6,000 clinicians, ensuring the delivery of high-quality eye care across the country.

The figure to the right shows areas where Primary Eyecare Services deliver clinical services.



Core Services - Clinical Services Delivered Through Optometry Practices

We deliver over 1,000,000 episodes of care annually with over 90% of those services delivered through our core model of utilising qualified experienced optometrists working within local optometry practices. These services are listed below.

Urgent Eye Care Services Providing timely access to care for patients with new onset symptoms.

- Community Urgent Eye Care Service
- Minor Eye Conditions Service

Cataract Services Providing pre-operative and post-operative care to patients requiring cataract surgery.

- Pre-operative Cataract Service
- Post-operative Cataract Service

Glaucoma Services Providing refinement of referrals and ongoing aftercare to patients suspected of glaucoma, at risk of glaucoma and diagnosed patients with glaucoma.

- Glaucoma Enhanced Referral Service
- Glaucoma Repeat Readings Service
- Glaucoma Monitoring Service

Children's Pathways Providing timely access to care for children where a visual deficiency is suspected.

- Post Vision Screening Service
- Integrated Children's Service

Health Inequalities/Hard To Reach Groups Services provided to improve access to eye care and to improve the quality of life for patients with sight loss.

- Low Vision Services
- Easy Eye Care – Sight Tests for people with learning disabilities and/or autism

Community Eyecare Services An all-encompassing service enabling clinicians to manage patients across a variety of clinical pathways.

Clinical Services Delivered by Primary Eyecare Services to Support and Enable Local Optometry Practices to Deliver Our Core Delivery Model

Our clinical services supporting the delivery of high-quality eye care includes:

Telemedicine Services

In some areas we support the delivery of clinical services through a central telemedicine service, allowing patients to receive virtual care from an experienced clinician. Approximately 60-65% of patients can be managed virtually – with those requiring face-to-face assessment, suitably risk-stratified and referred to a local optometry practice or hospital eye department to receive onward care.

Clinical Triage/Referral Services

These services support patients to be seen by the right clinician, in the right setting, at the right time. Experienced clinicians review patient referrals to ensure patients who can be seen by suitably trained optometrists/opticians in the community, are referred into local optometry practices to receive their car. Those patients requiring onward referral to hospital are risk-stratified and referred according to local protocols.

Approximately 30% of patients can receive their care through local optometry practices in the community, supporting local hospitals with waiting list initiatives.

Glaucoma Monitoring

This is a consultant led service working in partnership with clinicians in local optometry practices. The service is delivered by high qualified opticians providing virtual assessments and supports local hospitals to discharge low-risk patients into local optometry practices to receive their assessments in the community.

Non-Clinical Support Services Delivered by Primary Eyecare Services to Support and Enable Local Optometry Practices to Deliver Our Core Delivery Model

We also provide a variety of non-clinical services which support the delivery of our clinical services by offering patients wider, holistic, non-medical help and advice.

Defining Our Patient Safety Incident Profile

Stakeholder Engagement/Guidance

Primary Eyecare Services collaborate with national and local stakeholders to develop and deliver nationally recognised clinical pathways with local input through Clinical Leads, Hospital Clinicians, Local Optometrists and other local experts to address the diverse needs of the population. This framework and our delivery model are an integral part of our commitment to delivering safe and high-quality community care.

National Partners

The list below includes organisations who produce national guidance and/or work with Primary Eyecare Services to develop evidence-based service pathways and guidance:

- Local hospitals, including Ophthalmologists, Optometrists and Orthoptists
- Local Optical Committees (LOCs), including Optometrists and Opticians
- Third Sector organisation including patient groups
- Integrated Care Boards including local clinical experts

The organisations help us to tailor pathways to meet the local needs of the population. We work with these organisations to identify Key Performance Indicators (KPIs) which provide some of the measures we use to assess the quality of services delivered and our patient safety incident profile.

