Patient safety incident response policy (*gtd healthcare*)

Effective date: 01/02/2024

Estimated refresh date: 01/08/2025

	Name	Title	Signature	Date
Author	Callum Rimmer	Head of Risk and Safety	C.Rimmer	01/09/2023
Reviewer	Governance and Risk Committee	Governance and Risk Committee	Governance and Risk Committee	31/10/2023
Authoriser	*gtd healthcare* Board	*gtd healthcare* Board	*gtd healthcare* Board	30/11/2023

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out *gtd healthcare's* approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues to learn and improve 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 the development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approaches to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents and safety issues.
4. Supportive oversight focused on strengthening response system functioning and improvement.

Scope

gtd healthcare is a not-for-profit healthcare service provider. We are often the first contact a person has with the healthcare system when they have a health problem or issue that is not an emergency. This includes both remote and face-to-face clinical triage, and urgent and scheduled care services across parts of Greater Manchester, Cheshire, Merseyside, Lancashire, and Derbyshire. *gtd healthcare* provides and manages a variety of services including but not exclusively:

- Primary care.
- Out-of-hours.
- Urgent care centres.

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all *gtd healthcare* 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.

This policy should be read in conjunction with the Incident Reporting and Management Policy and Procedure that outlines *gtd healthcare*'s overall approach to incident management for non-patient safety related incidents.

Our patient safety culture

gtd healthcare promotes openness and transparency across the organisation. Through training, organisation-wide communications and initiatives (such as Patient Safety Awareness Month and World Patient Safety Day), *gtd healthcare* is clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk.

gtd healthcare employs a patient safety specialist who is responsible for implementing the NHS Patient Safety Strategy on a local level. The patient safety specialist plays a key role in the development of a patient safety culture, safety systems and improvement activity at *gtd healthcare*.

Organisation-wide policies are built on the principles of a Just Culture whereby staff are not automatically suspended when involved in patient safety incidents. Instead, *gtd*

healthcare operates a system of shared accountability whereby *gtd healthcare* is accountable for the systems we have designed and for responding to the behaviours of our employees in a fair and just manner.

The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame.

gtd healthcare ensures staff, patients and families have accessible methods to report events including (but not exclusively):

- Policies and procedures for reporting incidents.
- Policies and procedures for reporting complaints.
- Freedom to speak up procedure.
- Patient Participation Groups.
- Social media.
- Patient friends and family satisfaction surveys.
- NHS choices website.
- Health watch.
- Employee Connect Council.
- Ability to raise concerns through external bodies (e.g., Care Quality Commission, NHS England and Integrated Care Boards.

Reporting of events is overseen by the governance team to ensure an integrated approach and to enable the triangulation of information. This creates a system whereby risks can be identified and responded to in the most effective way, regardless of how they were first raised or reported.

Using the national Learning From Patient Safety Events service will enable *gtd healthcare* to record good care. This will enable the organisation to place greater attention on what is working well and share this learning throughout the organisation.

Patient safety partners

gtd healthcare's delivery of the national framework for involving patients in patient safety guidance on a local level will involve the recruitment of patient safety partners.

Patient safety partners will play a key role, in enhancing the patient voice throughout the organisation. The patient safety partners at *gtd healthcare* will:

- Hold membership on safety and quality committees whose responsibilities include the review and analysis of safety data.
- Be involved in patient safety improvement projects (including the review and development of the patient safety incident response policy and patient safety incident response plan).
- Work with the *gtd healthcare* Board to consider how to improve safety.
- Be involved in staff patient safety training.
- Participate in investigation oversight groups.

Addressing health inequalities

The NHS Long Term Plan emphasises the approach that is needed to address the longstanding health inequalities and inequities that have led to poorer outcomes, harm and premature deaths. Through the implementation of our patient safety incident response policy and plan, *gtd healthcare* will help address the national priorities (such as the learning from deaths initiative).

