Patient Safety Incident Response Policy

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	NAME	TITLE	SIGNATURE	DATE
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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Liverpool Women's NHS Foundation Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all patient facing services and departments delivering care.

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.

The Trust patient safety culture

Liverpool Women's NHS Foundation Trust promotes a fair and just culture approach in all work undertaken or planned to improve safety culture.

Psychological safety underpins openness and transparency to encourage incident reporting and raising concerns.

The Trust will always encourage and support incident reporting where an incident may have or is likely to occur which has caused, contributed to or may lead to harm of a patient, visitor or colleague.

Please refer to the Trust's current managing incidents policy is embedded for reference and will be updated further time for the PSIRF go live date of 1 September 2023.

http://imt012/Policies_Procedures_and_Guidelines/Guidance%20Documents/Managing%20Incidents%20%20Serious%20Incidents%20Policy.pdf

Patient safety partners

The Trust is currently in a process to recruit Patient Safety Partners in line with the NHSE guidance Framework for involving patients in patient safety .

Patient Safety Partners (PSP) will have a fundamental role in supporting PSIRF providing a perspective through a patient lens to support developments and innovations to drive continuous improvement in respect of quality and safety of services.

The PSP will be involved in the designing of safer healthcare at all levels in the organisation, to promote safety in the Trust and maximise opportunities for effective and embedded learning. They will use their experience as a patient, patient representative or member of the local community to provide support, guidance and challenge.

PSPs will be part of the Liverpool Women's Hospital Family and will work alongside all staff, volunteers and patients. They will attend quality and safety focussed meetings (face-to-face and online) and be intrinsically involved in patient safety and quality initiatives.

Full role descriptions will be provided for PSPs along with any training and support requirements identified so that they can fulfil their role to its' full potential and ensure the best patient safety outcomes for all patients.

Addressing health inequalities

Liverpool Women's NHS Foundation Trust (the Trust) specialises in the health of women, babies, and their families. As one of only two such specialist trusts in the UK and the largest women's hospital in Europe the trust holds a unique position. We recognise there are areas within Liverpool that have high levels ethnicity diversity and of deprivation.

The Trust has a key role to play in tackling health inequalities in partnership with local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system alone and are driven by a number of socio-economic factors.

Since April 2022 health inequalities data including ethnicity, preferred spoken language and patient postcode have been recorded to allow an assessment of the health inequalities factor of patients whose care was involved in a Serious Untoward Incident (SUI). As such, a review of Serious Untoward Incidents for 2022-2023 was undertaken. This included the performance of the investigatory process, health inequalities data and the themes and learning from the incidents. The review included those cases reported to HSIB and MBRACE. The learning from these events was reported through the Learning from Deaths process.

Through the implementation of PSIRF, the Trust will continue to follow this process, utilising data and learning to identify actual and potential health inequalities and make recommendations to the Trust Board and partner agencies in order to try and reduce the negative impacts on patients due to such inequalities.

Engagement with patients, families and wider following a patient safety investigation must also recognise the diverse needs of the communities that the Trust serve and ensure inclusivity for all.

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.

Involving Patients, Families and Patient Representatives

The Trust is committed to involving patients and families following patient safety incidents, engaging them at the earliest opportunity and throughout in the ongoing investigation process, fulfil the duty of candour statutory and non-statutory requirements.

Patients, families and patient representatives often provide a unique, or different perspective to the circumstances around patient safety incidents and may have questions or needs to that of the organisation that will need to be incorporated into the investigation ensuring that the process is patient centred throughout.

This policy refreshes and prioritises the existing guidance relating to the duty of candour and 'being open and honest' and recognises the need to involve patients, families and patient representatives as soon as possible in all stages of any investigation, or improvement planning, unless they express a wish not to be involved.

Further guidance in relation to involving patients and families following a patient safety incident is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/#heading-2

Please also refer to the Trust Being Open and Duty of Candour Policy http://intranet/Policies_Procedures_and_Guidelines/Guidance%20Documents/Being%20Open%20and%20Duty%20of%20Candour%20Policy%20and%20Procedure.pdf

Involving Colleagues and Partner Agencies

Involvement of colleagues and partner agencies at the earliest opportunity and throughout an investigation is fundamental when responding to a patient safety incident ensuring that there is a process of openness and transparency throughout.

