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NHS

Novus Health
Patient Safety Incident Response Plan

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Date: 17/03/2023
Review: Clinical Governance Commitee

Get better Stay better

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Introduction:

What Is PSIRF?

What is the Patient Safety Incident Response Framework.

The **PSIRF** is a requirement for all NHS providers that deliver NHS funded care. This framework sets out the requirement for this plan to be developed.

The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the **NHS patient safety strategy**.

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

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

We are using the PSIRF to progress our services. Using all incidents to develop continuous learning and improvement.

This patient safety incident response plan (PSIRP) outlines the approach Novus will adapt to respond to patient safety incidents. Aligning with the patient safety incident response framework (PSIRF) values to enhance learning and development across the organisation.

The PSIRP will demonstrate the key themes of persistent incidents across the services that we provide. Data collected from three years of incidents has discovered and identified key Incident profiles that will lead to improvement within our services. Our plan will identify the approach and response taken to the identified themes.

The patient safety incident response plan will help us demonstrably improve the efficiency of our patient safety investigations (PSIs). To do this we aim to;

1. Refocus PSIs towards the identification of causal factors and system issues.
2. Discuss the causal factors and system issues focusing on the use of improvement sciences to reduce repeat patient safety risks and incidents.
3. To reflect on quality of patient safety incident reporting to increase stakeholder (patients families carers and staff) confidence in the improvement of patient safety through the learning achieved through investigation
4. Signifying that value can be discovered from the above.

The plan is underpinned by our internal policies on incident reporting and investigation available to all staff via our organisation's intranet.

Strategic Aims

Novus Health provides NHS patients in Wakefield and Kirklees with adult hearing, physiotherapy, dermatology and minor surgery health services.

Our mission is to improve and develop the safety of care that Novus provides. To uphold our values 'Get Better, Stay Better'. Improving engagement and experience from patient care.

To deliver our mission we aim to uphold our values:

Our values should be embedded in everything we do and every patient contact:

- Working together for patients.
- Respect and dignity.
- Commitment to quality of care.
- Compassion.
- Improving lives.
- Everyone counts.

Our aims outline our purpose and intentions:

- Improving the safety and clinical quality of our services.
- Improving the experience for the patients, carers and families that we treat.
- Developing the range of services we provide and developing the integration of services between primary and secondary care.
- Delivering services closer to people's homes, with continually improved access to treatment times.
- Developing our organisation and workforce.
- Improving the financial stability of the organisation.

Our key priorities

Quality

- Delivering safe, harm free care focusing on evidence-based pathways, supervision and board level clinical leadership.
- Developing, maintaining and deploying clinical staff, who are competent, empowered and promote the core values of the organisation.
- Delivering personalised, responsive and compassionate care in partnership with patients and families, commissioners and other healthcare providers in appropriate environments safeguarding the most vulnerable.

Aims of the Patient Safety Incident Response Plan:

The objectives outlined in this PSIRP

- Further develop systems of care to provide consistent standards and improve the efficiency and quality of care.
- The objectives set to create a unified policy and plan that outlines how the four pillars of PSIRF can be achieved.
- Improving the working environment for staff in relation to their experiences of patient safety incidents. By developing a 'just culture' that will increase shared learning preventing recurrence in incident reports.
- Acting on feedback from patients, families and staff about current problems with patient safety incident response and investigations in Novus Health.
- Demonstrating and developing a climate within the organisation that supports effective change, just culture and learning responses to patient safety incidents.
- Development of a hierarchy capable of delivering our patient safety investigations and an alternate response to patient safety incidents. The system to promote ownership, rigor and expertise and efficacy across our services.
- Making use of current resources. External guidance and internal expertise to excel in a qualitative response to patient safety incidents. Transferring the emphasis from quantity and limited learning to maximise learning for each patient safety incident.

