Patient safety incident response policy

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A toolkit of learning response types is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/ 15

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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Orr Medicals' 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 Orr Medical Triage Services.**

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

Orr Medical promotes a just culture approach (in line with the NHS Just Culture Guide - https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf) to any work planned or underway to improve safety culture. Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

Orr Medical encourages and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). Please refer to significant event and incident reporting policy for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame.

Patient safety partners

Orr Medical has not set a definite number of Patient Safety Partners that it wishes to engage with.

Patient Safety Partners (PSP) will have an important role in supporting our PSIRF providing a patient perspective to developments and innovations to drive continuous improvement.

A Patient Safety Partner (PSP) may be involved in the designing of safer healthcare at all levels in the organisation. This means maximising the things that go right and minimising the things that go wrong for patients when they are receiving treatment, care and services from us. PSPs will use their lived experience as a patient, carer, family member or a member of the local community to support and advise on activities, policies and procedures that will improve patient safety and help us to deliver high quality care.

PSPs will work alongside staff, volunteers and patients, attend meetings (face-to-face and online), be involved in projects to co-design developments of patient safety initiatives, and join (and participate in) key conversations and meetings at Orr Medical focusing on patient safety. They will have a mind-set for improving outcomes, whilst representing the patient, carer, family view and ensuring committee/meeting members are “walking in the patients’ shoes”.

Addressing health inequalities

Orr Medical supports the agenda on tackling health inequalities alongside our partners and commissioners. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system, for example our education system; economic and community development in our most deprived neighbourhoods; employment levels; pay and conditions; and availability and quality of housing.

Through implementation of PSIRF, as required, we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to our Commissioners and partner agencies on how to tackle these. This holistic, integrated approach to patient safety under PSIRF will require Orr Medical to continue to collaborative with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda.

Our engagement with patients, families and carers following a patient safety incident investigation PSII will recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues will be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

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.

Involving Patients & Families: Orr Medical recognises the importance of and is committed to involving patients and families following patient safety incidents, engaging them in the investigation process and to fulfil the duty of candour requirements. It is recognised from experience and research that patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents, and / or may have different questions or needs to that of the organisation.

This policy therefore reinforces existing guidance relating to the duty of candour and 'being open' and recognises the need to involve patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved.

Involving Staff, Colleagues and Partners: Involvement of staff and colleagues (including partner agencies) is of paramount importance when responding to a patient safety incident to ensure a holistic and inclusive approach from the outset. This policy reinforces existing guidance (Significant Event & Incident Reporting Policy), it is recognised this approach must not be restricted to only those incidents that meet a threshold of harm or predefined categories. We will continue to promote, support and encourage our colleagues and partners to report any incident or near-misses.

It is also recognised that staff and colleagues need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame. We will continue to closely monitor incident reporting levels and continue promote an open and just culture to support this.

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, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

As an Organisation we welcome this approach so we can focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improving safety. It is also recognised that our planning needs to account for other sources of feedback and intelligence such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. PSIRF guidance specifies the following standards that our plans should reflect:

- A thorough analysis of relevant organisational data. We regularly review performance on a monthly basis and submit a monthly dashboard to the ICB including quality indicators and patient incident reports. There have been no patient safety incidents or complaints over the last 4 years to identify any trends.

- Collaborative stakeholder engagement

- A clear rationale for the response to each identified patient safety incident type

They will also be:

- Updated as required and in accordance with emerging intelligence and improvement efforts.

- Published on our external facing website

Resources and training to support patient safety incident response

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. It is therefore essential that as an organisation we evaluate our capacity and resources to deliver our plan.

All staff will be required to complete the patient safety training which covers the basic requirements of reporting, investigating and learning from incidents (Levels 1 & 2) and is found on Bluestream elearning platform.

Our patient safety incident response plan

Our plan sets out how Orr Medical 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.

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

PSIRF guidance states: “Where an incident type is well understood – for example, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the contributory factors are being implemented and monitored for effectiveness – resources may be better directed at improvement rather than repeat investigation (or other type of learning response).” *(PSIRF supporting guidance, Guide to responding proportionately to patient safety incidents. NHSE 2022)*

As an organisation we have two-way learning and feedback from our subcontractor GPs and ourselves. We also feedback to the ICB via contracting and patient safety mechanisms. This learning is then be shared more widely with other providers.

