Patient Safety Incident Response Policy

	NAME	TITLE	DATE
Author	Andrew McAnelly	Head of Integrated Governance	March 2024
Reviewer	Lesley Crosby	Director of Governance and Quality	March 2024
Authorising Committee	**Clinical Governance Committee**	**Sub Committee of Board**	**21st March 2024**

Effective date: 1st April 2024

Review date: 1st April 2025

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Connect Health'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 all Connect Health Group services delivering under the NHS Standard Contract. This includes Community Musculoskeletal (MSK), Community Pain Management, Rheumatology, and Improving Access to Psychological Therapy (IAPT) 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 Complaints Management, Information Governance concerns, Claims handling, Human Resources investigations into employment concerns, Professional Standards Investigations, Coronial investigations, 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.

The policy should be read in conjunction with our Incident Reporting, Management, and Investigation Policy (HS 3.11)

Associated Policies & Documents:	• Risk Management Policy • Being Open and Duty of Candour Policy • Complaints and Feedback Policy • Child Protection & Safeguarding Policy • Safeguarding Adults Policy • Prevent Policy • Management of Allegations Against Colleagues Policy • Whistle Blowing Policy • Diagnostic imaging safety Policy • Medicines Management Policy • Clinical Governance Framework • Health and Safety Policy • Cauda Equina Syndrome Policy

Our Patient Safety Culture

Connect Health is committed to promoting a climate that fosters a 'Just Culture'. The organisation has made significant progress in embedding and encouraging an open culture thereby improving collaboration within Connect Health.

Connect Health has particularly identified with the journey of Mersey Care Foundation NHS Trust who have been on an ongoing journey of implementing a 'Restorative and Just Culture'.

This policy is reliant on that continued buy in around a Just and Learning Culture. The widely reported mistakes in healthcare organisations were not helped by a reluctance amongst employees to report those mistakes. That reluctance came from concern about what the personal consequences might be for them as an individual. It also comes from the concept in some organisations that investigations often tend to see human factors as the cause of the mistake, seeing people as the problem thereby assuming that because we have policies and procedures in place things won't go wrong and if they go wrong people are to blame.

Connect Health has and will continue to foster an environment where colleagues feel supported and empowered to learn when things do not go as expected, rather than feeling blamed. This is a culture that instinctively asks, in the case of an adverse event: "what was responsible, not who is responsible". Connect Health has worked

hard to ensure it is not about ‘finger pointing’ and not blame-seeking. Connect Health balances that by ensuring that it is not the same as an uncritically tolerant culture where anything goes – that would be as inexcusable as a blame culture.

At Connect Health we will make sure that in our daily practice, our conduct and our dealings with colleagues is honest, kind and that we show, irrespective of seniority, we are willing to learn. The question we ask is, are you helping to shape the culture in your team or service with your positive attitude or willingness to help?

It is our ambition that all our colleagues, our patients and service users, all understand and feel a true part of our Just and Learning principles. Alongside our Freedom to Speak Up Guardians, our People team, our Integrated Governance Team, we are developing plans to embed a Just Culture across all sectors within Connect Health.

We have recently implemented a new ‘Incident Reporting’ mandatory training module in March 2023 alongside mandatory Patient Safety Training in September 2023 (relevant to PSIRF). We aim to improve and increase communications relating to lessons learned, actions taken as well as ensuring all reporters of incidents receive meaningful feedback. Closing that loop is very important to ensuring learning and continued high levels of reporting as reporters see their reports are acted upon.

Patient Safety Partners

Connect Health will recruit Patient Safety Partners (PSP) who will be standing members of our Clinical Governance Committee and other associated Committees. They will have at minimum quarterly meetings with the Integrated Governance Management Team, and they will be asked to review any current or completed Patient Safety Investigations to ensure the patient voice is appropriately represented and heard. They will also be asked to comment on and review our Quality Reporting that is submitted to board on a quarterly basis. Consideration will be given to including the PSP during After Action Reviews or Incident Review meetings to provide balance and an external ‘expert’ voice. This will obviously depend on their availability and the sensitivity of the incident. They will be given the opportunity to comment on any safety actions taken because of Patient Safety Investigations and will be a key reviewer in Annual Reports as well as the Annual Quality Account.