Analysis of Patient Safety Incidents

C; 2019-2022

Incidents and issues: Data sourced from April 2019 – April 2022

Incidents that required a PSI: (As incidents caused harm or had opportunity to cause harm)

Novus Health	2019/20	2020/21	2021/22
Never Events: A serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers	0	0	0
Serious Patient Harm: Any patient safety incident that appears to have resulted in serious harm	0	0	0
Low Patient Harm: Any patient safety incident that requires extra observation or treatment	1	2	3
No Harm: Any patient safety incident that did not result in harm or injury. Any patient safety incident with the potential to cause harm, that was prevented from happening, therefore no harm or injury was caused.	0	0	0

The analysis of data shows that high level learning from patient safety incidents is small. However, the opportunity to learn from all patient safety incidents can offer the insight and improvement service wide.

Patient Safety Incidents / Complaints Recorded 2019-2022

Novus	316

Notably Novus reports all incident that can cause delays to service or can affect opportunities to deliver high quality care.

Novus records all incidents on Intradoc under the remit of; access to treatment, delays to treatment, staff attitude, clerical error, patient issues, incorrect referrals, clinical error, clinic cancellations.

Patient Safety Priorities:

Common Agreed Themes

Agreed focus on key incidents to investigate collaboratively:

Analysis of patient safety insight, based on the original thematic analysis and updated incident review, we have determined 5 patient safety priorities that we will focus on for the next two years.

The patient safety priorities form the foundation for how we will decide to conduct patient safety investigations and patient safety reviews.

The patient safety priorities were agreed at the monthly PSIRF Collaborative Committee Feb 2023

1	Access to treatment	Failure to adhere to operational waiting time standards.
2	Delay of treatment	Unanticipated delays due to clinic cancellations or clinic scheduling.
3	Issues with treatment/ procedure	Reports of discomfort or failings to provide adequate care.
4	Patient Incident	Accidents and injuries / Patient Unhappiness
5	Staff Attitude	Reports mentioning staff communication or professionalism

Selection of incidents for investigation:

The above five priorities will always have a committed patient safety investigation. However, there are multitudes of other incidents that could warrant investigation. The selection criteria are:

- Potential and actual impact of the incident's outcome; Harm to people, service quality, reputational damage.
- Repetition, recurrence of incident; includes scope and spread.
- Potential for learning opportunity in terms of:
- Enhanced knowledge and understanding of the underlying factors.
- Improved efficiency and effectiveness
- Opportunity to influence wider system improvement

Commitment to recording every patient safety incident:

There is a commitment to record every patient safety incident for the sole purpose of learning & prevention of recurrence.

Although collectively five themes have been identified for shared reporting. It does not mean other incidents should not be reviewed if they come to fruition.

Every incident can create opportunities for learning and improvement.

Response Review & Plan of Incidents:

Themes, Response and Plan

Local response from identified themes for investigation (Appendix A):

Theme 1:

- Access to treatment – Failure to adhere to operational waiting time standards.

Response:

- An incident report to be written and uploaded on the staff Intradoc.
- After action review to capture expectations and perspectives for areas of improvement.

Theme 2:

- Delay of treatment – Unanticipated delays due to clinic cancellations or clinic scheduling.

Response:

- An incident report to be written and uploaded on the staff Intradoc.
- After action review to capture expectations and perspectives for areas of improvement.

Theme 3:

- Issues with treatment / procedure – Reports of discomfort or failings to provide adequate care.

Response:

- An incident report to be written and uploaded on the staff Intradoc.
- Clinical Review – to determine systematically whether the outcome was as expected/ intended.

Theme 4:

- Patient issue / incident

Response:

- A 'Being Open' discussion, to provide the opportunity for a verbal discussion about the incident with the patient and colleague (what happened) and to respond to concerns.
- After action review to capture expectations and perspectives for areas of improvement.
- Manage the risk assessments to determine the likelihood of future risks.

Theme 5:

- Staff Attitude - Reports mentioning staff communication or professionalism

Response:

- An incident report to be written and uploaded on the staff Intradoc.
- Clinical Review – to determine systematically whether the outcome was as expected/intended.

