PATIENT SAFETY INCIDENT RESPONSE POLICY

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PURPOSE

This policy supports the requirements of NHS England's Patient Safety Incident Response Framework (PSIRF), which replaces the current Serious Incident Framework, and sets out Cumbria Medical Services' (CMS) 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 is an NHS England initiative and a requirement to adopt for the services CMS is contracted to deliver by the NHS.

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.

This policy should be read in conjunction with the Patient Safety Incident Response Plan (PSIRP) which is a separate document setting out how this policy will be implemented.

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across CMS. CMS provides services at the following locations:

- Cockermouth Community Hospital
- Carlisle Healthcare South
- Victoria Cottage Hospital, Maryport
- Mary Hewetson Cottage Hospital, Keswick
- Workington Community Hospital

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 is 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.

The processes listed below are also out-with the remit of a patient safety response and are therefore not within the scope of this policy:

- Information governance concerns
- Estates and facilities concerns
- Financial investigations and audits
- Safeguarding concerns
- Complaints

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.

This policy applies to all permanent and temporary staff employed, or those working under contract for services or under service level agreement, within CMS. The policy also describes the arrangements for the management of incidents where more than one provider is involved.

PATIENT SAFETY CULTURE

CMS provides NHS specialist services in community dermatology, minor surgery and ophthalmology. Our culture is built around our commitment to the highest quality of healthcare and striving to do what is in the patient's best interests. The patient experience is paramount.

CMS promotes a supportive patient safety culture that enables individuals to speak freely about and raise patient safety concerns, without fear of blame, reprimand or intimidation, ensuring teams can learn from patient safety events to make care safer (in line with the NHS A Just Culture Guide).

CMS is committed to openness and transparency, sharing knowledge and insight to understand the communities we serve.

CMS maximises opportunities for learning so underlying issues around safe systems and ways of working can be identified and addressed in the wider system in the form of improvement, and staff can feel empowered and heard. The implementation of the PSRIF is anticipated to improve this further.

CMS promotes wellbeing conversations with all staff, providing a range of accessible resources and has introduced an annual staff survey which asks staff if they feel safe to speak up about unsafe clinical practice, if they have any concerns about the organisation and if they feel concerns raised by patients and staff are acted upon.

The Directors and practice manager review patient incidents, safety issues and near misses at their monthly practice meetings. Findings, actions and learning opportunities are identified and are then disseminated to staff and reports are provided to the ICBs. CMS encourages and supports incident reporting to enable its staff to share and learn from incidents and safety issues.

Within CMS we have a Freedom to Speak Up guardian who assists in promoting speaking up and equality, diversity and inclusion. They provide support and signposting after CMS staff have spoken up and are another source of insight into patient safety culture and can support in addressing specific concerns or trends that may affect patient safety.

CMS staff are encouraged to be transparent and open whenever there is a concern about care not being as planned or expected, or when a mistake has been made regardless of the level of harm involved. All staff follow CMS's Duty of Candour, Being Open policy.

Staff involved in patient safety incidents will also be supported and signposted as appropriate during the process, including occupational health, staff counselling and professional advocacy.

CMS is looking to introduce the following to support the sharing and learning from incidents:

Weekly safety messages
Weekly team briefings (safety huddles)
Meetings to support learning from adverse events and safety issues
Patient Participation Group

PATIENT SAFETY PARTNERS

CMS patients will be actively involved in reviewing, developing and maintaining CMS' patient incident response policy and plan. They will provide support to influence and improve patient safety across CMS services. The purpose of this role is to be the voice for the patients and community who use CMS' services and ensure that patient safety is at the forefront of everything we do. The role may include attendance at CMS meetings when reviewing patient safety, risk and quality and being involved with contributing to policies, investigations and reports.

ADDRESSING HEALTH INEQUALITIES

CMS will take into account the different ways in which patients may be disadvantaged by prejudice and systemic exclusion.

CMS will ensure that those involved in incident investigations have the competencies identified in the PSIRF which will be applied in all forms of communication with those affected by patient safety incidents and communication styles will be adapted to meet the needs of different people, including consideration of an individual's ability, culture, beliefs and preferences as well as adjustments such as translation services and any support systems the individual may require. Plain language will be used, avoiding jargon and acronyms and written information will be tailored to individuals taking into consideration their questions and concerns.

