Patient Safety Incident Response (PSIRF) Policy

Document Control

Responsible:	Clinical Lead	**Accountable:**	Professional Services Director
Consulted:	Incident Review Team	**Informed:**	Clinical Governance Meeting
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Version Control

Version	Date	Reason for Change
1	10/04/24	New Policy
1.1	03/05/24	**Updated:** Scope, Added reference to Duty of Candour Definitions: Added LFPSE 7. Updated to include how we work with partners Added 12.1 Support for Staff 11. Added Complaints 16. Updated to define learning responses 17. Updated to specify timeframes for responses 22.. Updated to reference specific training via E-Learning for Health

Contents

1 Introduction

This Policy supports the requirement of the Patient Safety Incident Response Framework (PSIRF) and sets out OutsideClinic's (OC) 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.

2 Purpose

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.

3 Scope

This policy relates specifically to patient safety incident responses conducted solely for the purpose of learning and improvement across the Audiology and Optical services provided to NHS Patients by OC.

There is no intent to apportion blame or determine liability - Preventability or cause of harm to patients in the response is conducted for the purpose of learning and improvement only.

Information from a patient safety response process can be shared with those leading other types of responses, i.e. Incident Review / Complaints Investigation, but other processes should not influence the remit of a patient safety incident response.

The Professional Servies Director is the nominated Duty of Candour lead and is responsible to ensure that staff act in accordance with the Duty of Candour Policy at all times in relation to this Policy.

4 Definitions

Patient safety Incident	Incident which has negatively impacted, or had the potential to impact the safety of a patient during an appointment or as a direct result of our presence / actions
Patient Safety Network (PSN)	Group of providers who review the findings of patient safety investigations and seek to gain understanding and learning from these incidents to improve safety.
Patient Safety Partner (PSP)	Independent person who attends PSN meetings and is available to advocate on behalf of patients if required.
Patient Safety Incident Response Framework (PSIRF)	Framework which provides overview and guidance on the requirements for Patient Safety Incident Response.
Patient Safety Incident Response Plan (PSIRP)	Plan specific to the company which provides overview and plan for how we will meet the requirements for Patient Safety Incident Response
Learn from Patient Safety Events (LFPSE) Service	A national NHS system for the recording and analysis of patient safety events that occur in healthcare.

Learning from Lives & Deaths People with Disability and autistic people (LeDeR)	A mortality review programme seeking to understand and improve the lives of people with disabilities and autistic people.

5 Responsibilities

Role/Position	**Responsibilities**
Professional Services Director	• Accountable for implementation of this Policy and ensuring it is available to staff via OneHub. • Member of Incident Review and Clinical Governance Meetings • Supports the Management and Reporting and Response to Patient Safety Incidents at Senior Leadership level. • Undertakes Training as required.
Clinical Leads	• Receiving Patient Safety Incident reports • Liaising with all parties to resolve issues • Managing the completion of all processes as per policy and procedure in the Plan and published Framework • Undertakes Training as required
Quality & Compliance Manager	• Co-ordinates Improvement Plans and reports findings. • Undertakes Training as required
NHS Contracts Manager	• Maintain awareness of the PSIRF and PSIRP and manage stakeholder engagement between OC and the ICB with any reports or amendments to policy. • Undertakes Training as Required

6 Implementation

PSIRF acknowledges that there are different requirements for small independent providers such as OC, under NHS contract which allows for proportionate implementation. OC has a written Patient Safety Incident Response Plan (PSIRP), which details the approach we will use, and the data gathered to determine our approach. The PSIRP is available on our website, and to any ICB requesting its submission directly, it will be reviewed quarterly at Clinical Governance Meeting as part of the Agenda.

Where a Patient Safety Review is required, this will be coordinated by the Quality & Compliance Manager in conjunction with the Clinical Lead and NHS Contracts Manager and others within the organisation as required.

7 Patient Safety and Just Culture

We are committed to creating the right foundations that foster a just culture, where staff are treated fairly and consistently when involved in patient safety incidents and ensures we emphasize patient safety and learning.

This is achieved by keeping patient safety at the forefront of our service and ensuring we take learnings where things may not meet the requirements and expectations of our patients. We will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimize delays to joint working cross-system incidents.

8 Patient Safety Partners

In conjunction with our Patient Safety Network (PSN) we will work with one or more Patient Safety Partners (PSP) as required under PSIRF. PSPs are lay people who play a part in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.

The PSP's role is to provide objectivity, challenge actions and focus on the perspective of the patient or family member.

9 Patient Safety Network

OC is an independent provider, however we are part of a PSN along with at least one other external organisation, which meets at a minimum of once per year or as required. The PSN is a forum for us to work together to meet our responsibilities to the NHS under PSIRF.

