Northern Lincolnshire and Goole NHS Foundation Trust

Chief Medical Officer Directorate

PATIENT SAFETY INCIDENT RESPONSE POLICY

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Northern Lincolnshire and Goole NHS Foundation Trust actively seeks to promote equality of opportunity. The Trust seeks to ensure that no employee, service user, or member of the public is unlawfully discriminated against for any reason, including the "protected characteristics" as defined in the Equality Act 2010. These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

Contents

1.0 Purpose

1.1 Northern Lincolnshire and Goole NHS Foundation Trust's policy for the national Patient Safety Incident Response Framework (PSIRF) demonstrates the systems and processes for responding to patient safety incidents and enabling learning and improving patient safety.

1.2 The framework provides 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.

1.3 This policy structures the patient safety incident response system based on the four key aims of the framework, being:

- 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.

2.0 Scope

2.1 This policy is specific to patient safety incident responses conducted for the purpose of learning and improvement across the Trust.

2.2 Learning Responses to patient safety incidents, set out through this policy follow a systems-based approach. This recognises that patient safety is a property of the healthcare work system. The work system includes components of the tasks, persons involved, tools & technology, internal environment, organisation and external environment. Investigation of interactions between these work system components, provides focus on system improvement rather than 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.

2.3 PSIRF learning response methods will not apportion blame or determine liability, preventability or a cause of death, as they are conducted for the purpose of learning and improvement. The Trust uses the Just and Learning Framework, for initial management of staff practice concerns. The Just Culture guidance from NHS England is used with consideration of other interventions in practice. Other processes, such as claims handling, formal disciplinary processes into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose and are outside the scope of this policy.

2.4 Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

3.0 Our patient safety culture

3.1 The patient safety culture of the Trust is seen through the attitudes and behaviours observed and demonstrated in a range of activities, clinical practice and experienced by the patient, but also the priority placed through the leadership of the Trust.

3.2 The Trust Board risk appetite sets this out as:

The Trust will not accept risks that impact adversely on patient safety and therefore has a greater appetite for financial risk in that they are prepared to take the necessary actions to safeguard safety despite the potential financial consequences and regulatory impact. The Trust also has a greater appetite to take considered risks in pursuit of innovation which may challenge established working practices and may pose a risk to its reputation, where positive gains can be seen.

3.3 The incident reporting culture in the Trust demonstrates slightly higher than expected proportions of no-harm reporting at 74.95% in 2022/23 compared to 72.7% in the most recent available national NRLS data (2020/21), illustrating signs of a good safety reporting culture.

3.4 As we continue our patient safety improvement journey, we promote reporting of incidents, identify safety actions from learning responses and share the learning, with continued focus on quality improvement.

4.0 Patient Safety Partners

4.1 Patient Safety Partners (PSP) are new to the Trust, although public governors have contributed in the past. The PSP's will be a part of culture development, enabling a voice for patients to contribute to learning and improvement. Having PSP involvement in the trusts governance meetings will link to the national ambition set out in the national Patient Safety Strategy.

5.0 Addressing health inequalities

5.1 The Trust aims to improve population health and equity for all, reducing inequality and impacts from avoidable differences in health for the population we serve.

5.2 Using a systems-based approach to respond to incidents will provide a prompt to identify a range of external and internal factors which could identify health inequalities. The opportunity to learn and address health inequalities will be included where relevant, accessing subject matter experts from the organisation as needed.

6.0 Engaging and involving patients, families and staff following a patient safety incident

6.1 Learning and improvement following a patient safety incident will be achieved with supportive systems and processes in place providing compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). 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 is essential.

7.0 Patient safety incident response planning

7.1 PSIRF enables the Trust to respond to incidents and safety issues in a way that maximises learning and improvement. The transition from the previous Serious Incident Framework has required planning and adjustment in processes, training, and thematic analysis to plan the Trust implementation. This is reflected through this policy and the Patient Safety Incident Response Plan, in Appendix 2, including national requirements and the Trust patient safety profile, providing a structured approach to learning response investigations and improvement plans.

8.0 Resources and training to support patient safety incident response

8.1 Staff undertaking various duties with the PSIRF approach will need appropriate training and support. This includes investigation leads, engagement leads to support the investigation processes and support to those exposed to incidents. The detail of training is aligned to the national recommendations using the Health Education England Patient Safety training, and the HSIB level 2 investigation training.

8.2 Supporting guides and templates to provide the structured approach required, are published on the Hub site.

9.0 Our patient safety incident response plan (PSIRP)

9.1 The patient safety profile that informs the plan uses the organisations historical data, including incident reporting, learning from deaths, inquests, claims, complaints, concerns, quality priorities, quality improvement activities and benchmarking with peers.

9.2 The plan applies to the whole Trust, but also includes specific elements, such as Maternity services, children and young people, vulnerability for mental health and learning disability. Where national standards are specified, these are adopted as part of the Trust pan.