The Trust will, in accordance with the Fair and Just Culture, continue to promote, support and encourage incident reporting, including near misses and all levels of harm. The Trust can only deal with and respond to incidents that are reported onto the Ulysses System and identify actions required to manage and mitigate risk.

Staff and colleagues need to feel supported to speak out and openly report incidents and concerns. They also need to be supported when they are involved in incidents and the Trust has a clear policy for managers and colleagues to ensure that the right support is identified and available at the right time.
http://intranet/Policies_Procedures_and_Guidelines/Guidance%20Documents/Supporting%20Staff%20following%20a%20work%20related%20traumatic%20event%20or%20Serious%20Incident.pdf

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.

Trust planning needs to account for and consider other sources of information such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. PSIRF guidance specifies the following standards that the Trust plans should reflect:

1. A thorough analysis of relevant organisational data
2. Collaborative stakeholder engagement
3. A clear rationale for the response to each identified patient safety incident type

They will be:

1. Updated as required and in accordance with emerging intelligence and improvement efforts
2. Published on the Trust external facing website

The Trust patient safety incident response plan (PSIRP) will reflect these standards and will be published alongside this overarching policy framework.

Resources and training to support patient safety incident response

PSIRF recognises that the Trust has limited resources and capacity to investigate and learn effectively from patient safety incidents. It is essential that Liverpool Women's Hospital ensure that it uses capacity and resources effectively to deliver the plan. The PSIRP provides more specific details in relation to this including the number of comprehensive investigations that may be required for single or small groups of incidents that do not fall into one of the broader improvement workstreams/priorities.

Currently the Corporate Governance Team / Wider Trust has the following working time equivalent posts to support and facilitate the PSIRF framework:

- 3 x Patient Safety Specialists and 1 Maternity Dedicated Patient Safety Specialist (additional role to substantive posts)
- 1 x Associate Director of Governance and Quality
- 1 x Head of Risk and Safety
- 1 x Head of Continuous Improvement
- 1 x Quality and Governance Facilitator
- 1 x Medical Device Safety Officer (additional role to substantive posts)
- 2 x Ulysses Governance Support Administrators

There is a pool of trained investigators who can undertake comprehensive investigations, however the majority have a substantive clinical or governance role, so must be allocated time within job plans to complete investigations

All staff are required to complete mandatory patient safety training levels 1 and 2 which covers the basic requirements of reporting, investigating, and learning from incidents.

Trust patient safety incident response plan

The Trust plan sets out how Liverpool Women's NHS Foundation Trust intends to respond to patient safety incidents for 2023 - 2025. The plan 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.

The plan is based on a thorough analysis of themes, patterns, and trends from:

- Serious Incident Investigations (last 5 years)
- Health inequalities data (associated with SI review)
- Formal Reviews
- HSIB investigations
- Complaints / PALS / PALS+
- Safeguarding reviews
- Mortality reviews
- Freedom to speak up concerns
- Trust staff survey annual results
- Legal claims (new / ongoing / settled)
- Inquests
- Quality improvement and Service evaluation projects
- Clinical audits – initial and reaudit
- PMRT

Reviewing the patient safety incident response policy and plan

The 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. Initially the plan will be reviewed within 6 months; with ongoing improvement work the 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 period.

Updated plans will be published on the Trust website, replacing the previous version.

A rigorous planning exercise will be undertaken, as agreed with the integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing Trust response capacity, mapping services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement

Responding to patient safety incidents

Patient safety incident reporting arrangements

Patient safety incident reporting will follow the Trust Managing Incidents and Serious Incidents Policy (currently under review) It is recognised that staff must continue to feel supported and able to report any incidents or concerns in relation to patient safety, whilst promoting a system of continuous improvement within the fair and just culture.

Responding to cross-system incidents/issues

The Corporate Governance and Divisional Governance teams will ensure any incidents that require external engagement are identified and shared through existing channels and networks, and that partnership colleagues are fully engaged in investigations and learning as and when required. This process will be reciprocated by the Trust.

Certain incidents will require external reporting to national bodies such as HSIB, HSE, RIDDOR and MHRA.

Patient safety incident response decision-making

The Trust has governance and assurance systems to ensure oversight of incidents at both Divisionally and Trust Wide. Corporate and Divisional Governance teams work managers to ensure the following arrangements are in place.

