Patient safety incident response policy

	NAME	TITLE	DATE
Author	Alma O'Rourke Emma Millar	Head of Governance and Quality Clinical Governance and Quality Officer	16/10/2023 16/10/2023
Reviewer	Executive Team		23/10/2023
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This Patient Safety Incident Response Policy will link with existing Everyturn related policy:

- **GG 10 Incident Reporting Policy and Procedure (including the Management of Serious Incidents)**

Document Control

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1. Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out **Everyturn Mental 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.

This policy should be read in conjunction with our Patient Safety Incident Response Plan (PSIRP) (Appendix A), which sets out how this policy will be implemented.

2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Everyturn services which include:

- Specialist Residential and Housing Services (Adult, Older people, and Crisis services)
- NHS Talking Therapies
- Community and Wellbeing services.

Further information about our organisation can be found on the Everyturn website https://www.everyturn.org/

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, people 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.

3. Our patient safety culture

Everyturn Mental Health promotes a positive patient safety culture by supporting staff to speak up about patient safety concerns and report incidents which maximises opportunities for learning. This enables underlying issues around safe systems and ways of working to be identified and addressed in the wider system in the form of improvement. As a consequence, staff can feel empowered and heard.

3.1 A Just Culture

A just culture is supported within the organisation to ensure a consistent, constructive, and fair evaluation for all staff involved in a patient safety incident. Our Peoples Team are supporting our development with regular pulse survey's and training programmes.

3.2 Openness and Learning

The organisation advocates a data driven approach to patient safety incident responses and our incident reporting system – Ulysses - is in place to encourage all staff to be open and transparent and report all near misses and incidents. The system allows for

improvements to be implemented, learnings to be identified and shared across all relevant services within the organisation. The system was rolled out in June 2023 and information analysis will be used to refresh this policy and the patient safety incident response plan.

The Governance and Quality Team has full overview of Ulysses and monitor all reported incidents, identify themes and trends, and take appropriate action to support services to respond to incidents.

Learning Bulletins and Good Practice Notices are produced by the central Governance Team and shared with relevant services across the organisation as well as producing a quarterly Sharing Learning Newsletter focusing on learnings from audits performed across our registered services, Talking therapies and community services, complaints, information governance and clinical incidents. A policy Spotlight focuses on new or amended policies for overall staff awareness.

Programs for Brilliant Basics across all our services and mock inspections for our CQC registered services help identify areas for improvement and support the organisation to ensure services are Safe, Effective, Caring, Responsive and Well Led. During quality and service reviews clinical practices are observed, as well as staff interactions with service users, and engagement with families. Areas of improvements are identified, and appropriate actions implemented.

3.3 Freedom to Speak Up (FtSU)

We are committed to ensuring that everyone working at Everyturn feels safe and confident to speak up enabling opportunities to learn and improve. We are seeking to improve the quality of speaking up arrangements across our organisation including the introduction of FtSU Champions. As well as empowering our staff to speak up, this will include support and signposting after our staff have spoken up, and another source of insight into our patient safety culture as well as any specific concerns or trends that may impact patient safety.

LFPSE will replace the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS). The organisations incident reporting system – Ulysses - will enable compliance with the requirement to provide safety events information to LFPSE via automatic uploads.

The new LFPSE service will provide a single national NHS system for recording patient safety events. It introduces improved capabilities for the analysis of patient safety

events occurring across healthcare, and enables better use of the latest technology, such as machine learning, to create outputs that offer a greater depth of insight and learning that are more relevant to the current NHS environment.

At a national level, this allows for new or under-recognised safety issues to be quickly identified and acted upon on an NHS-wide scale, ensuring providers take action to reduce risk. It will also provide a wealth of data offering essential insight to support ongoing national patient safety improvement programmes, as well as improvement work at a more local or speciality-specific level.

The introduction of LFPSE via the Ulysses system will support the organisation in encouraging reporting and supporting a culture of openness and transparency in the following ways.