Some patients are less safe than others in a healthcare setting. The PSIRF provides a mechanism to directly address these unfair and avoidable differences in risk of harm from healthcare:

- The PSIRF's more flexible approach makes it easier to address concerns specific to health inequalities. It provides the opportunity to learn from patient safety incidents regardless of severity.
- The PSIRF prompts consideration of inequalities during the learning response process including when developing safety actions.
- Engaging and involving patients, families and staff following a patient safety incident will take into consideration individual needs to ensure the process is inclusive and effective.
- The framework endorses a system-based approach (instead of a person-focused approach) and is explicit about the training and skill development required to support an approach. This will support the development of a Just Culture and reduce the ethnicity gap in rates of disciplinary action across the NHS workforce.

Implementation of the Learning From Patient Safety Events service will enable a deeper understanding of health inequalities, as data on protected individual characteristics will be collected. This will assist with the development of patient safety incident response policies and plans.

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.

gtd healthcare's Engaging and Involving Those Affected by Patient Safety Incidents Policy (including Duty of Candour Procedure) outlines the support mechanisms in place for all those involved in patient safety incidents including how *gtd healthcare* fulfils its professional and statutory duty of candour to patients and families.

gtd healthcare is committed to the engagement principles outlined in the NHS England engaging and involving patients, families and staff following patient safety incident guidance. This ensures that when patient safety incidents occur:

1. Apologies are meaningful.
2. Approach is individualised.
3. Timing is sensitive.
4. Those affected are treated with respect and compassion.
5. Guidance and clarity are provided.
6. Those affected are heard.
7. Approach is collaborative and open.
8. Subjectivity is accepted.
9. Strive for equity.

The four key steps of engagement (see appendix four) will be followed during the Patient Safety Incident Investigation process to ensure those involved/affected by patient safety incidents have an opportunity to contribute to the learning and improvement.

Patient safety incident response planning

Overview

The 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.

Resources and training to support patient safety incident response

gtd healthcare is fully committed to the PSIRF and ensures that all staff who undertake roles linked to patient safety incident response have the necessary training and competencies required.

The responsibilities set under the PSIRF will form part of existing job roles within the organisation. Although the implementation and delivery of the PSIRF will be a collaborative approach from all *gtd healthcare* staff members, three key roles have been identified:

1. **Learning Response Leads** who will lead Patient Safety Incident Investigations.
2. **Engagement Leads** who will assist with Patient Safety Incident Investigations through effective engagement and involvement with those affected.
3. **Investigators** who will complete investigations for patient safety incidents that meet our agreed list of patient safety priorities.

All *gtd healthcare* staff (clinical and non-clinical) complete level 1 (essentials of patient safety) and level 2 (access to practice) of the Patient Safety Syllabus as part of their mandatory training requirements. This ensures human factors and systems thinking are embedded across the organisation and will enable a proactive approach to identifying risks to safe care. *gtd* academy monitors all mandatory training compliance across the organisation.

Our patient safety incident response plan

Our plan sets out how *gtd healthcare* 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 on 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 (e.g., a full review of patient safety incident investigation reports, improvement plans, complaints, claims, staff survey results, inequalities data, reporting data and wider stakeholder engagement).

Responding to patient safety incidents

Patient safety incident reporting arrangements

In accordance with *gtd healthcare's* Incident Reporting and Management Policy and Procedure, all incidents (patient safety and non-patient safety incidents) must be reported to the Local Risk Management System, Ulysses within 24-hours of the incident occurring or knowledge of its occurrence.

The governance team discuss and triage all incidents reported on the Local Risk Management System during the daily patient safety huddle. It is the responsibility of the governance team to identify external notification requirements and ensure they are submitted by the most appropriate person.

gtd healthcare will ensure that all patient safety incidents are reported on the national Learning From Patient Safety Events system via our Local Risk Management System.

Patient safety incident response decision-making

The governance team is responsible for ensuring *gtd healthcare's* Patient Safety Incident Response Plan is implemented. This includes identifying levels of incident response when they arise.

gtd healthcare will ensure compliance with the national event response requirements and where necessary undertake Patient Safety Incident Investigations. The investigations will follow the stages outlined in appendix five.

A response should always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in *gtd healthcare's* Patient Safety Incident Response Plan.