Safety Incident Profile

We deliver over 600,000 episodes of care annually with over 90% of those services delivered through our core model of utilising qualified and experienced Optometrists working within local optometry practices. The three pillars to our service delivery and incident profile are:

- Core services delivered through optometry practices
- Clinical services delivered by Primary Eyecare Services to support and enable local optometry practices to deliver our core delivery model
- Non-clinical support services

Data

We continually review data across our services to help identify potential risks, improve care and prevent adverse events. We have reviewed service metrics and outcomes from 2021 onwards and continually grow the dataset to inform patient safety risk.

The methods we use include, but are not limited to, the following:

Benchmarking and Comparative Analysis: assessing clinical outcomes by clinician, provider and area. Understanding and utilising intelligence through local clinical leads to improve analysis.

Data Analytics: identifying trends and patters across services.

Patient Safety Indicators: data on patient outcomes across the variety of services delivered.

Issue, Incident and Complaint Reporting: we encourage reporting of all incidents (including low-level) to inform trends and service risks, there are used to evolve pathways and mitigate risks.

Investigations: these may identify a combination of factors which lead to a patient safety incident.

Patient Feedback: both positive and negative can identify risks and opportunities to improve patient safety.

Non-Clinical Data: we support the delivery of services through a range of non-clinical services/processes (e.g., referral management, data management).

System Engineering Initiative for Patient Safety (SEIPS) Framework

The SEIPS framework is a well-established and widely recognised model used across healthcare to understand and improve patient safety. The framework was developed to address issues related to patient safety in healthcare settings and helps in identifying and addressing factors that can affect the performance and safety of a system.

The SEIPS framework considers the following key components:

People: this includes healthcare professionals, patients and other individuals involved in the system. It considers their roles, skills, knowledge and behaviours.

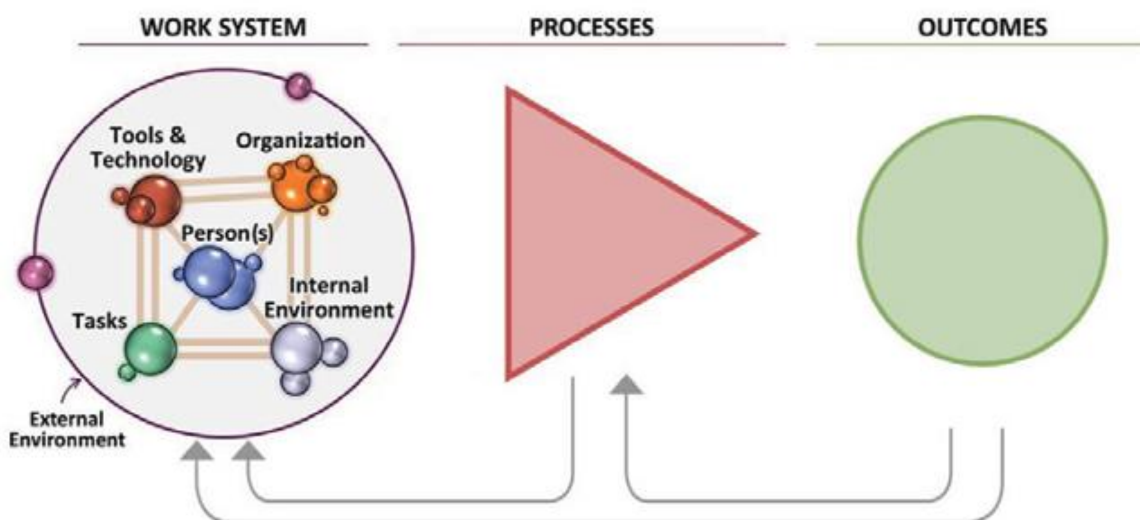
Tasks: includes activities and processes performed within the system. It involves understanding how it work is organisation and the sequence of tasks that need to be completed.

Tools and Technology: involve the equipment, technology and tools used in the system. It considers how well the technology supports the tasks and whether it's designed for safe and efficient use

Physical Environment: includes the layout of the workspace, the design of the facility and other environmental factors that can influence work performance and safety.