Oversight and Governance:

Regular committee meetings are held to review performance, identify areas for improvement, and enhance the patient experience. Here are the committees that focus on patient safety incidents and reviews:

Monthly:

A monthly governance meeting is held to discuss patient safety incidents and outcomes both internally and externally. This meeting aims to learn from patient safety incidents to improve overall safety.

Quarterly:

A committee with a patient safety partner, The Grange and Phoenix, meets quarterly to share incidents and outcomes. The main goal of this committee is to gather informed feedback and data to promote learning and improvements.

Nationally:

Every incident is shared on the LFPSE platform to develop learning opportunities. At Novus, incidents typically fall under the categories of “Low Patient Harm” or “No Harm”. In addition, Novus meets statutory Care Quality Commission notification requirements through reporting to the national reporting and learning system (NRLS) and LFPSE. The only exception is the death of a patient detained under the Mental Health Act, which is reported directly to the CQC.

Incident investigation techniques:

(Appendix A)

Technique	Method	Objective
An incident report	Disclosure of an incident	To provide a written overview of the incident on the staff Intradoc.
‘Being open’ discussion	Disclosure of an incident	To provide the opportunity for a verbal discussion about the incident (what happened) and to respond to concerns.
Safety Huddle	A short multidisciplinary briefing held at a set time and place, and informed by visual feedback of data.	• To improve situational awareness of safety concerns • To focus on the patients most at risk • To share understanding of the day’s focus and priorities • To agree actions • To enhance teamwork through communication and collaborative problem-solving • To celebrate success in reducing harm
After Action Review	A structured facilitated discussion of an event	To identify a group’s strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capture learning to share more widely.
Incident Timeline	Review	To provide a more detailed documentary account of an incident (what happened) in the style of a ‘Chronology’ using Intradoc.
Clinical Review	A care and treatment review	To determine and describe how the care provided compared with accepted standards.
Outcome Audit	Audit	To determine systematically whether the outcome was as expected/ intended.
Clinical Audit	Outcome Audit	A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality,
Risk Assessment	Proactive hazard identification and risk analysis.	To determine the likelihood of an identified risk and its potential severity (e.g. clinical, safety, business).

Just & Open Culture:

Approach to Just Culture

Just culture:

The safety of our organisation relies on both systems and the individuals who comprise them. Whether a nurse, GP, physiotherapist, audiologist or administrative staff, all teams work together towards the shared goal of patient safety.

Creating an environment of trust and open communication is essential to fostering a culture of safety. Encouraging colleagues to share successes and failures facilitates valuable dialogue and helps ensure that staff feel secure in speaking up when necessary.

In our organisations, we prioritise both patient and staff voices, striving to hear and address concerns without judgement or undervaluation. We believe in just culture, which emphasises fairness, openness, and learning. By supporting staff in sharing mistakes and lessons learned, we can strive to prevent future errors.

In a just culture, individuals are not afraid of unwarranted blame, and feel confident identifying areas of improvement. However, this does not negate accountability; rather, it encourages individuals to take responsibility for their actions and strive for ongoing improvement.

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. **END HERE**

No go to next question - **Q2. health test**

2a. Are there indications of substance abuse?

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. **END HERE**

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. **END HERE**

if **No to all** go to next question - **Q3. foresight test**

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

if **No** to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

if **Yes to all** go to next question - **Q4. substitution test**

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

if **Yes** to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. Were there any significant mitigating circumstances?

Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

if **No**

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

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Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

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NHS England and NHS Improvement

Appendix B (https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf)

Patient Safety Incident Reporting Arrangements:

Local and National

Reporting arrangements:

All staff (including locum and agency) have a duty of care to report all patient safety incidents and near misses to a service lead, management or the patient safety team. The responsible person would then create an open log on the electronic incident management system. (https://novus.intradoc247.com/

A record of the incident should be objectively documented in the patients' clinical records. Furthermore, future involvement with patient to consider their needs should be supported during and after incident.

