North West Ambulance Service NHS Trust

Patient Safety Incident Response Policy

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Change record form

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Patient Safety Incident Response Policy

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1. INTRODUCTION

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety events, for the purpose of learning and improvement.

Patient safety events are unintended or unexpected events (including omissions) in healthcare that could have, or did, harm one or more patients.

The PSIRF replaces the Serious Incident Framework (SIF), (2015) and makes no distinction between "patient safety events" and "serious incidents". It removes the "serious incidents" classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety events by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The new framework is not a different way of describing what came before; it fundamentally changes how the NHS responds to patient safety events for learning and improvement.

The PSIRF advocates a co-ordinated and data-driven approach to patient safety responses that prioritises compassionate engagement with those affected, including staff. It embeds a wider system of improvement and prompts significant cultural shift towards patient safety management.

2. PURPOSE

This policy supports the requirements of the PSIRF and sets out North West Ambulance Service NHS Trust's (NWAS) approach to developing and maintaining effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety.

This policy supports the four key aims of the framework:

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

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

3. SCOPE

This policy is specific to patient safety event responses conducted solely for the purpose of learning and improvement across NWAS.

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 event.

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 exist for that purpose, and therefore outside of the scope of this policy, such as:

- Claim handling
- Coronial inquests
- Criminal investigations
- Human resources/ employee relations investigations into employment concerns
- Professional standards investigations
- Safeguarding concerns
- Complaints (except where a significant patient safety concern is highlighted)

For clarity, 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 can be shared with those leading other responses, but these processes should not influence the remit of a patient safety learning response.

4. OUR PATIENT SAFETY CULTURE

NWAS is committed to work towards the move from a retribution approach to types of incidents, such as patient safety, to establishing a just culture within the organisation.

Leaders across NWAS are required to proactively embrace this approach and support from staff side colleagues will be instrumental in supporting the organisation transition to a just culture.

The goals of just culture include:

- Moral engagement,
- Fairness
- Reintegration of the practitioner, and
- Organisational learning

PSIRF will enhance these by creating stronger links between patient safety events and learning for improvement. NWAS anticipates fostering the approach and work collaboratively with those affected including patients and their families, and our people. This will continue to increase transparency and openness amongst our people to report events and allow for wider engagement.

We are clear that patient safety event responses are conducted for the sole purpose of learning and identifying system wide improvements; they are not to apportion blame, liability or define preventability or cause of death.

Our safety culture within NWAS continues to make progress and is a key organisation priority. We have programmes of work in place to improve this including:

- Introduction of new Datix Cloud IQ (DCIQ) system
- Establishment of programme of safety culture surveys across the organisation, with the development of local improvement programmes
- Development of safety data/safety dashboards
- Safety Training programme
- Focused improvement work on duty of candour

- Focused work on speaking up.

5. PATIENT SAFETY PARTNERS

The Patient Safety Partner (PSP) role is a new and evolving role developed by NHS England to help improve patient safety across the NHS.

At NWAS, we're excited to welcome PSPs who will offer support alongside our people, patients, families, and carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and offers great opportunities to share experiences and skills and provide a level of scrutiny. This exciting new role will evolve over time with the main purpose of the role is to be the voice for our patients and community who utilise our services, ensuring patient safety is at the forefront of all that we do.

PSPs will provide objective feedback focusing on maintaining safety and improvement. This may include attendance at our patient safety and quality governance meetings and involvement with the production and review of relatable policies and procedures. The information may be complex, and partners will provide feedback to ensure patient safety is our priority.

PSPs will be supported in their honorary role by the Safety Learning Team and Patient Experience Team who will provide expectations and guidance for the role. They will have regular reviews and training needs will be agreed together, based on the experience and knowledge of each partner.

The PSP role will be reviewed annually to ensure the role is aligned to the patient safety agenda as it continues to develop, and expanded to ensure we are represented by the diverse communities we serve, including population groups who may sometimes experience challenges in accessing our services.

6. ADDRESSING HEALTH INEQUALITIES

The NHS has a duty to reduce inequalities in health by improving access to services and tailoring those around the needs of the local population in an inclusive way.