There are likely to be five different types of incident response:

Incident response type 1 - Patient Safety Incident Investigations

- Patient Safety Incident Investigations are in-depth reviews of a single patient safety incident or a cluster of incidents to understand what happened and how.
- This must be used (but not exclusively) for the following:
    - Deaths thought more likely than not due to problems in care (incident meeting the learning from deaths criteria).
    - Incidents meeting the Never Events criteria.
- *gtd healthcare* may decide that a Patient Safety Incident Investigation is required for incidents outside of the national requirements e.g., where there appears to be a significant learning opportunity.
- An overview of the governance arrangement for Patient Safety Incident Investigations is outlined below:

Production of draft Patient Safety Incident Investigation report

1. Incident reported.
2. Triage at patient safety huddle[1].
3. Discussion at a governance significant case review meeting[2].
    a. Notification to the relevant director.

[1] Patient Safety Huddle is a daily meeting with members of the Governance Team, incidents that have been reported in the last 24 hours are discussed, triaged and sent for review.
[2] Significant Case Review is a weekly meeting between governance team members and GP clinical advisors.

b. Notification to Care Quality Commission registered manager.

4. Investigation takes place (including engagement with those affected/involved).
5. Governance team to produce initial draft of Patient Safety Incident Investigation report.

Approval process for draft Patient Safety Incident Investigation report

1. Discussion at a significant case review meeting – all members including the executive lead for PSIRF (Director of governance) to comment on the report.
2. Report to be reviewed by the relevant director.
3. Circulate / discuss a draft report with those involved / affected by the Patient Safety Incident Investigation (e.g., staff, patients and families).

Approval process for Patient Safety Incident Investigation report (final draft)

1. Report presented to the *gtd healthcare* Board for final approval.
2. Circulate / discuss the final report with those involved / affected by the Patient Safety Incident Investigation (e.g., staff, patients and families).
3. Agreed safety improvement actions are to be added to the safety improvement plan and monitored through the governance team and risk committee.

Incident response type 2 - listed as a safety priority on the PSIRF Plan - incidents that require a specific learning response (non- Patient Safety Incident Investigation**)**

1. Incident reported.
2. Triage at patient safety huddle.
   a. Identification of any notifications required (e.g., to the Care Quality Commission registered manager).
3. Relevant department/service to complete investigation (using specified investigation tool such as After Action Review (AAR)[3].
4. Relevant department/service to share investigation outcome with the governance team.
5. Governance team to review and share outcomes with those involved / affected (if applicable).
6. Governance team to ensure safety actions are recorded on local or organisation-wide safety improvement plans.

Incident response type 3 - incident not identified as a safety priority, investigation not required

1. Incident reported.

[3] The AAR investigation tool is a structured facilitated discussion of an event, the outcome of which gives individuals an understanding of why the outcome differed from that expected and will help identify the learning to assist improvement.

2. Triage at patient safety huddle.
    a. Identification of any notifications required (e.g., to the Care Quality Commission registered Manager).
3. Relevant department/service to put in place any immediate actions to mitigate the risk.

Incident response type 4 - incident resulting in moderate or above harm[4]

1. Incident reported.
2. Triage at patient safety huddle.
    a. Identification of any notifications required (e.g., to the Care Quality Commission registered manager).
3. Duty of candour process to be followed.
4. Relevant department/service to complete investigation (using specified investigation tools such as AAR).
5. Relevant department/service to share investigation outcome with the governance team.
6. Governance team to review and share outcomes with those involved / affected (if applicable).
7. Governance team to ensure safety actions are recorded on local or organisation-wide safety improvement plans.

Incident response type 5 - incident not identified as a safety priority but requires consideration for a learning response

1. Incident reported.
2. Triage at patient safety huddle.
3. Discuss at a significant case review meeting.
    a. Complete rapid assessment
4. Determine which process to be followed e.g., Patient Safety Incident Investigation, PSIRF investigation tool (e.g., AAR) or other local investigation.

Responding to cross-system incidents/issues

Due to the nature of the services *gtd healthcare* delivers we work closely with external partners across the healthcare system. When patient safety incidents occur that involve multiple partners, it is valuable to work together to identify system improvements.

gtd healthcare will continue to work with external partners to assist with any investigations led by other organisations.

