Patient safety incident response policy and plan

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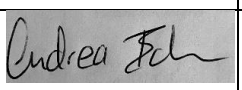
	NAME	TITLE	SIGNATURE	DATE
Author	**Jill Firth**	**Director Service Improvement (Pennine MSK Partnership)**		**08/12/2024**
	Emma Hughes	**Clinical Governance Lead and Specialist Pharmacist Rheumatology (Pennine MSK Partnership)**		**17/01/2024**
Reviewer	**Ruth Holden**	**Lead Director (Pennine MSK Partnership)**		**17/01/2024**
Authoriser	**Andrea Edmondson**	**Assistant Director Quality, GM ICB**		**24/05/2024**

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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Pennine MSK's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

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

- 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 and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Pennine MSK, including those that are led by Pennine MSK and involve the provision of care by other providers**.** Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. As an organisation Pennine MSK has a low threshold for capturing and collating events where the absence of a response may lead to risk to patients and members of the public. This is in keeping with the Patient Safety Incident Response Framework v1 (PSIRF, 2022), which replaces the Serious Incident Framework (SIF, 2015).

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Our patient safety culture

As an organisation Pennine MSK supports a culture of fairness, openness and learning to make staff feel confident to speak up when things go wrong. We have

promoted https://www.england.nhs.uk/patient-safety/a-just-culture-guide/ as part of line managers training. We encourage line managers to consider whether a staff member involved in a specific patient safety event needs individual support or whether there is a systems-based solution to support them to work safely. We embed risk management and service improvement into all areas of clinical practice and business functions to ensure that lessons are not only learned but that safety action plans are implemented.

Patient safety partners

We plan to continue to engage with patients as partners to identify and respond to patient safety concerns via direct consultation on a pathway-based basis. We also actively engage with any patients via Friends & Family test feedback and code concerns raised by patients in System One which are collated and investigated by our Patient Experience Lead. Our research is informed by patient and public involvement from co-production through to evaluation of projects.

Addressing health inequalities

We have recognised that we need better data on demographics (for example on age, gender, ethnicity and learning disability) in order to make it easier to identify health inequalities and gaps in care for people who need our care. This is also necessary to identify any disproportionate risk to patients with specific characteristics and how we can reduce inequality and inform patient safety incident responses. In 2023 we have adopted the use of digital tools such as SystmOne messaging to increase access to, and completion of, the NHS Equality and Diversity form. The transition to the Radar Risk Management system means that we will be prompted to record patient' protected characteristics and consider whether any disproportionate risk affects patients with specific characteristics. This information will be used to explore and analyse risk and trends to inform learning responses, safety actions and this policy and plan.

We will seek to engage with those who are seldom heard and plan to identify and engage with key stakeholders as our patient safety plan evolves. We have a track

record of using research to explore barriers to care e.g., digital inequalities and levers to overcome them. We will consider different needs of everyone involved following a patient safety incident.

All our staff will receive patient safety training commensurate with their role (see resources and training). We offer a variety of avenues for staff to report patient safety concerns, ranging from direct event reporting on Radar risk software and pathway review at Clinical Peer Review to access to both internal and external Freedom to Speak Up Guardians.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

The organisation is committed to compassionate engagement and involvement of patients, families and healthcare staff following patient safety incidents. We do this by supporting a culture of openness and transparency. This includes a commitment to discharging Duty of Candour as soon as possible when something goes wrong and not only when a patient safety incident is notifiable by the nature of the potential to cause death, severe harm, moderate harm or prolonged psychological harm to a service user. Any clinical, physical or emotional needs are prioritised to alleviate / avoid compounding any harm. We endeavour to apologise for the impact of an incident on the individual which acknowledges accountability but not necessarily responsibility ahead of an investigation.

Where a patient safety incident requires a full investigation, patients and their families and staff are invited to contribute to agreeing terms of reference for the investigation and sharing their experience and insights to inform learning responses. Support should be provided / signposted for patients and their families depending upon the needs and circumstances of those affected.

Support for staff starts with a just supportive learning culture that focuses on systems-based learning and normalises the need to develop and share coping strategies. In the Pennine MSK this includes regular peer review and support from colleagues and an ongoing focus on the importance of staff mental health. There are internal and external options for support, both formal and informal that can be tailored to the individual.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, Pennine MSK is committed to exploring patient safety incidents relevant to our service and the local population we serve rather than only those that meet a certain defined threshold. Hence, we encourage all staff (clinical and administrative), patients and their families to report patient safety events, including those which are categorised as a near miss, in order to improve patient safety.

Resources and training to support patient safety incident response

Learning responses will not be led by staff who were involved in the patient safety incident itself or by those who directly manage those staff. A learning response team has been developed to ensure that responses can be led by staff with dedicated time and the relevant knowledge and skills.