10.0 Review of the patient safety incident response policy and plan

10.1 The PSIRP is a ‘live document’ that will be revised through use, to remain relevant to the patient safety risk profile. Formal review of the plan every 12 to 18 months will ensure our focus remains up to date. It is fully expected that elements of the PSIRP will change due to ongoing improvement. This will also

provide an opportunity to maintain engagement with stakeholders, demonstrating learning in the previous 12 to 18 months.

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

10.3 A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (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 learning response capacity, mapping services, stakeholder views and the data from patient safety incidents, learning responses, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data.

11.0 Responding to patient safety incidents

11.1 Patient safety incident reporting arrangements

11.1.1 All patient safety incidents should be reported on the Trust incident reporting system, on the Trust intranet Hub site. DCP009 Incident Reporting Policy and Procedure should be followed. The Trust incident reporting system is connected to the national system for Learning from Patient Safety Events (LFPSE).

11.2 Patient safety incident response decision-making

11.2.1 The range of methods to respond to an incident will follow the PSIRP. The incident responses and the principles are set out below:

Incident Response	**Examples**
Local manager review *Incident data will feed into the reviews of the PSIRP.*	Low risk incidents which are: No harm Low/Minor harm and prevented incidents (near-miss)
After Action Review *This is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.*	Where an investigation is required to understand the events and identify learning using a structured facilitated session with clinical teams and leaders.
Swarm Huddle *Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.*	Rapid review of the circumstances of an incident that can enable learning points and also prevent distress from those involved promptly, within a day of the incident.
Multidisciplinary team (MDT) review	May work well with historical cases, with more reliance on

Incident Response	Examples
This method supports teams to: identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.	documentation rather than individuals involved.
Patient Safety Incident Investigation (PSII) *The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.*	Used for Never Event incidents, deaths that are likely to have been caused by the Trust and for emerging thematic incidents.
Quality monitoring and improvement activities *This will include formal oversight arrangements where a strategic action plan is in place, as well as existing working groups and quality improvement projects*.	Pressure ulcer review process; Deteriorating patient Quality Priority; Quality Improvement (QI) Showcase projects.

11.3 Responding to cross-system incidents/issues

11.3.1 In the event of any incident spanning organisations, there are arrangements in place formally with Hull University Teaching Hospitals NHS Trust, so the site where the patient was treated will determine the lead organisation, which we would seek the same for other shared boundary incidents. For this arrangement and for any other shared incidents with other organisations, the Terms of Reference for any PSII case will be agreed with partner organisation.

11.4 Timeframes for learning responses

Investigation timeframes are a challenge for all involved, as can impact on the welfare of anyone involved, but they cannot be rushed to be completed if the focus is on time rather than quality of the learning response. However, the ideal timeframes are shown below.

Learning response methods and processes	Ideal timeframe
Local Manager review	1 week
After Action Review	2 weeks
Swarm Huddle	As soon as possible, ideally within 1 day
Multidisciplinary (MDT) review	2 weeks
PSII	3 months, but up to 6 months if complex or multi-organisational.
PSII thematic reviews (multiple cases)	Up to 6 months

Learning response methods and processes	Ideal timeframe
Duty of Candour – moderate or greater harm incidents, as part of regulatory requirements.	Notification verbally, followed up in writing within 10 working days of the incident being known.
Duty of Candour Learning response outcome communication.	Within 10 working days of the approval of an investigation. If linked to a completed Learning response, then the outcome can be shared in a single follow up letter, if completed within 10 working days.

11.5 Safety action development and monitoring improvement

Outcomes from learning responses require identification of safety actions. Some of these will be easily identifiable and cost neutral, while some may require due consideration to support resource allocation or require more significant practice or process changes. Therefore, it is important to ensure engagement with or involvement directly with the leadership teams who have accountability for relevant services and processes. This is particularly relevant for Swarm Huddles, After Action Reviews and MDT reviews having a significantly senior leader attending will enable proportional safety actions to be agreed.

For PSII cases or any circumstance where there is independent investigation, the relevant leadership team will be presented with findings and recommendations, which will require the Safety Actions to be set as a response, demonstrating the accountability of the leadership team.

11.6 Safety improvement plans

There are a series of improvement activities taking place in the Trust, from working groups, Investigation action plans, Quality Improvement Projects, Quality Priorities, CQUINs projects, local and national audit activities and action plans developed from best practice evidence developments. As part of the incident response plan, there is linkage between incidents, learning responses and anticipated improvement routes. While some of the functions have specific improvement plans, there will be new information that adds to existing plans, and emerging themes that require new patient safety improvement plans, beyond the safety actions of a specific incident.

As part of the review of the Patient Safety Incident Response Plan, correlation of the patient safety profile and improvement plans and routes will be required, fully recognising the evolution and refinement that comes through implementation of a change in processes, such as this.