The Trust is committed to delivering on its statutory obligations under the Equality Act, (2010) and will use data intelligently to assess any disproportionate patient safety risk to patients from across the range of protected characteristics. This data can be captured via our Electronic Patient Records (EPR) and DCIQ system.

In our response toolkit, we will directly address any features of an event which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to any population group, including all protected characteristics. When constructing safety improvement actions in our patient safety learning responses we will consider inequalities.

We will look to address health inequalities as part of our safety improvement work, understanding our services provide care to a proportion of the Core20PLUS5 population cohort identified by NHS England (2021). In establishing our future policy and plan we will work to identify variations of inequality by using our population and patient safety data to ensure it is considered as part of the development process for the future.

Engagement of those involved (patients, families/carers, and our people) following a patient safety event is crucial to our patient safety learning responses. We will ensure that we use available tools to include easy read, translation, and interpretation services alongside any other method appropriate to meet their needs and maximise the potential of being involved.

Information resources produced by NWAS can be made available in alternative formats, such as easy read or large print and may be available in alternatives languages upon request. These requests can be made to our internal communications team.

NWAS endorses a zero tolerance of racism, discrimination, and unacceptable behaviours from and towards our people, our patients, carers, and families.

7. ENGAGING AND INVOLVING PATIENTS, FAMILIES AND OUR PEOPLE FOLLOWING A PATIENT SAFETY EVENT

PSIRF recognises that learning and improvement following a patient safety event can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety response system that prioritises compassionate engagement and involvement of those affected. This involves working with those affected to understand and answer any questions in relation to the event and signpost to relevant support as required.

We are committed to continuous improvement throughout the services we provide. We want to learn from any event where care does not go as planned or expected by our people, patients, their families, carers, and other organisations. Getting involvement right with patients and families in our response is crucial, particularly to support the improvement of the services we provide. This involves being open and honest whenever there is a concern about care/ treatment provided, or when a mistake has been made.

Alongside professional and statutory requirements for Duty of Candour, NWAS commits to being open and transparent because it's the right thing to do; this is regardless of the level of harm caused by an event. In-line with the PSIRF we will support those involved via a network of Engagement Leads who will guide our people, patients, and their families through our patient safety learning responses to conclusion.

In addition, we have a Patient Advice and Liaison Service (PALS) for those with a concern or are unhappy about their experience with NWAS. This allows the organisation to review the concern and make improvements where necessary and feasible.

NWAS loves to hear great things about our people and the services we provide and NWAS welcomes compliments from our patients and their families which are used to assist with learning from excellence.

Our teams at NWAS can support with the following:

- Raising a concern, or a complaint.
- Sending a thank you.
- Healthcare Professional (HCP) and social care concerns/ enquiries.

All relevant contact details and associated forms can be found here.

For our people, NWAS recognises it can be beneficial to seek support because of a patient safety event they have been involved in and NWAS advocates the equal importance of both mental and physical health. Our people are encouraged to access the dedicated 'Invest in Yourself' webpage where there are a range of guides and supportive resources.

Patients/ families and carers may find support from one of the following sources: (please note this is not an exhaustive list).

- **Learning from Deaths:** *Provides an explanation of what happens following a bereavement (including those referred to a coroner) and how families and carers can comment on care received.*
  https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/

  Help is at hand – Bereavement following suicide: *Specifically, for those bereaved by suicide; practical support and guidance for those who have suffered loss.*
  https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf

- **Mental Health Homicide Support:** *For staff and families; this information has been developed by London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.*

- **Child Death Support:** *Child Bereavement UK and lullaby trust both provide support and practical guidance for those who have lost a child at any age.*

- **Complaints Advocacy:** *The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings, and review information given during the complaints.*

- **Healthwatch:** *Healthwatch are an independent statutory body who provide information to help make a complaint, you can find a list of your local Healthwatch on their website.*

- **Parliamentary and Health Service Ombudsman (PHSO):** *Make final decisions on complaints for patients, families and or carers when deemed not to have been resolved fairly by the NHS in England.*

- **Citizens Advice Bureau:** *Provides UK citizens with information about healthcare rights, including how to make a complaint about care received.*

8. PATIENT SAFETY RESPONSE PLANNING

PSIRF supports organisations to respond to patient safety events and issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, we can explore patient safety events relevant to their context and the populations we serve rather than only those meeting a defined threshold.