[4] Based on national physical and psychological harm guidance

gtd healthcare will invite external partners to participate in joint reviews of incidents where appropriate to enable a collaborative approach to cross-system issues that are identified.

gtd healthcare will assist our Integrated Care Board colleagues with any cross-system patient safety initiatives that take place within the care systems in which we operate.

Timeframes for learning responses

Patient safety learning responses start as soon as possible after the incident is identified.

Learning response timeframes are agreed in discussion with those affected, particularly the patient(s) and/or their carer(s), where they wish to be involved in such discussions.

In agreement with those involved/affected by patient safety incidents, *gtd healthcare* will aim to complete Patient Safety Incident Investigations within three months of the incident being reported. However, depending on discussions with those involved, learning responses should take no longer than six months to complete.

gtd healthcare will aim to complete non-Patient Safety Incident Investigation investigations within one month of the incident being reported.

Safety action development and monitoring improvement

Incident investigations will be used to identify areas for improvement. Areas for improvement can relate to a specific local context or to the context of the wider organisation. Local context improvements relate to a specific area for improvement highlighted by a single (or multiple) learning response. In comparison to wider organisation improvements that cover a broader area for improvement identified across several learning responses, likely not in response to any single patient safety incident but incidents with common contributory factors across events.

Through our system-based investigation approach safety actions will be developed to address areas for improvement. Safety actions identified through the Patient Safety Incident Investigation process will be monitored by the governance and risk committee to ensure any risks highlighted through the investigation process are mitigated effectively. In addition, *gtd healthcare's* committee structure enables areas for

improvement and safety actions to be discussed and overseen by the appropriate committees.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The governance team supports the alignment of improvement efforts across the organisation.

gtd healthcare's organisation-wide safety improvement plan captures safety actions and areas for improvement identified through the Patient Safety Incident Investigation process. In addition, local investigations into our patient safety priorities that also identify organisation-wide areas for improvement should be recorded on our organisation-wide safety improvement plan.

Local improvement plans on a department and service level capture safety actions and areas for improvement relevant to their department and/or service. The safety actions will be monitored by the department and/or service to enable the effective mitigation of any risks identified.

Oversight roles and responsibilities

Oversight under the PSIRF focuses on engagement and empowerment rather than more traditional command and control. *gtd healthcare* embraces the oversight principles outlined in the national oversight roles and responsibilities specification whereby:

1. Improvement is the focus.
2. Blame restricts insight.
3. Learning from patient safety incidents is a proactive step towards improvement.
4. Collaboration is key.
5. Psychological safety allows learning to occur.
6. Curiosity is powerful.

gtd healthcare's executive lead for PSIRF (director of governance) has organisational accountability for patient safety incident response. The executive lead will:

- Ensure the organisation meets national patient safety incident response standards.

- Ensure the PSIRF is central to overarching safety governance arrangements.
- Quality assures learning response outputs.

gtd healthcare will work collaboratively and share information with the Integrated Care Boards, regulators and other stakeholders to demonstrate improvement. Appendix six represents how *gtd healthcare* will work with the external stakeholders to ensure effective governance and oversight exists.

gtd healthcare will report all patient safety incidents via the Local Risk Management System, Ulysses to Learning From Patient Safety Events and implement our patient safety incident response plan to facilitate local and national learning and improvement.

The *gtd healthcare* Board are responsible for approving all Patient Safety Incident Investigation reports and the accompanying safety improvement plans derived from the incident(s). The governance and risk committee have delegated responsibility from the Board to monitor the implementation of the safety improvement plans.

The *gtd healthcare* Board will be provided with quarterly summaries of patient safety incidents reported and informed of progress with ongoing safety improvement plans.

The *gtd healthcare* Board is responsible for approving *gtd healthcare's* Patient Safety Incident Response Policy and *gtd healthcare's* Patient Safety Incident Response Plan.

Complaints and appeals

gtd healthcare's Complaints Policy outlines the organisation-wide approach to managing complaints ensuring compliance with the NHS complaints regulations.