Patient safety incident reporting arrangements

Patient safety incident reporting will remain in line with Orr Medical's Significant Event and Incident Reporting Policy. It is recognised that staff must continue to feel supported and able to report any incidents, or concerns in relation to patient safety, to promote a system of continuous improvement and a just and open culture.

Managers and Directors will ensure any incidents that require cross system or partnership engagement are identified and shared through existing channels and networks (ICB contracting mechanisms) as well as reporting via the LFPSE system, and that partnership colleagues are fully engaged in investigations and learning as required. Likewise, we will ensure we are responsive to incidents reported by partner colleagues that require input from Orr Medical.

Patient safety incident response decision-making

Reporting of incidents will continue in line with existing Orr Medical policy and guidance. Orr Medical has governance and assurance system in place to ensure oversight of incidents to ensure the following arrangements are in place:

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends or clusters of incidents within a specific service
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risks and issues
- Identification of any incidents requiring external reporting or scrutiny (eg – Never Events, Neonatal deaths, RIDDOR)
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures
- Reporting of Patient Safety Incidents to the LFPSE system or any system that replaces it.

Timeframes for learning responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

One of the most important factors in ensuring timeliness of a learning response is thorough, complete and accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team. These principles are set out in the current incident reporting guidance but must be reinforced through the PSIRF.

A toolkit of learning response types is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

Safety action development and monitoring improvement

PSIRF moves away from the identification of 'recommendations' which may lead to solutionising at an early stage of the safety action development process.

A Quality Improvement approach is valuable in this aspect of learning and improvement following a patient safety investigation.

Safety actions arising from a learning response should follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and thought must be given to monitoring and measures of success. Further guidance on this can be found in NHSE Guidance at https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Monitoring of completion and efficacy of safety actions will be through organisational governance processes.

It is important that monitoring of completion of safety actions remains a means to improve safety and quality outcomes and reduce risk. Orr Medical will continue to develop governance systems focused more on measuring and monitoring these outcomes, utilising subjective as well as objective measures.

Safety improvement plans

The Patient Safety Incident Response Plan (PSIRP) will clarify what Orr Medical improvement priorities are. The PSIRP details how we will ensure patient safety incidents are investigated in a more holistic and inclusive way, to identify learning and safety actions which will reduce risk and improve safety and quality.

The themes detailed in the PSIRP, will be based on an extensive analysis of historic data and information from a range of sources (eg: incident trends, complaints, mortality reviews, risk registers, legal claims and inquests) and feedback from staff and patients. Each theme will have its own improvement plan to determine what the key drivers are to patient safety risks, how improvements can be made and how these can be monitored for completion and effectiveness.

Oversight roles and responsibilities

Responsibility for oversight of the PSIRF sits with Orr Medical Board. The Executive Lead is the Medical Director who holds responsibility for effective monitoring and oversight of PSIRF.

Orr Medical is committed to close working, in partnership, with the ICB and other national commissioning bodies as required. They also collaborate and share two-way learning with their GP subcontractors as well as disseminating learning to other providers via the ICB. Oversight and assurance arrangements will be developed through joint planning and arrangements must incorporate the key principles detailed in the guidance above, namely:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Policy, planning and governance
3. Competence and capacity
4. Proportionate responses
5. Safety actions and improvement

Complaints and appeals

Orr Medical has a robust complaints policy in place for all service users to follow.

Availability of information

Orr Medical will ensure that there are notices advising on the complaints process displayed on their website which contain sufficient details for anyone to make a complaint without the need to ask. We will also signpost the complainant to the help available through the NHS Complaints Ombudsman.

Who can a formal complaint be made to?

Either the Orr Medical or to NHS England (NHSE).

In the event of anyone not wishing to complain directly to Orr Medical they should be directed to make their complaint to Lancashire and Cumbria ICB:

By telephone: 0300 311 22 33.

By email: england.contactus@nhs.net

By post: NHS England. PO Box 16738. Redditch. B97 9PT.

In those cases where the complaint is made to the ICB, Orr Medical will comply with all appropriate requests for information and co-operate fully in assisting them to investigate and respond to the complaint.

Who is responsible at Orr Medical for dealing with complaints?

The "Responsible Person" is Dr Matthew Orr, Director. He is charged with ensuring complaints are handled in accordance with the regulations, that lessons learned are fully implemented, and that no Complainant is discriminated against for making a complaint.