As part of their regular meetings with the Integrated Governance Team led by the Director of Governance and Quality they will be kept up to date with emerging themes and trends and any planned thematic reviews throughout the year via reports and face to face meetings.

Addressing Health Inequalities

As an NHS provider of health services across the country, Connect Health Group has a key role to play in tackling health inequalities in partnership with our local partner agencies in the areas we serve. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system alone, 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 also play a major part.

Through our implementation of PSIRF, we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to our services to work with partner agencies on tackling these. This more sophisticated holistic, integrated approach to patient safety under PSIRF will require Connect Health to be even more collaborative with the patient experience and equality, diversity 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 investigation, must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues will always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process, will be bespoke to ensure they consider the individuality of those involved.

To meet the needs of the people involved in any Patient Safety Incident Investigation (PSII), any specific communication needs will be accounted for and enacted ensuring they are compliant with our policies on Accessible Information and Communication.

At the start of any PSII, the Terms of Reference will need to be agreed by all stakeholders. This is to include the patients and Subject Matter Expert's preferred methods of communication. These will be agreed upon and timelines set at the outset of the PSII. While Connect Health will welcome the input and participation of patients in the PSII, there is no guarantee that they will choose to be a part of the process.

By following a SEIPS (System Engineering Initiative for Patient Safety) approach to the PSII the investigation will look at not only the person, but also the environment, the tools used and the Organisation as part of the process. Connect Health will ensure staff have the relevant training and skill development to support this approach. This will further support the continued development of a Just Culture.

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 may be required.

Where a relevant incident is identified, either due to the impact on the life of the patient or as a learning opportunity, the patient and or their family will be contacted. Duty of Candour is a legal duty requiring providers to ensure that patients and their families are informed when things go wrong resulting in moderate harm, severe harm, or death. This includes receiving an apology and sharing the investigation findings and actions to

prevent recurrence. Our Duty of Candour Policy provides further information and is available on request. It is important to recognise that patient safety incidents can have a significant impact on staff who were involved in or who may have witnessed the incident. Like patients and families, they will want to know what happened and why and what can be done to prevent the incident happening again. Colleagues involved in patient safety incidents should have the opportunity to access professional advice from their relevant professional body or union, colleague counselling services and occupational health services.

As stated previously Connect Health 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 recognises the need to involve patients and families as soon as possible in all stages of an investigation, or improvement planning, unless they express a desire not to be involved.

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. This is an approach that is welcomed by Connect Health. 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.

Connect Health has outlined our response planning process within our Patient Safety Incident Response Plan. Connect Health operates a current ‘Incident Review Panel’ process which is currently aligned to the Serious Incident Framework. We will be modifying this process, as it currently works well, to align with the new Patient Safety Incident Response Framework. This will follow the After-Action Review (AAR) process.

Following this we may decide to complete a Patient Safety Incident Investigation (PSII) if it is felt that the learning would be beneficial.

Resources And Training to Support Patient Safety Incident Response

Connect Health has committed that all colleagues will receive Level 1 Patient Safety Essentials Training as a mandatory requirement.

All Clinical Delivery Leads and Operational Managers who have overall responsibility for Patient Safety Investigations within their areas will complete Access to Practice 1 and Access to Practice 2 (Level 2) Patient Safety training. This will be supplemented by materials and presentations delivered by the Organisational Patient Safety Specialist.

There will be a core team of Learning Response Leads who will complete Level 3 training and will take a supportive role for any more significant PSIIs completed within the organisation. This will include the executive sponsor for PSIRF (Director of Governance and Quality), our Heads of Clinical Delivery and our Patient Safety Specialist.

Senior Leadership Team Oversight training will be delivered during implementation of the framework.