Organisation: focuses on the policies, culture and leadership within the system. It addresses how organisational factors impact the people, tasks, technology and physical environment.

The SEIPS framework (below) enables us to analyse the interactions among these components to identify areas to improve outcomes. The goal is to optimise these interactions to enhance safety, efficiency and performance.



Defining Our Patient Safety Improvement Profile

Quality Team

We have reviewed roles and completed a workforce gap analysis within the organisation which has led to the development of an updated internal structure combining patient safety and compliance roles in form our Quality team.

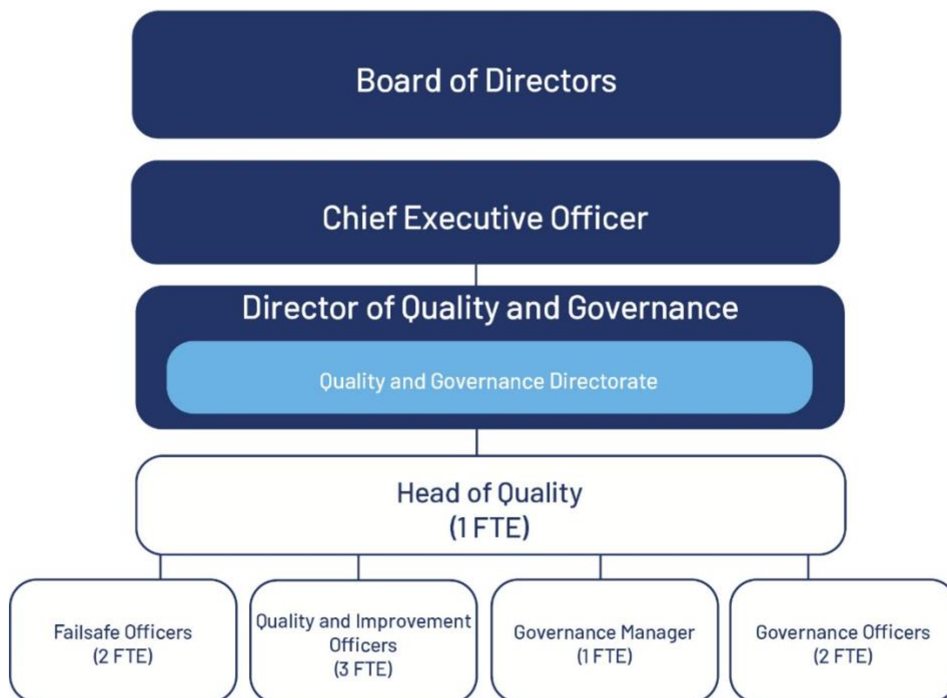
This team will focus on patient safety, enabling the organisation to continue to improve the quality of services we deliver and lead the implementation of Patient Safety Incident Response Framework (PSIRF).

The team has extensive experience and training in healthcare quality improvement and patient safety principles to ensure that this framework aligns with regulations and standards, whilst mitigating risks associated with patient safety incidents.

The Quality team also adapt the internal framework to continuously improve in response to evolving patient safety dynamics, safeguarding and patient wellbeing to ensure transparency and accountability in incident management.

The Quality team will focus on continuous improvement, standardise incident response processes, support the development of essential training and SOPs, ensure organisational compliance and lead the organisation's Continuous Quality Improvement Programme (CQIP).

The Quality team will include the Head of Quality, 2 x Failsafe Officers, 3 x Quality and Improvement Officers, 1 Governance Manager and 2 x Governance Officers. This structure will be reviewed at least annually in line with our patient safety profile.



Safety Culture

We promote a 'no-blame safety culture'. This is an organisational approach that emphasises learning from errors, near-misses, complaints, issues and incidents without assigning blame or punitive actions to individuals involved. This culture recognises that errors can often result from complex system failures rather than individual negligence and it focuses on understanding and improving the systems to prevent future occurrences. These are a variety of actions we have taken:

Leadership Commitment: Senior Leaders champion a culture of safety and actively support a blame-free environment.