We have agreed the following purpose for the PSN:

- **Improving Patient Safety and Quality** - By supporting reviews of incidents, identifying and reducing clinical errors, preventing infections, enhancing communication and promoting cross-organisation learning to ensuring best practice in healthcare delivery, patient safety and quality is improved.
- **Data collection and analysis**: - The PSN may opt to collect and analyse depersonalised data relating to adverse events, near misses, patient feedback and other data that may impact on patient safety and by analysing this data seek to identify and eliminate the causes.
- **Research and Innovation -** PSIRF may support research projects and studies focussed on innovative approaches to enhance patient safety.
- **Knowledge Sharing** - The PSN will serve as a platform to share information, experiences and best practice. This collaboration can lead to the adoption of standardised safety protocols and dissemination of valuable insights.
- **Education and Training** - The PSN may provide education and training opportunities for the members and their organisations. This may include training on error reporting, patient safety culture and the use of safety tools and resources.
- **Advocacy and Policy influence** -During the work completed by the PSN, there may be a need to advocate for patient safety changes at the policy level. Partner services may agree to work together to shape healthcare policies, regulations, and standards to prioritise patient safety.
- **Reporting** - Each provider service may be required to individually report details of the work completed by the PSN to NHS partners and other regulated bodies as part of their contractual obligations. The PSN will support the creation of appropriate reporting to meet these obligations in line with the terms of this agreement.

10 Addressing Health Inequalities

Due to the nature of our service, we acknowledge that the fundamental factors contributing to health inequalities are beyond our responsibility.

Through the implementation of PSIRF we will utilise data and learnings from investigations to drive improvements in our service and sector.

We will engage with patients, their families and other stakeholders and recognize their needs on a case-by-case basis.

11 Learning from Lives & Deaths (LeDeR)

Due to the nature of our services, it is highly unlikely that an incident covered by PSIRF will fall within this programme. However, should it be necessary, we will report and liaise with the respective ICB.

12 Safeguarding Incidents

We are contracted to provide service to adults (over 18) as reflected in our Safeguarding Policy. Safeguarding Incidents are recorded and managed via our Incident Reporting System.

Safeguarding Children – as above, we do not provide service to persons under 18 years of age, however we do have regard for the safety and wellbeing of children should we encounter them in the course of providing our services and will report in accordance with our Safeguarding Policy.

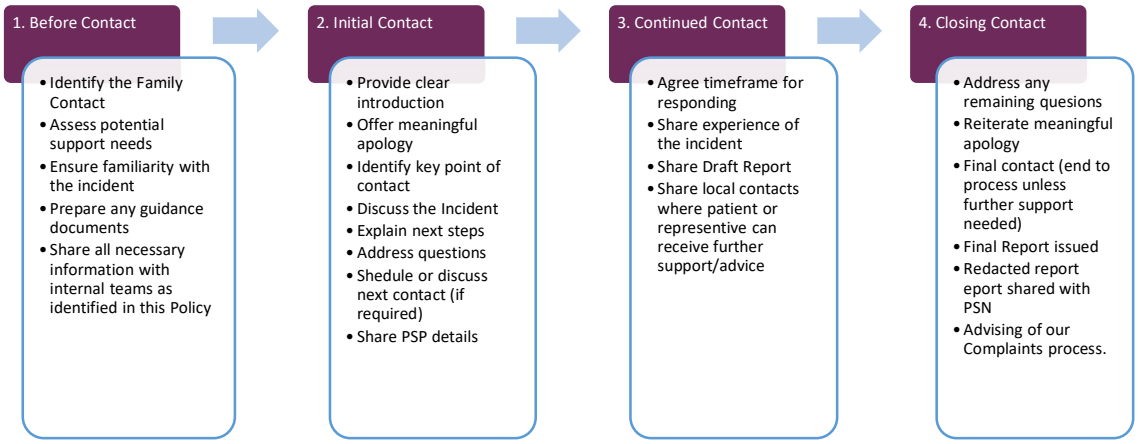
13 Complaints

We recognise that Complaints are a valuable source of information for identifying patient safety incidents and areas for improvement. We will ensure that patients and their representatives who wish to express dissatisfaction with our response to a patient safety incident or to appeal a decision are advised of our Complaints process.

14 Engaging and Involving Patients following a Patient Safety Incident

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 patent safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents, alongside our PSP, to understand and answer any questions they have in relation to the incident and signpost them to support as required.