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.

CMS is committed to continuously improving the services we provide and want to learn from any incident where this does not go as planned or expected by patients and their families/carers to prevent recurrence and improve quality.

Patients, their family members and carers will be given the opportunity to contribute to the terms of reference for a learning review and receive a copy of the draft report before it progresses to CMS Directors for approval.

CMS will demonstrate its commitment to compassionate engagement by ensuring that engagement leads have the foundations for effective and compassionate engagement which meet the competencies required in the Patient Safety Incident Response Standards.

Patients and families will be supported throughout a patient safety incident by Patient Engagement Leads. Engagement leads will have competencies to actively listen, show openness, demonstrate empathy and create a rapport with those affected and will have undertaken specific training to perform this role.

CMS will adhere to the nine core principles of the PSIRF for engaging and involving those affected by patient safety incidents:

- **Apologies are meaningful**
- **Approach is individualised**
- **Timing is sensitive**
- **Those affected are treated with respect and compassion**
- **Guidance and clarity are provided**
- **Those affected are 'heard'**
- **Approach is collaborative and open**
- **Subjectivity is accepted**
- **Strive for equity**

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.

This approach will allow CMS to focus resources on incidents, or groups of incidents, that provide the greatest opportunities for learning and improving safety. PSIRF guidance specifies the following standards that plans should reflect:

- A thorough analysis of relevant organisational data.
- Collaborative stakeholder engagement.
- A clear rationale for the response to each identified patient safety incident type.
- Is updated as required and in accordance with emerging intelligence and improvement efforts.
- Is published on the CMS' website

RESOURCES AND TRAINING TO SUPPORT PATIENT SAFETY INCIDENT RESPONSE

Resources

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. CMS has identified the following to support and facilitate the PSIRF framework:

1. CMS Directors

2. CMS Practice Manager
3. CMS Advanced Operating Department Practitioner

Guiding principles applied will include:

- Learning responses will not be led by staff who were involved in the patient safety event itself or by those who directly manage those staff.

- Learning response leads will have an appropriate level of seniority and influence within the organisation – this may depend on the nature and complexity of the event and response required.

- Learning responses are not undertaken by staff working in isolation. A learning response team should be established to support learning responses wherever possible.

- Staff affected by patient safety incidents will be given time and will be supported to participate in learning responses.

- Learning response leads will have dedicated paid time to conduct learning responses.

- Subject matter experts with relevant knowledge and skills are involved where necessary through the learning response process to provide expertise (e.g. clinical or human factors review), advice and proofreading.

- There is a dedicated staff resource to support engagement and involvement of those affected.

Training available for staff to support PSIRF

Patient Safety Syllabus

Level 1a - Essential for all staff

Level 1b - For senior leaders and board members

Level 2 Introduction to systems thinking and human factors – staff who will undertake any learning response

Systems based approach to incident investigation - Investigation Lead

Learning Response Leads Training and Competencies

Training

- Any CMS learning response will be led/overseen by those who have had a minimum of two days formal training and skills development in learning form patient safety events and experience of patient safety response.

- Learning response leads must have completed level one and two of the national Patient Safety Syllabus.

- Learning response leads will undertake appropriate continuous development on event response skills and knowledge.

- Learning response leads will need to contribute to a minimum of two learning responses per year.

Competencies

CMS expects those staff leading learning responses to evidence the following competencies in their learning response:

- Apply human factors and systems thinking principles to gather qualitative and quantitative information form a wide range of sources.
- Summarise and present complex information in a clear and logical manner and in report form.
- Managing conflicting information from different internal and external sources.
- Communicate highly complex matters and in difficult situations.

Engagement and Involvement Training and Competencies

Training

- Engagement and involvement with those affected by a patient safety event will be undertaken by those who have undergone a minimum of six hours of compassionate and involvement training.
- Engagement leads must have completed level one and two of the national patient safety syllabus.
- Engagement leads will undertake appropriate continuous professional development on event response skills and knowledge.
- Engagement leads will need to contribute to a minimum of two learning responses per year in order to maintain competencies.