Open Communication and Reporting: encouraging all staff providing services to report error, omissions without a fear of retribution.

Learning and Improvement: we focus on learning from incidents rather than attributing blame.

Non-Punitive/Systems Focused Approach: focus on identifying how systems and processes can be improved to prevent future occurrences.

Continuous Education and Training: regular training is provided to staff to enhance their skills and understanding of safety protocols.

Patient-Centred Focus: a culture which encourages involvement of patients and their carers and acknowledges the potential for error, while working to prevent them.

Transparent Communication: open communication about safety concerns, incidents and the changes made to improve patient safety.

Accountability for Systems: responsibility is shared with a focus on improving systems and processes rather than singling out individuals.

Professional Development Programme for Optometry Practice Staff: our learnings from patient safety incidents inform our professional development programme.

Compassionate Engagement

We will treat all patients with compassion and dignity and will respect their individual needs working with them to create a safe environment where they can talk about and share their experience, there is no 'one size fits all'.

Our investigations will be transparent, fair and inclusive. Compassion is at the core of everything we do, involving and focusing on the needs of all those affected to avoid compounded harm. Our aim is to support patients in their own understanding of what happened and find answers to the questions that are important to them.

Taking the learning from these investigations, adapting our processes and influencing improved outcomes for all our patients.

Training

Our Quality team has been activity engaged in a comprehensive training programme aimed at strengthening our PSIRF response capabilities. They've collectively undertaken numerous courses designed to enhance our preparedness and response strategies.

These initiatives are essential in refining our skills and expertise, enabling us to develop more effective and coordinated responses to a wide range of critical situations, ensuring the highest quality standards.

A staff complete role-specific mandatory training. Further training courses for members of the Quality team have been identified and procured in response to a training needs analysis. All members of the Quality team have completed the Healthcare Safety Investigation Branch level two training. Additional training is role dependent.

We hold a comprehensive training log of previous and upcoming programmes that each member of the Quality team will attend. This log contains:

- Job role
- Webinar/interactive online session name
- Formal training course title
- Date held
- Completed/future

Continuous Quality Improvement Programme (CQIP)

Primary Eyecare Services' CQIP is informed by feedback from patients, families and carers. The organisation's CQIP delivers a continuous cycle of quality assurance assessments across the organisation, informing the approach to quality and governance.

The new Quality team will be responsible for implementing the CQIP, enhancing patient care and safety. The team will also monitor the outcomes from CQIP, to adjust our approach and strategy as required. The organisation will access support (as required) from our lead commissioner for PSIRF and collaborate with any local commissioner, where this occurs within their boundaries.

Our CQIP will be delivered across the three pillars of service delivery identified in our patient safety incident profile.

CQIP - Core Services Delivered Through Optometry Practices

Primary Eyecare Services has an established process of clinical audit, in which data is used to inform trends and outliers, with reporting to clinicians and optometry practices delivering services to enable personal reflection and inform service improvements.

Clinical Leads review service level data to identify areas of improvement and support local clinicians and optometry practices to deliver high-quality, safe services. This process supports continuous improvement and will inform and be supported by, our professional development programme.

CQIP - Non-Clinical Support Services

The Quality team will tailor internal assessments using data-led techniques to inform areas of risk and identify opportunities to strengthen our patient safety profile. These assessments will be aligned to the Care Quality Commission's (CQC) current regulatory framework, using the quality statements across the five domains to guide focus and analysis. This approach supports proactive identification of patient safety risks, enables targeted assurance activity and informs continuous improvement across services.

The example below is non-exhaustive and includes areas which assessments will focus on:

- Activity/task overview
- Responsibility
- Frequency
- Standard Operating Procedures (SOPs)
- Patient safety risks
- Existing patient safety management processes
- Potential risk(s)
- Risk mitigation recommendation
- Review date

Where recommendations are made, the Quality team will provide support to implement the change.