4. Patient safety partners

Patient safety partner (PSP) involvement in organisational safety relates to the role that patients and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.

Everyturn will work towards engagement of PSPs at all levels of the organisation. They will provide a different perspective on patient safety; one that is not influenced by organisational bias or historical systems. By reinforcing the patient voice at all levels in the organisation and across integrated care systems, our PSPs will support a patient-centred approach to safer healthcare within Everyturn.

The PSP role is expected to develop and evolve over time and will be a key priority for our Executive Team. Our aim is that our PSPs will:

- Participate in our safety and quality groups and committees whose responsibilities include the review and analysis of safety data.
- Work with us on patient safety improvement projects/workstreams
- Contribution to policy-writing and patient information that is clear and accessible.
- Contribute to staff patient safety training.
- Encourage patients, families, and carers to play an active role in their safety, to report events and participate in their review to promote learning, and to help design safer systems of care.
- Constructively question staff about the safety of organisational procedures and systems that impact on patients.
- Help to develop our Patient Safety Incident Response Plan and Policy
- Work with the Board to consider how to improve patient safety.

5. Addressing health inequalities

Everyturn Mental Health will ensure each Patient Safety Incident response addresses health equality and reduces inequality by applying flexible approaches to identify risks to service users with specific characteristics by using a system-based approach when responding to an incident.

In line with our Equity, Diversity and Inclusion strategy – 'Championing Equity, Diversity and Inclusion for the benefit of all', staff training and development will be available to support this approach and staff will have awareness of the available tools to access to develop safety actions in response to an incident.

Staff, service users and families will be engaged and involved following a safety incident in identifying improvements and learnings that can be implemented to prevent reoccurrence.

The PSRIF framework endorses a system-based approach (instead of a 'person focused' approach) and will be used across the organisation with each incident being reviewed and a decision will be made on the best method to use to review the incident and how improvements will be actioned.

This will support the development of a just culture and reduce the ethnicity gap in rates of disciplinary action across the NHS workforce.

Everyturn endorses a zero tolerance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/service users, carers and families. Everyone in our organisation is mandated to undertake 3-yearly training in equality, diversity and human rights and one of our key strategic actions is to deliver our 3-year equality, diversity and inclusion strategy to make EDI central to our organisation's culture. We will also continue to consider work programmes to support delivery of the Core20PLUS5 approach to support the reduction of health inequalities at both national and system level.

6. 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.

Everyturn Mental health will engage with and support service users, their families and staff following an incident to seek their input to the response and develop a shared understanding of what has happened. Those persons directly affected by an incident will be encouraged to be involved in the learning response in a time sensitive manner, where appropriate and will be treated with respect and compassion.

Communication is vital when engaging those affected by an incident and should be a culturally aware two-way dialogue to allow the imparting and receipt of helpful and accurate information. The use of plain language and avoiding jargon or acronyms will aid understanding. Where appropriate, checking understanding and summarising can ensure the intended message has been received and is understood. Good communication must continue throughout the Patient Safety Incident Response (PSII), providing updates where appropriate and as agreed with those affected.

Following a patient safety incident engaging with service users, families and staff will be aligned with Duty of Candour. This will be applied where applicable to ensure an open, transparent, and honest culture within the organisation, ensure apologies are meaningful with an overview of the response process to be fostered for a specific incident and what, if any improvements have already been implemented as a result.

7. 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.

7.1 Resources and training to support patient safety incident response

Everyturn is committed to ensuring that we work towards becoming fully compliant with the patient safety incident response standards. Training and resources will be available

to staff required to respond to an incident in line with the Patient Safety Incident Response standards below: -

- policy, planning and oversight.
- competence and capacity
- engagement and involvement of those affected by patient safety incidents.
- proportionate responses

The Governance and Quality team will be responsible for responding to incidents proportionately in partnership with Service Managers and Clinical Leads, with wider staff involvement and engagement as appropriate. This work will guided by the principles of the following standards.