There is a statutory requirement to investigate and respond to complaints. If the complainant agrees, the complaint investigation and patient safety incident investigation should be combined so that the patient/family get all the answers they are seeking together.

Appendix one – definitions

Duty of candour

The duty of candour is a critical element of our healthcare system to ensure openness and transparency with patients, families and relevant persons. There is a statutory duty of candour and a professional duty of candour. Both types ensure patients, families and relevant persons are aware when something goes wrong with their treatment or care, or has the potential to cause, harm or distress.

Health inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

Just culture

In a just culture investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However, a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts.

Near miss

A near miss is any incident identified above which has not given rise to actual personal injury, ill-health, harm/major harm, loss, damage or death, but which has the potential to do so.

Patient safety incident

Any unintended or unexpected event (including near misses) which could have, or did, lead to harm for one or more patients receiving healthcare.

Risk

The effect of uncertainty on objectives.

Safety actions

The process starts by identifying and agreeing on those aspects of the work system where
change could reduce risk and potential for harm. Safety actions are then generated about each defined area for improvement. Following these measures to monitor safety actions and the review steps are defined.

Those affected

Those affected include staff and families in the broadest sense; that is: the person or patient (the individual) to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred.

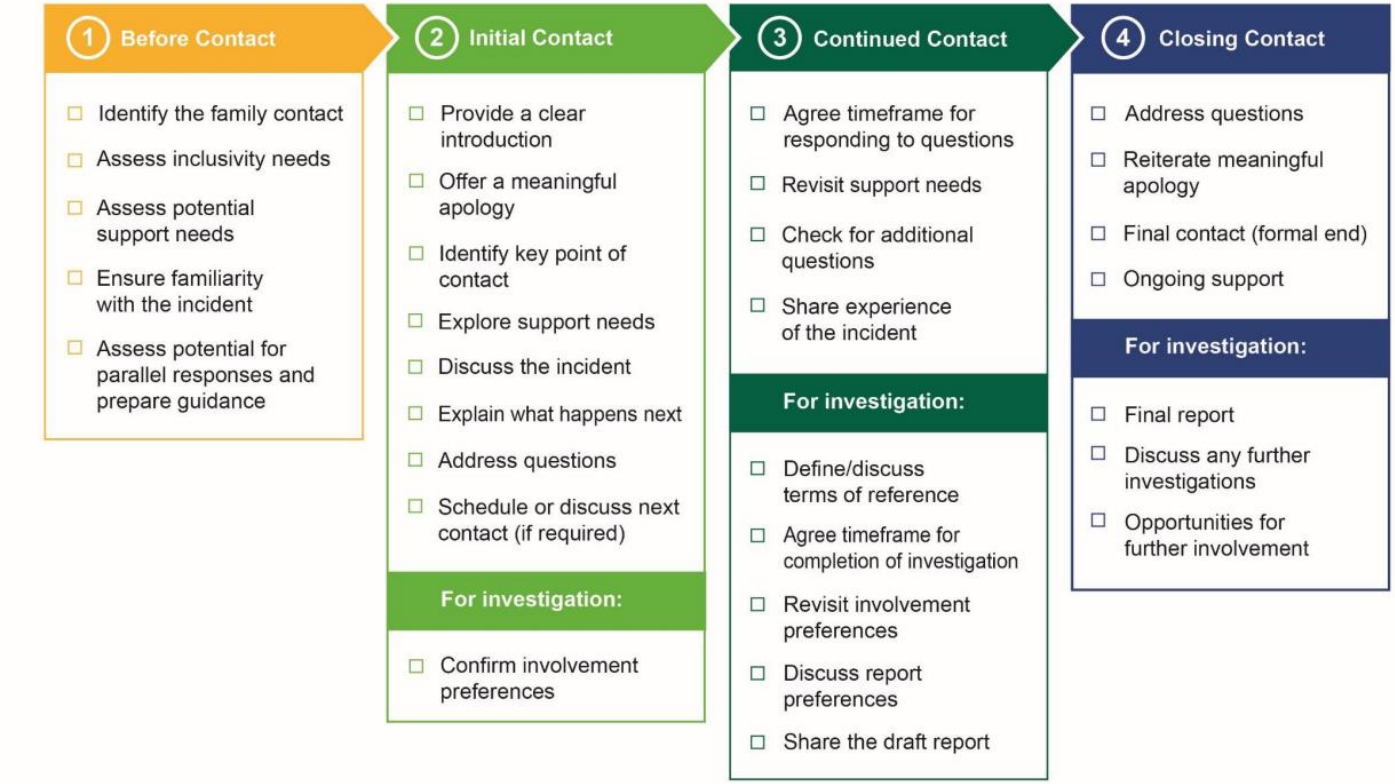
Appendix two – related documents and policies