Learning responses are led by those with at least two days' formal training and skills development in learning from patient safety incidents and experience of patient safety incident response. Learning response leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus. Those with an oversight role on the Senior leadership team have completed level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the patient safety syllabus.

Learning response leads will undertake continuous professional development in incident response skills and knowledge, and network with other leads at least annually to build and maintain their expertise. Our outgoing Patient safety lead had undertaken the Health and Safety Investigation branch (HSIB) Bronze level patient safety training and there are plans in place for the Learning response lead who succeeds her in 2024 to access this training with dedicated time for completion. Opportunities for networking are already in place with access to the Greater Manchester PSIRF Northwest collaborative. Learning responses will not be undertaken by staff working in isolation and there will be the opportunity for challenge and feedback within team. There will also be the opportunity for oversight and learning across the Vita Health Group.

Our patient safety incident response plan

Our plan sets out how Pennine MSK intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Stakeholder engagement

We plan to hold brainstorm sessions at Clinical Peer Review for Pennine MSK Staff to identify patient safety risks and concerns that should be addressed as part of our patient safety plan. This will not only involve staff in its development but will also provide an opportunity to learn from near misses/ concerns that may not have been reported previously.

We have liaised with the Vita Health Group Director of Governance & Quality, Safety & Risk team in the development of this policy and it has been shared with the Quality & Safety team at the Oldham locality ICB. In the future work will begin to integrate further into the Spire Healthcare Group and at that time we will work to engage them as a partner.

Defining our patient safety risk profile

We have reviewed data from a variety of sources recorded between 1st October 2021 and 30th September 2023:

- 99 patient safety events
- 1 serious untoward incident
- 24 corporate risks; 6 currently active on Risk Register
- 15 formal complaints and 151 informal concerns raised
- 42 safeguarding concerns

We identified the following themes:

- Delays in onward referrals to other services (orthopaedics and 2 week waits): service improvement plans completed, including actions arising from SUI which generated cross pathway learning responses

- Access to diagnostics e.g., MRIs including reported – internal service improvement plan completed to ensure that scans are requested; external reporting times have improved

- Barriers to accessing Fracture Liaison service & osteoporosis management – service improvement plan in progress

- Access to Homecare medicines – we have raised recurrent issues with Homecare company Incident and Investigation team; a British Society for Rheumatology led campaign has led to a parliamentary report with a number of service improvement recommendations: https://www.rheumatology.org.uk/news/details/Joint-statement-on-homecare-medicines-services-report

- Safety of medicines – many of these are near misses relating to methotrexate – we have implemented a range of safety actions to promote adherence and patient safety.

- Communication – across complaints this was a cross cutting theme with access to diagnostics and onwards referrals to services – but staff attitudes and communication also featured strongly in keeping with the national trend. We have involved patients in learning; maintain training and evaluation of shared decision-making and plan to extend our focus on patient experience in 2024.

- Risk register – we currently have six active items on the risk register. These are reviewed regularly to identify what actions can be taken to minimise these risks in the future.

- Safeguarding referrals were made in line with our policy but we continue strategies to raise awareness.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan 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 to 18 months 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 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

Patient safety incident reporting arrangements

As part of the Vita Health Group we are implementing an electronic patient safety risk management system known as the Radar Risk Management system. This will help us to capture patient safety data from incidents, complaints, risks, and concerns, ensuring a 'no wrong door' approach. All employees have been trained on system use, which is embedded into day to-day practice. Patient safety and risk data will be aggregated and made available to across organisational learning. Phase One implementation includes PSIRF and Learning from Patient Safety Events (LfPSE). This will be followed by Risk Registers; Policy management and Audit to help us track and manage risks to patient safety across different services and locations. Our implementation plan means that we can increase stakeholder engagement, monitor the status of actions as part of an investigation and ensure accountability, track deadlines and ensure service improvement plans are implemented in a timely manner.

We encourage all our staff – healthcare and administrative, directly employed and sub-contracted - to report patient safety events and have a low threshold for including near misses and events that the reporter feels could inform service improvement plans. Moving forwards there is an intention to facilitate patient and public reporting via the National Reporting and Learning System.

Arrangements and processes for reporting safeguarding events are covered in the Safeguarding and Prevent policy v12.

Patient safety incident response decision-making

Pennine MSK is committed to a systems-based approaches to learning which recognises that outcomes in complex healthcare systems result from the interaction of multiple factors. In a just culture NHS England » A just culture guide, learning and improvements plans need to be collaborative, resourced and monitored over time to see if they deliver the desired impact.

Radar risk management software has been embedded across our IT systems and rapid access has been installed within our electronic health record (System). Staff are also encouraged to raise any concerns with any member of the patient safety team or the Freedom to Speak Up Guardian.