- Learning response leads, those leading engagement and involvement and those in PSIRF oversight roles will require specific knowledge and experience and have the appropriate level of seniority.
- 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 responses are not undertaken by staff working in isolation. A learning response team will be established to support learning responses wherever possible.
- Staff affected by patient safety events will be given time and supported to participate in learning responses.
- Subject matter experts with relevant knowledge and skills will be involved, where necessary, throughout the learning response process to provide expertise (e.g. clinical or human factors review), advice and proofreading.
- Those leading, involved in or affected by a learning event will be afforded the necessary managerial support and be given both the time to lead or engage in learning responses.

A working group has been established to ensure the patient safety incident response standards are appropriately resourced and that those undertaking responses have undertaken the required training and have the competencies required.

All staff will complete level 1 (essentials of patient safety) and;

Learning response leads will complete level 2 (access to practice) of the patient safety syllabus.

Additional training for patient safety specialists and Directors and Boards will also be available and key staff roles will continuously develop their expertise in patient safety by identifying training needs and attend training sessions to update their knowledge and skills.

All modules will be added to Everyturn's Learning Academy. Further information can be found at - https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/

7.2 Our patient safety incident response plan

Our plan sets out how **Everyturn Mental Health** 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.

7.3 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 boards (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.

8. Responding to patient safety incidents

8.1 Patient safety incident reporting arrangements

Everyturn Mental Health will ensure all patient safety incidents are reported via our reporting system Ulysses. All staff across the organisation have access to the system and are responsible for reporting incidents as they occur (within 24 hours).

Each reported incident is assigned to a Service Manager or Clinical Lead to respond appropriately, and the system is overseen by the Governance and Quality team daily to identify any themes/trends and ensure incidents are responded to within an effective time frame with a proportionate response.

Incidents are escalated to the ICB where appropriate to ensure a collaborated approach is used and a response plan will be implemented.

Following review of incidents, improvements and learnings will be highlighted, actioned, and shared across the wider organisation where appropriate.

CQC will continue to be notified of patient safety incidents as applicable, with immediate actions taken by the organisation.

8.2 Patient safety incident response decision-making

PSIRF does not mandate investigation as the only method for learning from patient safety events; nor does it prescribe what to investigate. PSIRF supports organisations to respond to events in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm. Each reported incident will be reviewed using a system-based approach to decide on the appropriate response required in accordance with the patient's safety incident response plan, using allocated resources for a proportionate response.

A system-based approach recognises that patient safety is an emergent property of the healthcare system: that is, safety arises from interactions and not from a single component, such as actions of people. This approach therefore recognises that it is insufficient to look only at one component, such as only the people involved.

The methods promoted by PSIRF for learning from patient safety incidents differ from Root Cause Analysis (RCA) in the following core ways:

- They recognise that outcomes in complex systems result from the interaction of multiple factors – learning should not focus on uncovering a (root) cause, but instead should explore multiple contributory factors.
- They do not distinguish between care and service delivery problems. Instead, they explore contributory factors, including 'individual acts' in the context of the whole system.
- They use tools to explore multiple interacting contributory factors rather than forcing a single analytical pathway.
- A framework based on the well-established SEIPS (Systems Engineering Initiative for Patient Safety3) replaces the contributory factors classification framework. This is made up of six factors or elements that when considered together cover all elements of a 'system'.

SEIPS is a framework for understanding outcomes within complex systems which can be applied to support the analysis of incidents and safety issues more broadly.

8.3 Responding to cross-system incidents/issues

Where a cross system learning response is required for a specific incident, Everyturn will work in partnership with local NHS Integrated Care Boards (ICB) to co-ordinate learning responses as appropriate to each organisation. ICBs have a responsibility to establish and maintain structures to support a coordinated approach to oversight of patient safety incident response in all the services within their system.

Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control.

A variety of data will be used, and focus should be on supporting an organisation's capacity to deliver healthcare safely, rather than on purely administrative activity when collecting information.