NWAS will take a proportionate approach to its response to patient safety events, ensuring the focus is on maximising improvement. To fulfil this, we will proactively undertake planning of our current resources for patient safety learning response and our existing safety improvement workstreams.

Our Patient Safety Incident Response Plan (PSIRP) will detail how this will be achieved alongside how we intend to meet both National requirements and our NWAS Local Priorities for patient safety incident responses.

9. RESOURCES AND TRAINING TO SUPPORT PATIENT SAFETY RESPONSES

NWAS has committed to ensuring that we fully embed PSIRF and meet the national training requirements. We have utilised NHS England Patient Safety Response Standards, (2022) to provide resources and the training required for this to happen.

We will have governance arrangements in place to ensure patient safety learning responses are not led by NWAS staff who were involved in the patient safety event itself. Responsibility for patient safety learning responses from our locally agreed NWAS priorities sits with the Patient Safety Incident Response Team.

Patient Safety Learning Responses (PSLRs) sitting outside of our priorities will be led by a suitable senior leader within the relevant service line. Patient Safety Incident Learning Response Leads will have an appropriate level of seniority to influence within the trust, this may depend on the nature and complexity of the patient safety event and the learning response required.

The governance arrangements will ensure patient safety learning responses are not undertaken by staff working in isolation. Patient Safety Incident Response Team will support patient safety learning responses wherever possible and can provide advice on cross-system and cross-area working where this is required.

Our people affected by patient safety events will be afforded the necessary support and given time to participate in patient safety learning responses. All NWAS leaders will work within our just culture principles and utilise other teams to ensure our people are supported. NWAS service lines will ensure processes are adopted so leaders work within this framework to ensure psychological safety.

We will utilise both internal and (where necessary) external subject matter experts with relevant experience, knowledge, and skills.

10. TRAINING

NWAS has invested in one of the nationally mandated training providers from NHS England to ensure those with responsibility for responding and supporting patient safety events had adequate skills and knowledge to support those involved.

A training needs analysis has been developed and will be monitored on an ongoing basis, to ensure those with responsibility for, responding to and supporting patient safety events remains up-to date. This training will be delivered alongside an ambitious programme of safety skills training, including the Patient Safety Syllabus.

11. OUR PATIENT SAFETY INCIDENT RESPONSE PLAN (PSIRP)

Our PSIRP sets out NWAS intends to respond to patient safety events over a period of 12-to-18-month period. 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 event occurred, and the needs of those affected as well as the plan.

A copy of our PSIRP can be located on both our internal platform, the Greenroom, and our website.

12. REVIEWING OUR PATIENT SAFETY RESPONSE INCIDENT POLICY AND PLAN

Our PSIRP is a "live document" that will be appropriately amended and updated as we use it to respond to patient safety events. We will review the plan regularly, and at least annually to ensure our focus remains up to date, with ongoing improvement work, our patient safety 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 24 months.

Updated PSIRP and policy will be published on our website, replacing the previous versions.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our lead Integrated Care Board) to ensure efforts continue to be balanced between learning and improvement.

This more in-depth review will include our response capacity, mapping services, a wide review of organisational data (patient safety incident reports, improvement plans, complaints, claims, staff survey results, inequalities data and any other relevant reporting data) and wider stakeholder engagement.

13. RESPONDING TO PATIENT SAFETY EVENTS

Patient Safety Event Reporting Arrangements

All our people (staff and volunteers) are responsible for recording and reporting potential or actual patient safety events on the trusts DCIQ system. The reporter will record the level of harm they believe to have been experienced by those affected. Each patient safety record will be reviewed and triaged by a corporate team and allocated to the relevant service line(s) for review, response, feedback to the reporter and closure.

The organisation has corporate oversight of all patient safety events and service lines have their own mechanisms in place to ensure patient safety events are responded to proportionately and in a timely manner. This will include consideration of Duty of Candour (Duty of Candour Procedure, found on the Green Room here). Most events will require a local review and learning response (if necessary), undertaken by individual service lines. Those events where the opportunity to learning and improvement would be of greatest value, will be led by the trust Patient Safety Incident Learning Response Team.