- Being Open Policy.
- Complaints Policy and Procedure.
- Engaging and Involving Those Affected by Patient Safety Incidents Policy (Including Duty of Candour Procedure).
- *gtd healthcare* Patient Safety Incident Response Plan.
- Incident Reporting and Management Policy and Procedure.
- Risk Management Policy and Procedure.
- Whistleblowing Procedure.

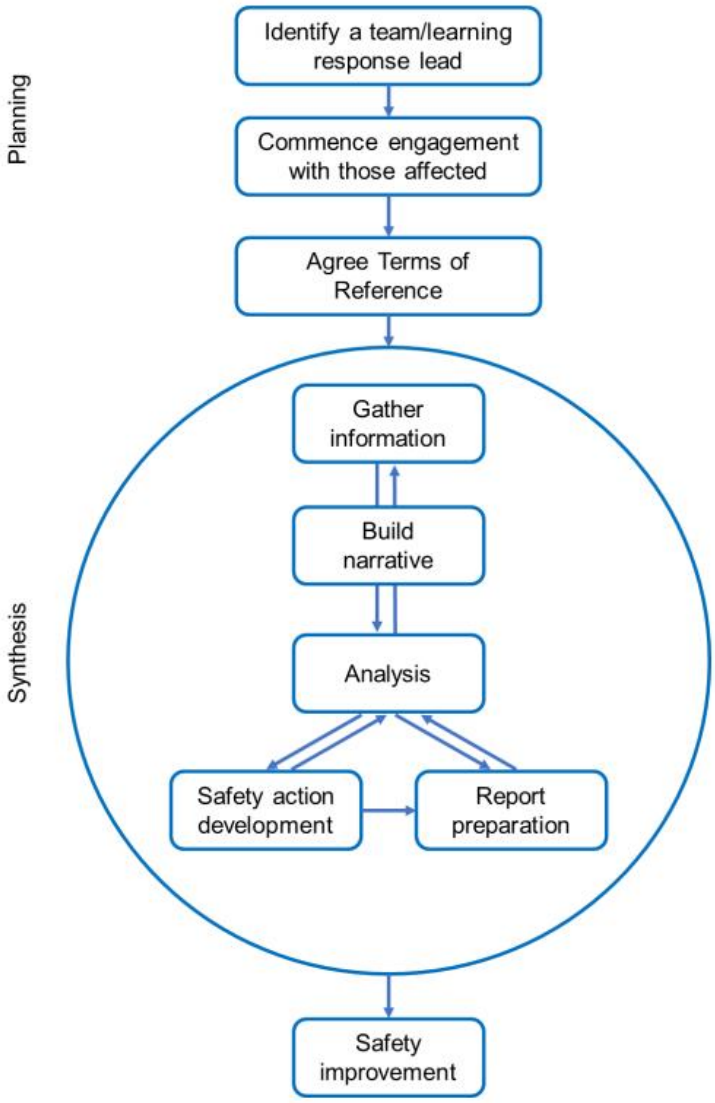
Appendix three – references

- A just culture guide.
- Engaging and involving patients, families and staff following a patient safety incident guidance.
- Framework for involving patients in patient safety.
- Oversight roles and responsibilities specification.

Appendix four – steps of engagement



Appendix five – stages of a patient safety incident investigation



Appendix six – oversight governance arrangements

Figure 2: Organisational responsibilities for an effective governance structure