CQIP - Clinical Services Delivered by Primary Eyecare Services to Support and Enable Local Optometry Practices to Deliver Our Core Delivery Model

Our CQIP will include a combination of data-driven methods aligned with the core delivery model and internal assessments. These will be supplemented with a quality assurance programme focusing on core skills, decision-making and outcomes.

The quality assurance programme will be service specific and may include:

- Test sets: reviewing clinical decision-making against service outcomes
- Clinical audit: reviewing clinical outcomes by clinicians and service type
- Monitoring of calls: ensuring high-quality service delivery
- Mandatory training events: to improve quality and consistency

The quality assurance programme will be led by the clinical service leads and will be tailored to the clinical service delivered.

Raising Awareness and Communications

As part of our ongoing PSIRF development, our Quality team is working with our Communications team to determine the best way to raise awareness abut the new framework and to share updates with our key stakeholders. We have developed a PSIRF communications plan which includes a cycle of social media outputs, that will be updated quarterly, distributed to all practices and shared across our social media platforms.

PSIRF Policy

Our PSIRF policy is currently in development alongside the implementation of the PSIRF plan. This policy will be shared with our Board and formed approved ahead of our PSIRF go live date.

Our Patient Safety Incident Response Plan

Types of Response

Patient Safety Incident Investigation (PSII): a patient safety incident investigation is undertaken when an incident or near-miss indicates significant patient safety risks and the potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences and not causes.

Swarm Huddle: a meeting to explore an incident in a non-punitive way and deliver learning. It is a facilitated discussion on an incident or event to analyse what happened, how it happened and decide what needs to be done immediately to reduce risk.

It enables understanding and expectations of all involved and allows for learning to be captured and shared more widely.

Thematic Review: a thematic review aims to identify patterns in data to help answer questions, show links or identify issues. Thematic reviews can sometimes use a combination of qualitative data with quantitative data.

We deliver eye care services to patients identified as low risk. We do not deliver surgical care and hance our risk profile to different to many other large providers. The table of incident types below have been tailored for the services we deliver; these include low level issues which impact the quality of care received by patients.

National Requirements

Patient Safety Incident Type	Required Response	Anticipated Improvement Route
Never event – Fall from poorly unrestricted window	PSII	Create local organisational actions and feed these into the quality improvement strategy

Local Focus

Patient Safety Incident Type	Required Response	Anticipated Improvement Route
Delayed referral to primary or secondary care	PSII/Swarm Huddle	Implement corrective action to address the immediate issue. Explore factors and implement preventative measures to eliminate repeat of incident
Unexpected charges when attending MECS/CUES/CES appointments e.g. charging for prescriptions	Swarm Huddle/Thematic Review	Review appropriateness e.g. Local communications and determine if issue is throughout locality. NHS England – Items which should not be routinely prescribed in primary care
Diagnosis concern/enquiry in practice	PSII/Swarm Huddle	Clinical Lead escalation with local communication. Education and training as appropriate
Diagnosis concern/enquiry in telemedicine	PSII/Swarm Huddle	Telemedicine team escalation with targeted education and training as appropriate
Call handling/Referral Management error	Swarm Huddle with responsible team leaders	Immediate action with follow up of education and training. Review SOPs and update as appropriate
Practitioner/practice issue identified by patient	PSII/Swarm Huddle	Clinical Lead escalation with local communication. Education and training to ensure best practice
Practitioner/practice issue identified by internal team member	PSII/Swarm Huddle	Clinical Lead escalation with local communication. Education and training to ensure best practice
Patient identification errors	Swarm Huddle	Staff training, patients asked for minimum 3 data points, positive verification by patients
Equipment failure on NHS contractor premises	Swarm Huddle	Escalation to Primary Eyecare Services Clinical Lead, risk stratification. If urgent assessment required, refer to alternative provider
Clinical event, occurrence or complication associated with the diagnosis and treatment of patients	PSII/Swarm Huddle	Refer to local specialist services
Abuse directed toward staff, visitors, patients	PSII/Swarm Huddle	Contact emergency services for support

Our planned responses were derived from service metrics and outcome data collected from 2021 onward.