The following four step process will be followed:



14.1 Support for Staff

As part of our commitment to a just culture we are committed to supporting staff and will ensure that staff, who may suffer from high levels of stress and distress following an incident, and throughout an investigation, are offered wellbeing services. For example:

- Line Manager will ensure that they are available to allow staff to reflect on the situation and how it has made them feel.
- The HR Team is available for independent confidential discussions where required.

- Access for all staff to external counselling services 24/7 to all staff via the Health Assured program.

15 Patient Safety Incident Response Planning

The focus of PSIRF is to respond to incidents in a way that maximises the learning and improvement outcomes.

Due to the nature of our service and the small number of patient safety incidents experienced, we will review these as they occur and respond accordingly and in accordance with the PSIRP.

Where deemed necessary we may undertake a Patient Safety Incident Investigation (PSII) where it is felt that the learning would be beneficial.

16 Resources and Training to Support Patient Safety Incident Response

We will ensure that the necessary resources are available to deliver our PSIRP an ensure that staff involved at any stage are trained and receive necessary updates. This will include

Any response will be led by a Clinical Lead and engage with other staff as necessary.

17 Patient Safety Incident Response Plan (PSIRP)

Our PSIRP is available internally via the Policies section on the company intranet 'OneHub' and externally via our Website.

The Plan will be regularly reviewed at Clinical Governance Meetings.

18 Patient Safety Incident Response Decision-Making

All reported patient safety events will be reviewed initially by the Clinical Governance Team who will agree appropriate learning responses and share with external agencies where required. The Learning responses available include:

After Action Review (AAR)

An AAR is a method of evaluation that is used when outcomes of an activity have been particularly successful or unsuccessful and aims to capture learning from these to identify opportunities for improvement or share learnings to increase instances of success. AAR's are about learning not blame or holding people to account.

Patient Safety Incident Investigation (PSII)

A PSII is a comprehensive investigation which will utilise the System Engineering Initiative for Patient Safety (SEIPS) framework. These investigations may be initiated when it is felt a patient safety event meets the criteria to be defined as a national or local priority. *(See the Patient Safety Incident Response Plan for details).*

19 Timeframe for Learning Responses

A learning response is to be started as soon as possible after the patient safety incident is identified and is expected to be completed within one to three months of the start date. No learning response should take longer than six months to complete.

20 Reporting

Reporting will be in line with our established Incident Reporting Policy. Reports will be presented to the Clinical Governance and Risk and Compliance Board.

OutsideClinic are registered with the NHS Learning from Patient Safety Events (LFPSE) and will report patient safety events to support improvements in safety.

21 Safety Action, Development, Monitoring Improvement and Safety Improvement Plans

OC have quarterly Clinical Governance Meetings which will be the forum for discussing incident themes, improvements, and resolutions. It enables oversight across the business and is where patient safety incidents will be discussed, and action plans monitored. This Meeting is also the route for escalations where necessary.

22 Oversight Roles and Responsibilities

We will collaborate with relevant internal and external stakeholders, including ICBs, to ensure that they are satisfied with the implementation of the framework and that learnings are shared, and improvements monitored.

We hold regular contract meetings with all ICBs, and this will provide the forum for reporting on PSIRF activities relevant to their patients, unless an urgent case arises, where immediate notification will be made.

23 Monitoring and Compliance

Compliance with the requirements of this Policy will be monitored via our Clinical Governance Meeting and any breaches will be addressed as appropriate.

24 Dissemination and Implementation

This Policy and any associated procedures / guidance documents will be stored electronically, available to staff via OneHub. Implementation within each department is the responsibility of the Manager.

25 Training

All staff are trained in the use of the internal Incident Reporting System for reporting patient safety incidents. Staff who support or have the potential to support or lead patient safety management are required to undertake the relevant level 1 and/or 2 of the E-Learning for Health, Patient Safety Syllabus and thereafter this training is to be included at Induction for new starters (where relevant to their role), and repeat each three years.

External:	• NHS Patient Safety Incident Response Framework (PSIRF) • NHS A Just Culture Guide
Related Documents (Internal):	• Duty of Candour Policy • Incident Reporting Policy • Death of a Service User Policy • Safeguarding Policy • Complaints Policy

26 Document Control

This Policy has been created following the Document Management Policy, it should not be altered in any way without the express permission of the person responsible. It will be reviewed and updated every two years or in accordance with any business, legislative or statutory developments as they occur. This Policy will remain current until superseded by a new version.

All or part of this document can be released under the Freedom of Information Act 2000.

This document is to be retained for 10 years from the date of expiry.

This is a controlled document and is only valid on the day of printing.

27 Equality and Diversity

This document complies with OutsideClinic's Equality and Diversity Policy and has been viewed as having no apparent negative impact for any patients with protected characteristics.