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends, or clusters of incidents within a specific service
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risks and issues (eg – CQC concerns)
- Identification of any incidents requiring external reporting or scrutiny (eg – Never Events, Neonatal deaths, RIDDOR)
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures

This data will be reviewed regularly against the identified priorities in the PSIRP to determine whether any shift in focus is required, which will be agreed by the Quality and Committee if required.

The process for completion of a Patient Safety Incident Review, currently identified as a 72-hour rapid review, to determine further investigation or escalation required will remain. This will include a wider range of options for further investigation outlined in the PSIRF.

The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under the Trust's PSIRP. This may often mean no further investigation is required, especially where the incident falls within one of the improvement themes identified in the PSIRP and this will be considered on a case-by-case basis with justification where necessary.

Timeframes for learning responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

The PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident. Initial incident investigation – as soon as possible, within 5 working days of reporting

- Further learning response (eg: Patient Safety Incident Investigation's (PSII's), After Action Review (ARR), Swarm huddle – within 20 working days of reporting
- Comprehensive Investigation – 60 - 120 working days depending on complexity

A toolkit of learning response types is available from NHSE at https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

Safety action development and monitoring improvement

PSIRF moves away from the identification of 'recommendations' which may lead to determining a resolution at an early stage of the safety action development process.

"Learning response methods enable the collection of information to acquire knowledge. This is important, but it is only the beginning. A thorough human factors analysis of a patient safety incident does not always translate into better safety actions to reduce risk. You must move from identifying the learning to implementation of the lessons. Without an integrated process for designing, implementing, and monitoring safety actions, attempts to reduce risk and potential for harm will be limited."

Quality Improvement to support embedded learning and improvement following a patient safety investigation is key to improving patient safety outcomes. Close links have been and will continue to be developed and maintained with the Continuous Improvement Team. PSIRF provides an opportunity to strengthen this and for the QI and Patient Safety functions to work hand in hand.

Safety actions arising from a learning response should follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and thought must be given to monitoring and measures of success. Further guidance on this can be found in NHSE Guidance at https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Monitoring of completion and effectiveness of safety actions will be through organisational governance processes reporting within Divisions and their associated governance meetings, to Safety and Effectiveness Sub Committee and Quality Committee.

The Corporate Governance Team will maintain an overview across the organisation to identify themes, patterns and trends via the Integrated Governance Report supported by Divisions on a quarterly basis.

Safety improvement plans

The PSIRP details how the Trust will ensure patient safety incidents are investigated in a more holistic and inclusive way, to identify key learning and safety actions which will reduce risk, improve safety and quality of services and improved patient safety outcomes for all patients.

These themes are clearly detailed in the PSIRP.

The Trust will continually review its' governance processes in line with the PSIRF guidance so it is clear how the PSIRP improvement priorities will be overseen through the Trust Governance Processes to provide 'ward to board' assurance.

Oversight roles and responsibilities

"When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures". To achieve this, organisations must look carefully not only at what they need to improve but also what they need to stop doing (eg panels to declare or review Serious Incident investigations).

Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control."

NHSE, PSIRF Guidance 'Oversight roles and responsibilities specification and Patient safety incident response standards'

Responsibility for oversight of the PSIRF for provider organisations sits with the Trust Board. The Executive Lead is the Chief Nurse who holds responsibility for effective monitoring and oversight of PSIRF.

The Trust is committed to working with the ICB and other national commissioning bodies as required. Oversight and assurance arrangements will be developed through joint planning and arrangements must incorporate the key principles detailed in the guidance namely

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Policy, planning and governance
3. Competence and capacity
4. Proportionate responses
5. Safety actions and improvement

Complaints and appeals

Complaints relating to this guidance, or its implementation can be raised informally with any of the the Trust Patient Safety Specialists, initially, who will aim to resolve any concerns as appropriate.

Formal complaints from patients or families can be lodged through the Trust's complaints procedure via PALS@lwh.nhs.uk 0151 702 4353 or in writing as follows:

PALS
Liverpool Women's NHS Foundation Trust
Crown Street
Liverpool
L8 7SS

Directly with the Chief Executive:

The Chief Executive,
Liverpool Women's NHS Foundation Trust,
Crown Street,
Liverpool,
L8 7SS