All incidents reported as causing harm to a patient will be discussed immediately by the staff involved, service lead and patient experience lead to determine if further information is required and advise on the type of investigation required. (Appendix A, C)

Incidents requiring consideration as a potential patient safety investigation will be reviewed and discussed urgently with the relevant service lead or stakeholder to determine the type of investigation required. Incidents which meet the criteria for an investigation will be reported nationally on the LFPSE – Learn From Patient Safety Events system.

Incidents that meet the Statutory Duty of Candour thresholds:

There is no legal duty to investigate a patient safety incident. Once an incident that meets the statutory duty of candour threshold has been identified, the legal duty, as described in regulation 20 says we must:

- Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
- Apologise. For example, "we are very sorry that this happened"
- Provide a true account of what happened, explaining whatever you know at that point.
- Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
- Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
- Keep a secure written record of all meetings and communications.

National Response:

Novus Health undertakes external reporting and notification requirements in line with the national guidance available at appendix 6 of the patient safety incident response framework (PSIRF – 2020)

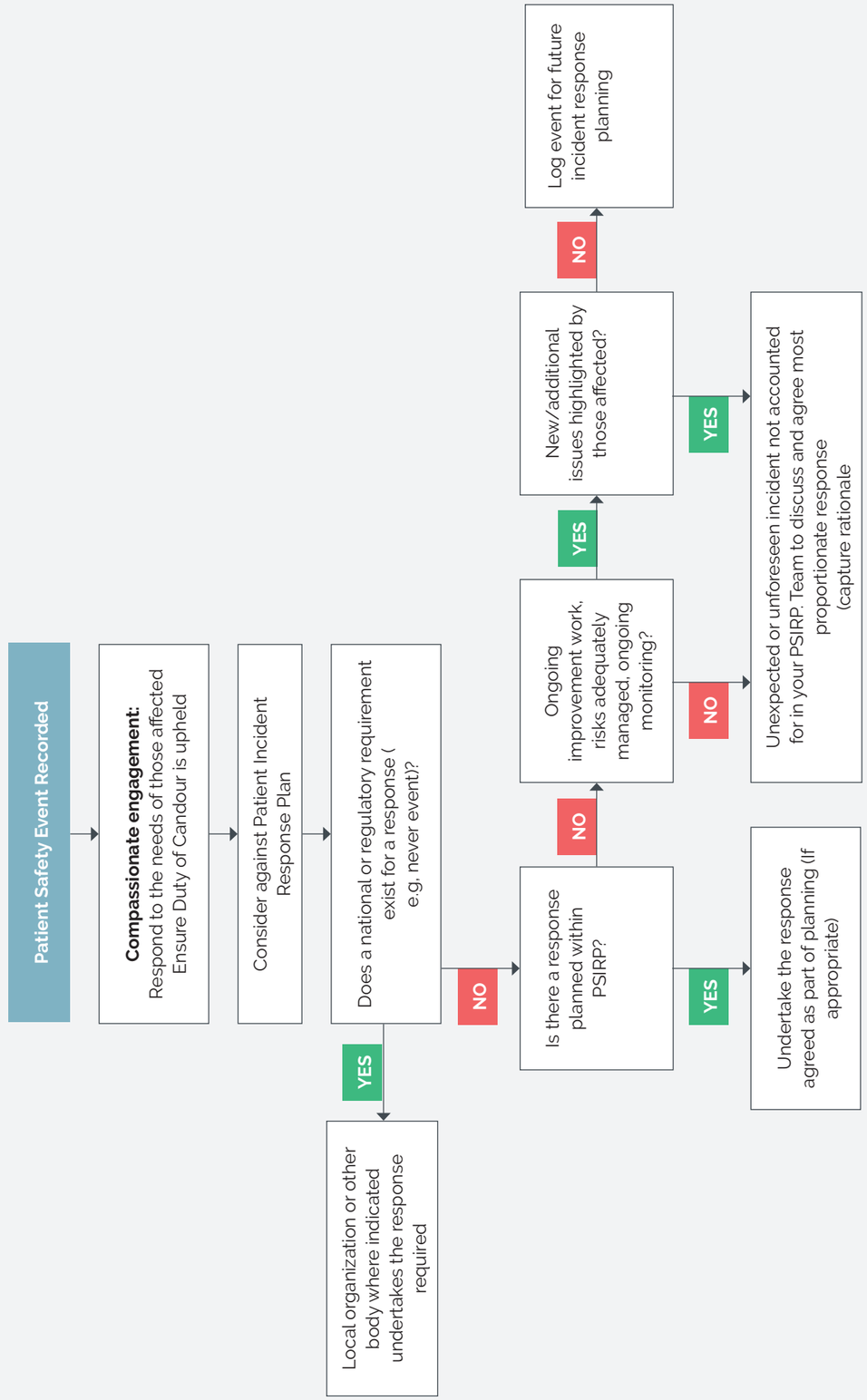
Currently reporting of patient safety incidents nationally is processed **Monthly**. On the learning from patient safety system as opposed to weekly reports.