Events and/or incidents highlighted that appear to meet requirements for reporting externally will be handled by the Patient Safety Incident Learning Response Team. There will be occasions where events require the efforts of cross-system working with relevant partners, the Integrated Care Board (ICB) will support a collaborative approach with these arrangements if required.

Patient Safety Incident Response Decision-Making

NWAS will have arrangements in place to meet the requirement to review patient safety events under PSIRF. Some of these will require a mandatory response, others will require review or referral to another body and/or team; these are set out in the PSIRF plan.

PSIRF itself sets no further national thresholds to determine what method of response should be utilised for learning and improvement. NWAS has developed a range of response mechanisms to balance the efforts between learning and exploring emerging issues alongside ongoing improvement work. During the work to create our plan, we considered our event insight and engagement with key stakeholders to identify our patient safety profile. We have used and will build on this intelligence for our local priorities and our toolkit for responding to patient safety events.

We have established a process for our response to events, that allows for a clear set of mechanisms allowing for oversight of our learning responses.

We will hold a weekly decision-making governance meeting to review events from escalation within service lines, and a decision is made on an appropriate level of response, this is to identify those events that appear to meet the need for further exploration due to the possibility of meeting the criteria for a full review. This group will have delegated responsibility for the consideration of events for PSII (Patient Safety Incident Investigation) or a patient safety learning response for oversight of outcomes. All recommendations made will focus on system-based approaches utilising the SEIPS (systems engineering initiative for patient safety) model, ensuring recommendations are valid and contribute to existing safety improvement plans or establishment of such, if they are required.

The Quality and Performance Committee will hold overall oversight of such processes, allowing for challenge where required, to ensure the Board of Directors can be assured the true intent of PSIRF is being implemented across our organisation to ensure we are meeting to the national response standards.

14. RESPONDING TO CROSS-SYSTEM EVENTS/ISSUES

The Patient Safety Incident Response Team will assist in the coordination of these events identified to other providers directly, via each organisations reporting processes. Where required summary reporting can be utilised to share insights with other providers about their patient safety profile.

We will work with partner providers and relevant ICBs to establish and maintain robust procedures to facilitate flow of information and minimise delays to joint working on cross-system events. The patient safety team will act as a single access point for such working arrangements and hold supportive procedures to ensure this is effectively managed.

NWAS will refer to ICBs to assist with the co-ordination where a cross-system event is felt to be complex to be managed by a single provider, we anticipate the ICB will provide support and advice with identifying a suitable reviewer, should this circumstance arise.

15. TIMEFRAMES FOR LEARNING RESPONSES

Timescales for Patient Safety Incident Investigations (PSIIs)
Where a full PSII is indicated, this will be started as soon as practically possible following the identification and completed within three months. Locally- led PSIIs should not exceed six months.

Timeframe for completion will be agreed with those affected, as part of setting the terms of reference; this remains subject to them willing and able to be involved in that decision. A balance will be drawn between conducting a thorough review, the impact extended timescales can have on those involved and the risk of delaying findings may adversely affect safety.

In exceptional circumstances (i.e., when a partner organisation requests a pause, or processes of external bodies delay access to information) NWAS can consider whether to progress and determine whether new information would indicate the need for further review once this is received. The decision for this would be made by the Patient Safety Event Cases (PSEC) group.

There may be occasions where a longer timeframe is required for completion, in this case, all extended timeframes will be agreed between NWAS and those affected.

Timescales for Patient Safety Learning Responses (PSLRs)
A Patient Safety Learning Response must be started as soon as practically possible following a patient safety event is identified. These learning responses should not exceed six months in duration.

16. SAFETY ACTION DEVELOPMENT AND MONITORING IMPROVEMENT

NWAS acknowledges any form of patient safety learning response will allow the circumstances of an event or set of events to be understood, but this may only be the beginning. To reliably reduce risk, better safety actions are required.

We will have systems and processes in place to design, implement and monitor safety actions using an integrated approach of reducing risk and limit the potential for future harm. This process follows from any initial findings of any form of learning response which could result in aspects of trust's working systems where change could reduce risk and harm. NWAS will generate safety actions in relation to each of these defined areas for improvement. Following this, we will have measures to monitor safety actions and set milestones for review.