Capacity to complete investigations is not thought to be a significant issue within Connect Health as we have a relatively low number of significant incidents spread across 52 different contracts that the Organisation currently holds. With the additional support of the Connect Health National Learning Response Leads it is not felt that capacity of investigators will be a particular issue for the organisation. We will review this on an ongoing basis as we progress through the implementation of the framework.

The local learning will be supported by the local investigation teams and any national learning will be supported by the organisational Patient Safety Specialist in conjunction with our Patient Safety Partners and our wider Patient Engagement team.

Our Patient Safety Incident Response Plan

Connect Health's plan is available on our Policy Management platform PolicyStat.

All colleagues have access to PolicyStat and will be encouraged to review our Patient Safety Incident Response Plan. Our policy platform is fully version controlled and will ensure timely reminders when the plan is up for review.

Our plan sets out how we intend 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 and must remain fluid to ensure we also adapt and learn as we go along. 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.

In developing and reviewing the plan Connect Health will engage with key internal and external stakeholders, identify our Patient Safety Incident Profile, and consider the patient safety and quality improvement priorities identified.

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, which in turn will change our plan. 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 (www.connecthealth.co.uk), replacing the previous version.

A rigorous planning exercise, led by the Head of Integrated Governance, will be undertaken every three years, or more frequently if required, to ensure we 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

Outlined in detail in our Incident Reporting Policy, all incidents are reviewed and collated on Datix Cloud IQ. Our incident reporting portal that all colleagues have access to. All departments are aware of the importance of reporting incidents, and we have a good reporting culture. This will be reiterated as part of the implementation of PSIRF. Our incident reporting modules are a mandatory modules in our training.

The Integrated Governance team do a daily, weekly, and monthly review of reported incidents to ensure any of significance are escalated, as required. The Integrated Governance team, supported by the local services and our Patient Safety Specialist will ensure that cross system issues are reported to the appropriate providers as soon as possible. As part of the implementation process Connect Health has developed links with relevant Patient Safety Networks and Integrated Care Boards (ICBs) which we will use to ensure cross system investigations are completed collaboratively.

We will agree with our ICB partners which incidents they want to be made aware of. All Connect Health's Patient Safety Incidents will be reported on Learning from Patient Safety Events (LFPSE) and therefore are available to ICB's at request.

Patient Safety Incident Response Decision-Making

PSIRP – Incident Response Panels

Relevant Incidents will be monitored daily by the Patient Safety Specialist and Integrated Governance Team. Any identified incidents will be escalated for discussion with the Director of Governance and Quality as soon as practical but within 24 hours. If the Director of Governance and Quality is unavailable the Chief Medical Officer or Chief Operating Officer will deputise. The Head of Clinical Strategy will also be informed. Any incidents identified outside of the agreed incidents within the PSIRP will be discussed in a collaborative discussion as an After-Action Review. Following this discussion, the level of investigation, the identified investigator, agreed actions and engagement with the patient will be agreed and initiated. Follow up meetings will be scheduled as required to ensure appropriate actions are completed.

Care will be taken to ensure that emerging themes and trends will also be regularly identified by the Integrated Governance team. These can also be raised directly by any function within Connect Health including Clinical, Operations, Patient Care Coordination (our appointment and enquiries call centre), People team etc.

Resource will primarily be allocated within existing service/function budgets unless there are extraordinary circumstances. In this scenario agreement for additional funding will be discussed and agreed by the Director of Governance and Risk following discussion with the Senior Leadership Team (SLT). Long term funding will be agreed by SLT as required.

Responding To Cross-System Incidents/Issues

Connect Health is committed to and has a history of sharing feedback with other healthcare providers via our existing Healthcare Professional Feedback policy which sits within our Feedback Policy.

Connect Health is an active participant in Patient Safety Networks within the ICB areas that we operate within. Operations Managers and Clinical Delivery Leads within our individual services act as a liaison with our ICB's to ensure that we act on feedback given and collaborate on Patient Safety Incident Responses. Connect Health will use ongoing engagement meetings with ICBs as well as Patient Safety Network meetings to ensure learning responses are co-ordinated, where required.