Reporting PSIs and PSIIs to the new 'learning from patient safety events' system will be migrated by September 2023 as expected from the projected deadline.

Statutory Care Quality Commission notification requirements are to be met by reporting to the national reporting and learning system (NRLS) and its successor system (LFPSE). One notable exception is the death of a patient detained under the Mental Health Act which, in line with national guidance, will be reported directly to the CQC.

Patient Safety Investigation Flow Chart:

(Appendix C)



Supporting Patients and Families:

The commitment of Novus to create a culture of openness with patients and families particularly when outcomes are clinical and not as expected or planned.

The patient safety specialist is nominated to be the key contact for communication with patients and families during a patient safety investigation.

Being open requires the patient safety specialist(s) to:

- Communicate with the effected involved in a patient safety incident to explain objectively what has happened, the current investigation taking place and the provision of contact detail.
- Hearing a direct account of the incident from the patient perspective and gather any questions they would like the review to answer.
- Provide the patient with appropriate on-going support;
- Document details (chronologically) of all discussions relating to the incident. All information provided by the patient. Ensuring all letters or correspondence are uploaded to the relevant incident record on LFPSE and Intradoc.
- Keeping in close communication with the patient, family and /or carer as per their wishes. Contact will also take place when a conclusion of the investigation is made to share the findings, lessons learned and actions being taken.
- Continuity of care, after an incident a patient can expect to continue to receive all usual treatment and to be treated with respect and compassion. If the patient expresses interest to be discharged and referred back to the GP then this should be arranged.

All patient safety investigations and patient safety review will be undertaken by the patient safety specialist and relevant stakeholders. It is the responsibility of patient safety specialist to adapt the being open strategy.

Outcomes of Patient Safety Incidents & Patient Safety Reviews

Reports and monitoring of incidents will be created monthly to review and collect data. The data and contents may vary, but will likely include aggregated data on:

Patient safety incidents;

- The findings from patient safety incidents.
- The findings from patient safety reviews.
- The methods of review from the patient safety incident.

Progress against the PSIRP:

- Findings from identified themes.
- Learning outcomes.
- Levels of patient harm

Progress on system improvement;

- The value from reporting.
- Change as a result indicating improvement of service.

Friends and Family Test Surveys:

- Reacting to positive and negative feedback.
- Using negatives for learning outcomes
- Monitor recurring reviews for systemic change.

Feedback from colleagues:

- Using feedback from colleagues to better our services as a result from patient safety incidents.

The reporting and monitoring will introduce mechanisms to improve services through statistics and analysis of incidents, the aim to consider incidents with learning response priority and to reduce reporting of recurring incident profiles.