Patients, families, and staff affected by patient safety incidents can provide some of the best and most pertinent warnings of poorly functioning patient safety incident response systems.

In some circumstances learning responses under PSIRF will coincide with other responses, and co-operation and collaboration between partner agencies is essential to minimise duplication, uncertainty and/or confusion relating to the different processes, particularly for those affected.

8.4 Working with Coroners

PSRIF requires all deaths to be investigated where the death is thought more likely than not to have been due to problems in care.

Where there is a death of a service user/patient an investigation may include an inquest hearing. The coroner will establish how, when and where a person died.

Everyturn Mental Health will have a good working relationship with coroners, and respond when they ask for information and involve them in patient safety incident response plan development.

8.5 Timeframes for learning responses

Timeframes for learning responses will be dependent on the specific incident that has occurred and will start as soon after the incident is identified, time frames will be agreed

in discussion with those affected (service users/families where they wish to be included) and completed within one to three months, and no longer than six 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.

If an organisation's local responses are often taking more than 6 months, or exceeding timeframes set with those affected, then processes should be reviewed to understand how timeliness can be improved.

In exceptional circumstances (e.g. when a partner organisation requests an investigation is paused), a longer timeframe may be needed to respond to an incident. In this case, any extension to timescales should be agreed with those affected (including the patient, family, carer, and staff).

8.6 Safety action development and monitoring improvement

Safety action plans will be developed following incident reviews by understanding processes and systems in place in the organisation and identifying areas of improvements.

Actions will be SMART (Specific, Measurable, Achievable, Relevant, Timebound), allocated to an action owner and be continuously reviewed following implementation, to monitor the reduced risks and safe clinical practices.

Safety action plans will be monitored by tracking changes such as during audit process and future incidents reported in line with PSIRF guidelines.

Learning bulletins/Newsletters will be shared across the organisation which will highlight findings identified from reviews and areas of improvements and will align with services as appropriate.

8.7 Safety improvement plans

Safety improvement plans will bring together findings from the responses to patient safety incidents and will be shared with the relevant services within the organisation.

Safety improvement plans will either be one of the following: -

- An organisation wide safety improvement plan to tackle broad areas for improvements if applicable.
- Individual safety improvement plans that focus on a specific service or location relating to single incidents.

The key is to demonstrate why a specific safety improvement plan approach is the right one for your organisation based on available data, stakeholder views, improvement priorities, patient safety incident profile and insight from patient safety incident responses.

There are no thresholds for when a safety improvement plan should be developed; for example, after completing a certain number of learning responses. The decision to do so must be based on knowledge gained through the learning response process and other relevant data.

9. Oversight roles and responsibilities

The Executive Lead will be the Chief Quality Officer who will:

1. Ensure the organisation meets the patient safety incident response standards, including oversight of the development, review and approval of our policy and plan for patient safety event response in line with these standards.
2. Ensure PSIRF is central to overarching safety governance arrangements.
3. Quality assure learning response outputs. To monitor improvements across the organisation, made in response to incidents and events, to support continuous improvement.

Oversight of patient safety incidents will be by the Governance and Quality team in order to meet the response standards of PSIRF.

Collaboration with ICB, CQC and other providers will be used to ensure information is shared for complete overview of safety incidents and learning responses.

There will be continuous development across the organisation to monitor improvements made in response to learning from incidents and events.

10. Complaints and appeals

It is acknowledged that there will be occasions when patients, service users or carers are dissatisfied with the outcome of a patient safety review, and it has not been possible to resolve this as part of the review.

The points of contact for individuals will be:

- Governance and Quality Department – by email governance@everyturn.org, by letter to: Everyturn Mental Health Governance & Quality Department 2 Esh Plaza Sir Bobby Robson Way Newcastle upon Tyne NE13 9BA, by telephone 0191 217 0377

- Or in writing to our Chief Executive, Adam Crampsie, adam.crampsie@everyturn.org or 2 Esh Plaza Sir Bobby Robson Way Newcastle upon Tyne NE13 9BA