12.0 Oversight roles and responsibilities

12.1 Divisional Leadership Teams

Investigation and Learning response reports will be require oversight through the Divisional or Directorate leadership team when external communication to a patient or their families is required.

12.2 Learning Response Panel

Outcome reports from the learning responses, other than local manager investigations will be taken to the Learning Response Panel for consideration of proportional investigation, system focused investigation, findings and recommendations, and a sense check of safety actions from the relevant service.

12.3 Local Maternity and Neonatal Systems (LMNS)

The LMNS provides external support and oversight for the Maternity and Neonatal services, including the sharing of learning between Trust's, review of patient safety incident responses, peer review, quality improvement and opportunities for collaboration across the system.

12.4 Executive Oversight

Further to this, high profile cases, including PSII's, with their findings and recommendations, from the Learning Response Lead and the safety actions from the relevant leadership team will be reported the Learning Response Panel and reviewed, prior to the structured sign off process through the Head of Risk and Patient Safety, Associate Director of Quality Governance and relevant Director.

13.0 Complaints and appeals

Patients, their representative or family member, who has the required consent, are asked to contact the Trust Patient Advice and Liaison Service and share their concerns: The relevant contact details can be found on the Trust website:

Patient Advice and Liaison Service (PALS) - Northern Lincolnshire and Goole NHS Foundation Trust (nlg.nhs.uk)

14.0 Monitoring Compliance and Effectiveness

Element to be monitored	Frequency	By whom	Reported to
National reporting thresholds	Annual	Head of Risk	Quality Governance Group (QGG)
PSIR Plan Learning response method alignment in practice	Annual	Head of Risk	QGG
Key roles training completion	Annual	Head of Risk	QGG
Quality of report content and findings	Monthly	Head of Risk	Learning Response Panel
Safety action completion: • Evidence of completion • Timeliness of completion	Monthly	Head of Risk	Learning Response Panel

15.0 Associated Documents

- Patient Safety Incident Response Plan
- Incident reporting policy
- Complaints policy
- Risk Assessment policy
- Trust Strategy and Quality Strategy
- Quality Account annual reports

16.0 References

16.1 NHS England Patient Safety Incident NHS England » Patient Safety Incident Response Framework

17.0 Consultation

17.1 This policy has been consulted on with members of the Patient Safety Incident Response Framework implementation group and the Quality Governance Group in the Trust. In addition to this the Chief Medical Officer, Chief Nurse and Chief Operating Officer, and also external colleagues from the Integrated Care Board in the Place Locations of North Lincolnshire and North-east Lincolnshire.

18.0 Dissemination

18.1 This policy will be disseminated through the following routes:

- Group Executive
- PSIRF Implementation Group membership
- Quality Governance Group membership
- Quality and Safety Committee membership
- Hub publication
- Communications Team bulletin
- Publication on the Trusts Public Website

19.0 Implementation

19.1 Phased implementation in Quarter 3 and 4 of 2023/24, with oversight through the Learning Response Panel and Quality Governance Group.

19.2 Change to other linked policy documentation such as the Incident reporting Policy and Terms of Reference for relevant committees.

19.3 The resources to support investigation and learning responses will be published on the Hub.

19.4 Additional support through undertaking practice of various learning responses will be provided through trained investigators, patient safety specialists from the Quality Governance and Risk teams, with a wider peer support network developed as more learning responses are undertaken and training can be consolidated through application in line with the plan and this policy.

19.5 Oversight of the implementation will continue through the implementation group for a minimum of 6 months.

20.0 Document History

20.1 This is the first version of this policy. It is derived from the NHS England template policy and the PSIRF implementation project undertaken in the Trust.

21.0 Equality Act (2010)

21.1 Northern Lincolnshire and Goole NHS Foundation Trust is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

21.2 The Trust is committed to building a workforce which is valued and whose diversity reflects the community it serves, allowing the Trust to deliver the best possible healthcare service to the community. In doing so, the Trust will enable all staff to achieve their full potential in an environment characterised by dignity and mutual respect.

21.3 The Trust aims to design and provide services, implement policies and make decisions that meet the diverse needs of our patients and their carers the general population we serve and our workforce, ensuring that none are placed at a disadvantage.

21.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably by reason of age, disability, gender, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

22.0 Freedom to Speak Up

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with this policy, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to the Freedom to Speak Up Policy for the NHS (DCP126) which has been adopted by the Trust in line with national guidance. Staff can raise concerns verbally, by letter, email or by completing an incident form. Staff can also contact the Trust's Freedom to Speak Up Guardian in confidence by email to nlg-tr.ftsuguardian@nhs.net or telephone 07892764607. More details about how to raise concerns with the Trust's Freedom to Speak Up Guardian can be found on the Trust's intranet site.

The electronic master copy of this document is held by Document Control, Directorate of Corporate Governance, NL&G NHS Foundation Trust.

Appendix 1 – Process overview diagram