We will also ensure that any issues identified during our investigations are shared with external providers to give them the opportunity to learn and contribute to our investigation as is appropriate. This will be done with the support and collaboration of the relevant ICB partner.

Timeframes For Learning Responses

Our current Incident Response Timeframes are 30 working days as standard, but our average closure time is currently 15 working days. Where more complex investigations are required, the organisation may need up to 60 working days to complete PSI investigations, however, the importance of timely investigation and safety actions will be prioritised with the aim of completing these investigations much sooner. Our internal timeframe for final report review is 40 working days. We do now have to factor into this the availability of the [patient and/or family who may wish to be involved.

This will be reviewed continuously as we implement new investigation tools. Connect Health is committed to ensuring a prompt but thorough and robust investigation.

Safety Action Development and Monitoring Improvement

Safety Actions (SA's) will be monitored on a regular basis. Every month the Integrated Governance Team will ensure that all actions are reviewed and updated through our Datix Cloud IQ platform. Any overdue actions will be escalated appropriately through the Datix system. Once an action is overdue by one month the Director of Governance and Quality will be informed and appropriate escalation/action, will take place.

The effectiveness of actions taken will be monitored through Connect Health's monthly Clinical Governance Committee (CGC) and the quarterly Quality Improvement, Policy, and Practice Group. There will be a regular item on these agendas to ensure actions are audited and monitored for effectiveness.

Safety Improvement Plans

Safety Improvement Plans bring together findings from various responses to patient safety incidents and issues.

Connect Health's Patient Safety Incident Response Plan has outlined the local priorities for focus of investigation under PSIRF. These were developed based on the opportunity they offer for learning and improvement.

Connect Health will use the outcomes from existing Patient Safety Incident Reviews (previous Serious Incident RCA reports) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans which in turn will help us to focus our improvement work. We will work collaboratively to ensure there is an aligned approach to development of plans and resultant improvement efforts.

Where overarching systems issues are identified by learning responses outside of the outlined local priorities, a safety improvement plan will be developed. These will be identified through the Clinical Governance Committee (CGC) or SLT decision, who may commission a specific safety improvement plan. The members of these groups will ensure there is an aligned approach to development of the plans and resultant improvement efforts.

Monitoring of progress regarding safety improvement plans will be overseen by reporting by the designated lead to the IQACC (Integrated Quality, Audit and Compliance Committee) on a quarterly basis.

Oversight Roles and Responsibilities

Connect Health's Clinical Governance Committee (CGC) acts as a sub-committee of the board. Any relevant Patient Safety Issues will be escalated by the Director of Governance and Quality as appropriate to the Senior Leadership Team. Connect Health has quarterly assurance meetings (IQACC) where the Patient Safety Incident Response Plan (PSIRP) and Safety Improvement Plans will be reviewed and monitored by the Connect Senior Leadership Team.

The Senior Leadership Team will provide oversight and sign off of appropriate Patient Safety Investigations and Safety Improvement Plans. The SLT will be given appropriate Oversight Training to review and discuss key Patient Safety Issues.

The Director of Quality and Governance will be the Executive Lead for the organisation and will be responsible for escalating Patient Safety Issues for discussion by the Senior Leadership Team.

All Clinical Delivery Leads, Operational Managers and Clinicians including support staff will be involved in ensuring the PSIRP and any associated Safety Improvement

Plans are responded to and operationalised ensuring patient safety remains a priority.

Complaints And Appeals

Any patient/carer/family member complaints related to Connect Health's patient safety incident response process should be made through the company's formal complaints process.

Please refer to the following policies for any complaints related to the Connect Health's Patient Safety Incident Response Process:

- Feedback (Complaints) Policy.
- Accessible Information Standards included within multiple policies.
- Incident reporting Policy and Procedure.
- Whistle-blowing Policy and Procedure.