The type of investigation required will be locally determined and where contributory factors are not well understood we will use national learning response methods to inform learning and improvement. A Patient Safety Incident Investigation (PSII) will be undertaken where an in-depth review of a single patient safety incidents is required or a cluster of incidents to understand what happened and how.

Vita Health Group has registered for a Learn from Patient Safety Events account to improve patient safety learning across the NHS. During a transition period until the end of April 2024 we will continue to inform our locality Quality and Safety team of any incidents whereby:

- a patient was harmed, or could have been harmed
- there has been a poor outcome but it is not yet clear whether an incident contributed or not
- risks to patient safety in the future have been identified
- good care has been delivered that could be learned from to improve patient safety.

This means that incidents which would previously have been flagged as Serious Untoward Incidents under the Serious Untoward Incident Framework (SUI, 2015) will still be captured and flagged during the transition period to PSIRF. We will also flag any incidents that meet the criteria under the Never Events policy and framework (2018). A review of the 2018 Never Events List is currently being conducted and we will update our patient safety incident reporting arrangements as changes are published. Patient safety events that meet the criteria for a SUI or Never Event require a locally led PSII by an appropriately trained investigator. Within Pennine MSK this will be the Patient Safety Lead, supported by the ICB Patient Safety Lead.

Responding to cross-system incidents/issues

Our Patient Safety Incident Response Framework Executive Lead is Emma Hughes who works with and reports to the Senior Leadership Team. She or a nominated deputy is responsible for ensuring that:

- patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress are discussed at the board or leadership team's relevant sub-committee(s) e.g. Information Governance board.

- roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to incidents.

The PSIRF Executive Lead and Service Improvement Lead will meet at least monthly to review open incidents and safety actions and improvement plans in progress. An overall review of the patient safety incident response policy and plan will be undertaken at least every four years alongside a review of all safety actions. Support for this role is provided by the Vita Health Group governance team and the Quality and Safety officer at the locality ICB.

Any patient safety events that are reported which require investigation by partners in other organisations will be downloaded and forwarded via secure email to the appropriate governance lead. Patient safety events that require a PSII investigation that require a cross-learning response will be shared with the Quality and Safety team at the locality ICB to facilitate agreeing shared terms of reference; roles and responsibilities and collation of patient and staff involvement; learning responses and safety actions. The Care Quality Commission will be informed (via the regional relationship lead) if any high profile or complex incidents occur as part of the co-ordinated response, as well as being provided with all statutory notifications as required by the Health and Social Care Act (2008) and set out in CQC's guidance on statutory notifications.

Timeframes for learning responses

Incidents are triaged by the Patient Safety or Service Improvement lead within one working day and risk rated using the Vita Health Group risk assessment template version 2 (see Appendix one) based on the NPSA risk matrix allocated to an investigator with a time frame for feedback. A response will start as soon as possible after an incident has been identified and usually be completed between one to three months.

The timeframe for completing a PSII should be agreed with those affected by the incident, as part of setting the terms of reference for the PSII, provided they are willing and able to be involved in that decision. We will endeavour to ensure that PSIIs (and other internal responses) do not take longer than six months, in exceptional circumstances (eg when a partner organisation requests an investigation is paused), any extension to timescales will be agreed with those affected (including the patient, family, carer, and staff). Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the local response leads will use all the available information they have to complete the response to the best of their ability. If new information indicates the need for further investigative activity, the incident will be reopened.