Competencies

CMS expects that those staff who are engagement leads to be able to do the following:

- Communicate and engage with patients, families, staff and external agencies in a positive and compassionate way.
- Listen and hear the distress of others in a measured and supportive way.
- Maintain clear records of information gathered and contact with those affected.
- Identify key risks and issues that may affect the involvement of patients, families and staff.
- Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

Oversight Roles Training and Competencies

Training

All individuals who have a role in patient safety incident response oversight (Directors) must undertake:

- At least one day (6 hours) training in oversight learning from patient safety incidents.
- Level 1 and level 2 of the Patient Safety Syllabus.
- Continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

Competencies

Staff with oversight roles will be expected to be able to do the following:

- Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).

- Apply human factors and systems thinking principles.

- Obtain (e.g. through conversations) and assess both qualitative and quantitative information from a wide range of sources.

- Constructively challenge the strength and feasibility of safety actions to improve underlying system issues.

- Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g. inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).

- Summarise and present complex information in a clear and logical manner and in report form.

This will be monitored at the CMS Practice meetings.

OUR PATIENT SAFETY INCIDENT RESPONSE PLAN

Our plan sets out how CMS intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set out 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 response 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 Boards) to ensure efforts continue to be balanced between learning and improvement. The more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (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

All staff are responsible for reporting any potential or actual safety incident and will follow CMS' incident reporting process.

Externally incident reporting is via:

- The NHS England website
- The ICBs
- CMS' complaints policy

Incidents are reported to external and internal stakeholders to enable identification of risk for patient safety and potential opportunities for learning and improvement.

All patient safety incidents will be reported through Learning from Patient Safety Events (LFPSE) regardless of the level of the investigation required.

Patient Safety Incident Response Decision Making

CMS will ensure arrangements are in place to meet the requirements for a review of safety incidents under PSIRF. Incident responses will include immediate actions to ensure the safety of patients, their family and/or carers, the public and staff. Escalation arrangements are in place to support decision making about appropriate actions to be taken in response to a safety incident.

RESPONDING TO CROSS-SYSTEM INCIDENTS/ISSUES

CMS will liaise with the relevant ICB to facilitate any incident that crosses more than one NHS organisation. This encourages a cohesive and effective method of learning from incidents that are cross system.

TIMEFRAMES FOR LEARNING RESPONSES

Patient safety learning responses start as soon as possible after the incident is identified. The response timeframes will be agreed in discussion with those affected, particularly the patient(s) and/or their carer(s) where they wish to be involved in the discussions. Depending on the discussions with those involved, learning responses are completed within one to three months and/or not longer than six months.

SAFETY ACTION DEVELOPMENT AND MONITORING IMPROVEMENT

CMS will have systems and process in place to agree, implement and monitor safety improvements. CMS will use an integrated process for developing, implementing and monitoring safety actions. All system improvement plans will be reviewed by the CMS Directors on a monthly basis to monitor development and effectiveness.

SAFETY IMPROVEMENT PLANS

Following review of safety incidents CMS will identify opportunities for improvement and create a safety improvement plan. Depending on the incident CMS may create individual service improvements plans that focus on a specific service or a plan to tackle broad areas for improvement (i.e. overarching system issues).

OVERSIGHT ROLES AND RESPONSIBILITIES

CMS Directors are responsible and accountable for effective patient safety incident management. This will include supporting and participating in cross-system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required. They will provide challenge and support to ensure and review final versions of patient safety incident investigation reports and safety improvement plans. CMS Directors will ensure that the PSIRF plan and policy are monitored.

CMS Directors have appointed a PSIRF Lead who will provide direct leadership, advice and support in complex/high profile cases and liaise with external bodies as required – this will be the Practice Manager.

The PSIRF Lead responsibilities are:

1. Ensure CMS meets national patient safety incident response standards.

2. Ensure PSIRF is central to CMS overarching safety governance arrangements.

   It is the PSIRF Lead's responsibility to ensure:

   - Patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress are discussed at the Directors' practice meetings.

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

3. Quality assure learning response outputs before presenting to CMS Directors.

All staff will be required to identify and report patient safety incidents following CMS' incident reporting procedure.

COMPLAINTS AND APPEALS

CMS is committed to dealing with any complaints as quickly and effectively as possible as set out in its Complaints Policy.

If a concern cannot be resolved, then the complainant can contact the Practice Manager at Cumbria Medical Services, Lower Ground Floor, Cockermouth Community Hospital, Isel Road, Cockermouth CA13 9HT.