Roles And Responsibilities:

Novus Health describes clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents:

Chief Executive:

The Chief Executive has the responsibility for all aspects of risk management and safety, including the management of incidents. This includes ensuring that suitable arrangements are in place for systemic investigations, analysis and improvements, both locally and corporately, including ensuring resources are available to comply fully with this plan.

Patient Safety Partner:

A patient safety partner (PSP) is actively involved in the design of safer healthcare at all levels in the organisation.

This includes roles in safety governance – eg sitting on relevant committees to support compliance monitoring and how safety issues should be addressed and providing appropriate challenge to ensure learning and change – and in the development and implementation of relevant strategy and policy.

Patient Experience / Patient Safety Specialist:

The patient experience lead ensures the management of patient safety incidents the patient experience lead works closely with Service Leads in supporting timely and appropriate reporting, recording, investigating and co-ordinating of all incidents. The patient experience lead is responsible for ensuring that risks and trends from incidents are escalated through the risk management process. Any learning is then shared as required to involved.

Service Leads / Management:

The service leads offer a wealth of expertise from their field of work. This allows for a thorough, concise investigation. Their knowledge offers insight to aid in discovery. The service leads work alongside the patient experience lead to assist in investigations and to help provide learning opportunities.

All Staff:

All staff are required to provide information either verbal or written to aid in any investigation for an unexpected event or incident in a culture of being open and honest. Supporting colleagues with a view to learning lessons in a just culture. It is expected that all staff are able to access any information where lessons learned could apply to them.

Committees to discuss improvement, evaluate performance and enhance patient experience are held routinely. Below are the committees that discuss patient safety incidents and reviews

Novus:

Clinical Governance Committee:

This committee has a sub-section dedicated to patient experience, FFT results, audit data and incidents and complaints. Any issues that are of note are discussed and reviewed at length to develop any learning outcomes. These meetings are held monthly.

Health and Safety Committee

Health and safety committees give a structured approach to consultation. They provide a forum where management and employees can work together to resolve any health and safety issues.

The Health and Safety committee reviews all risk assessments to discuss change in strategy and policy. To discuss factors that can show risk to patients, colleagues and others.

Collaborative:

A Monthly Patient Safety network is held over Microsoft Teams with collaborative partners The Grange and Phoenix to discuss quality, improvement and any patient safety incidents that can present learning opportunities.

An annual review of the PSIRP to re-evaluate themes and demonstrate how the plan aligns with the patient safety incident response framework.

Complaints & Appeals

Our Commitment:

We are committed to listening to our patient's comments and complaints regarding our services and facilities with the aim of resolving any issues as well as improving the quality of our service. We will show this commitment by ensuring our complaints process is:

- Easy to access and understand, clear and simple to use.
- Responsive to the reasonable needs of complainants
- Prompt, with established time limits for action, and keeping people informed of progress, especially when investigations take longer than expected.
- Fair, with an opportunity for a full impartial investigation.
- Proportionate to the matters complained about
- Informative, by using lessons learnt from complaints to improve services and by reviewing the results of such changes.

Feedback helps us improve our service,

If you wish to Raise a concern or complaint, please contact our complaints manager:

Operations Lead – Stacey Young

Novus.complaints@nhs.net Or 01924 898 874

Quality and Patient Experience – Nick Osburn

Nick.Osburn1@nhs.net

Website: www.NovusHealth.co.uk

If you are dissatisfied with the outcome

You have the right to approach the parliamentary & Health Service ombudsman

Their contact details are:

The Parliamentary and Health Service
Ombudsman, Millbank Tower, 30 Millbank,
London, SW1P 4QP
Tel: 0345 015 4033
Website: www.ombudsman.org.uk/make-a-complaint

Healthwatch Wakefield: https://www.healthwatchwakefield.co.uk

Wakefield District Health & Care Partnership: https://www.wakefielddistricthcp.co.uk

Citizens Advice Bureau: https://www.citizensadvice.org.uk

novus **health**

Our Vision

"To improve the health and wellbeing of our community, together."