Patient Safety Learning Responses should not describe recommendations, as this can lad to premature attempts to devise a solution. To achieve successful improvement, safety action development will be completed in collaborative way with a flexible approach and support from the Quality, Improvement, and Innovation Directorate.

Development of Safety Actions
NWAS will utilise processes for development of safety actions as outlined by NHS England; Safety Action Development Guide, (2022):

- Agree areas for improvement: specify where improvement is needed, without defining solutions.
- Define context: this will allow agreement on the approach taken to safety action development.

- Define safety actions to address areas of improvement focuses on systems in collaboration with those teams involved.
- Prioritise safety actions to decide on testing for implementation.
- Define safety measures to demonstrate if actions are influencing what is intended.
- Safety actions will follow SMART principles and have designated owners.

Safety action monitoring
Safety actions must continue to be monitored within service lines governance arrangements to ensure any actions put in place remain impactful and sustainable.

17. SAFETY IMPROVEMENT PLANS (LOCAL PRIORITIES)

Safety improvement plans bring together findings from various responses to patient safety events and issues. NWAS will have several safety improvement plans in place which are adapted to respond to outcomes of improvement efforts and other influences as national safety improvement programmes.

The NWAS PSIRP has outlined local priorities for focus or response under the PSIRF. These were developed due to the opportunity they offer for learning an improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in risk or harm.

The trust will use the outcomes from existing patient safety reviews and any relevant learning response conducted under PSIRF to create related improvement plans to assist focus on our improvement work. NWAS service lines will work collaboratively with NWAS Corporate Teams and others to ensure there is an aligned approach to development of plans and resultant improvement efforts.

Where overarching systems issues are identified by patient safety learning responses outside of trust priorities, a safety improvement plan will be developed. These will be identified through the PSIRF governance processes.

Monitoring of progress for safety improvement plans, will be overseen by Regional Improvement and Learning Forum on a scheduled basis.

18. OVERSIGHT ROLES AND RESPONSIBILITIES

Principles of oversight
Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.

NWAS follows the "mindset" principles to underpin the processes we have in place to allow us to implement PSIRF as set out in the framework and supporting guidance.

Responsibilities
Alongside the Trust's responsibilities, our lead ICBs, and our regulator the Care Quality Commission (CQC), will have specific responsibilities under PSIRF.

Trust Board

The Trust Board is responsible and accountable for effective patient safety incident management across NWAS. This includes supporting and participating in cross-system/ multi-agency responses, and/or independent patient safety incident investigations (PSIIs) where required.

Executive Leads

To meet these requirements, NWAS has designated the Director of Corporate Affairs as the executive lead to support PSIRF. This enables us to:

- Ensure NWAS meets the national patient safety standards.
- Ensure that PSIRF is central to overarching safety governance arrangements.
- Quality assuring learning response outputs.

The Director of Corporate Affairs will provide direct leadership, advice, support in complex/ high profile cases, and liaise with external bodies, as required, in collaboration with the Director of Quality, Innovation and Improvement and the Medical Director.

The Director of Corporate Affairs has the overarching responsibility for the quality of patient safety learning responses and PSIIs. The Director of Quality, Innovation and Improvement has the overarching responsibilities for safety learning and improvement. The Medical Director is overall accountable for patient safety for the Trust.

Each Executive Director are equipped with the training and professional development as described in the national patient safety incident response standards.

19. COMPLAINTS AND APPEALS PROCESS

NWAS recognises that there will be occasions when patients, services users and carers are dissatisfied with the aspects of care and services provided by the trust.

It is important to understand that there is a distinction between complaints and concerns as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process.

The first point of contact with the trust, to raise a concern is via the PALS team.

Complaints are defined as expressions of dissatisfaction from a patient, their family or carer, a person acting as their representative or any person who is affected or likely to be affected by the action, omission or decision of the trust and requires a formal review.

NWAS is committed to dealing with any complaints that may arise quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints and concerns can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services.

Outcomes and recommendations from a complaint will be shared with service lines to ensure any necessary changes can be considered and implemented where appropriate.

If patients, relatives and or carers have a concern or complaint in relation to how a patient safety learning response has or is being handled, they should contact their nominated Patient Safety Incident Learning Response Lead or Engagement Lead in the first instance. Every effort will be made to address specific concerns.