Safety action development and monitoring improvement

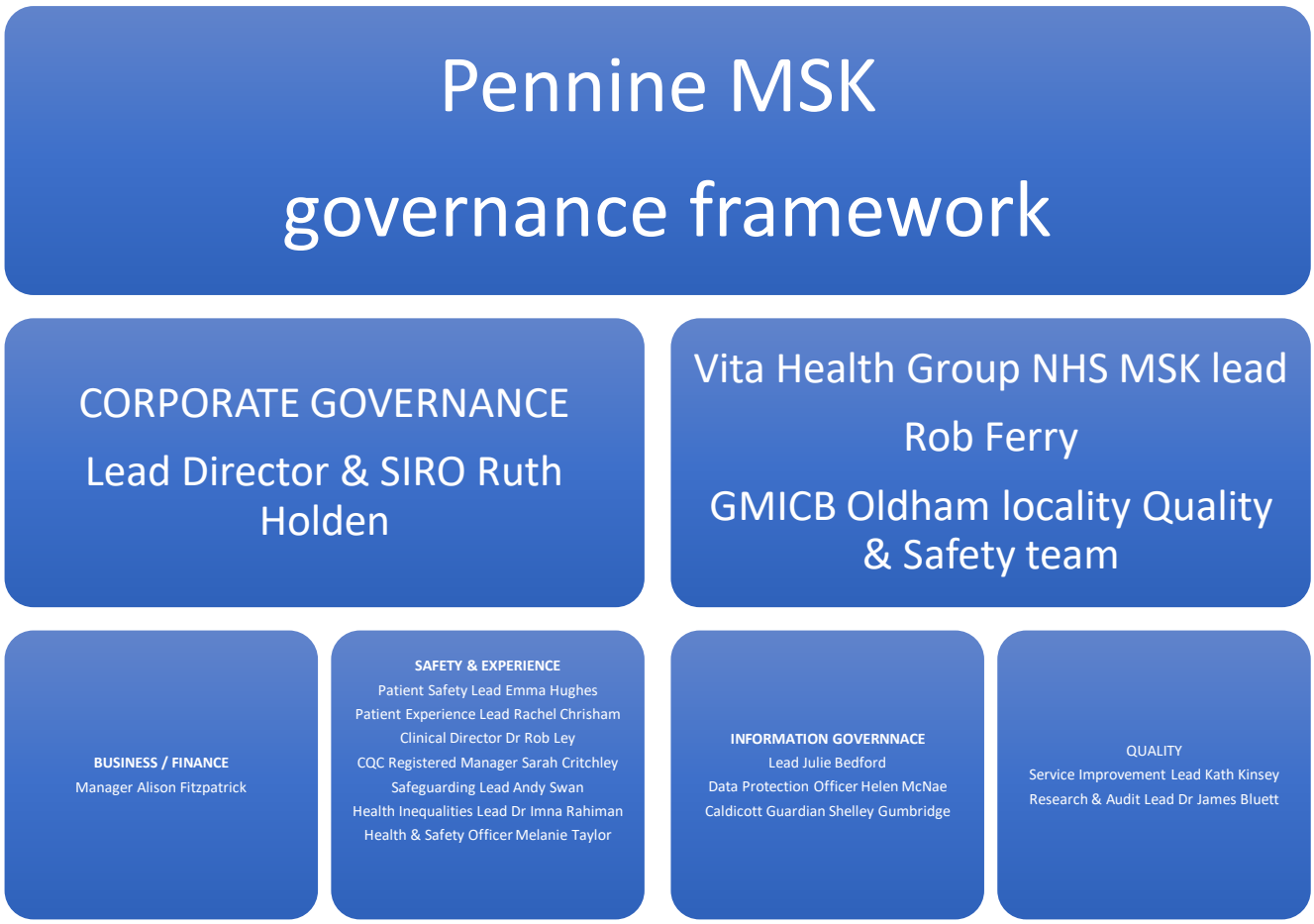
Once areas for improvement are identified and agreed, we will work collaboratively to define safety actions focussing on the system rather than individuals. We will engage with staff to test the feasibility of safety actions in the area for improvement and obtain feedback. We will identify metrics that will determine the effectiveness of agreed safety actions to improve patient safety and who is responsible for collecting, analysing and reporting on the data. This will be documented within Radar contributing to the development of a safety improvement plan with dates set for review.

Safety improvement plans

Any patient safety events which require an improvement plan will be sent to the SIIT using an action via Radar. These will then be added to the Pennine MSK Service Improvement Plan with responsibilities and timeframe allocated. Once this has been completed the patient safety even can be signed off as completed in Radar. The SIIT will feedback to the Learning Response Lead regarding progress until the plan has been implemented and evaluated.

Oversight roles and responsibilities

The Senior Leadership team is responsible and accountable for effective patient safety incident management in their organisation. This includes supporting and participating in cross-system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required. Figure 1 shows the individuals responsible for different elements of patient safety and their accountability.



The ICB Quality & Safety Improvement officer (Oldham) provides additional support and oversight through review of incidents / complaints reports, contract management meetings and remote support upon request. Serious Untoward Incidents are currently reviewed by the locality SI panel.

Complaints and appeals

We welcome our patients to submit comments, compliments, or complaints regarding any aspect of their care and also welcome this in relation to the organisation's response to patient safety incidents. This can be done either by completing a "Comments, Compliments, Complaints form" which is available in clinic or by completing the form via the website and posting it to us. Alternatively patients can write directly to our Patient Care Manager, letters should be addressed to Rachel Chrisham, Patient Care Manager, Pennine MSK Partnership, Integrated Care Centre, New Radcliffe Street, Oldham, OL1 1NL.

In the event that a patient remains dissatisfied with the outcome of a complaint they have the right to take their complaint to the Health Service Ombudsman. They can be contacted by:

- calling the helpline on 0345 015 4033 (Mon- Fri 8.30am-5.30pm),
- emailing phso.enquiries@ombudsman.org.uk
- visiting www.ombudsman.org.uk
- writing to: The Parliamentary and Health Service Ombudsman, Millbank Tower, Millbank, London, SW1P 4QP

Appendix 1: Vita health group Risk Assessment Template:

Vita Health Group
Risk Assessment Ter