Patient Safety Incident Response policy

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1. Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how BPAS will approach the development and maintenance of 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, multi-disciplinary 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, both staff and patients.
- Application of a range of system-based approaches, often referred to as Human Factors or Ergonomics, 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.

This policy should read in conjunction with our current patient safety incident response plan, which is a separate document setting out how this policy will be implemented.

2. Scope

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

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 a cause of an incident.

There in no remit to apportion blame or determine liability or preventability or cause of death, in a response conducted for the purpose of learning and improvement. Other processes exists for that purpose:

- claims handling,
- human resources investigations into employment concerns,
- professional standards investigations,
- information governance concerns
- estates and facilities concern
- financial investigations and audits
- safeguarding concerns
- coronial inquests and criminal investigations
- complaints (except where a significant patient safety concern is highlighted)

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.

3. Our patient safety culture

BPAS' Safety Strategy 2021 – 2024 outlines our approach to Patient Safety. It sets out our ambition to

- Achieve an inclusive approach, where both patients and front-line staff are actively involved in helping us learn.
- Deliver a fair and just culture that provides psychological safety for all staff
- Ensure that actions are driven by Human Factors principles and theories to design safe systems of working
- To continuously learn by empowering and supporting staff and patients to make the changes needed.

The introduction of the daily incident reporting reviews, chaired by divisional Quality Matrons working alongside operational, medical and unit level staff with input from our Patient Safety officer is now well established. This system has provided a platform to discuss the learning from incidents throughout the organisation. Post incident in-person debriefs has enabled unit level teams to come together in a supportive setting to understand the process and importance or incident reporting as well as to learn from finding. This process is supported by our Professional Midwifery Advocates/Professional Nursing Advocates (PMA/PNA) and the Employee Assistance Programme (EAP) for all staff. The learning is shared amongst the Quality Matron team and hence across the organisation. Monthly reports summarising themes, trends and learning are presented to the Executive Leadership Team for scrutiny, assurance and escalation. These reports are shared at unit level highlighting the floor to board pathway.

As part of the Duty of Candour pathway, patients are invited to participate in the review of their care. They are invited to ask questions, receive feedback and have an opportunity to speak directly with practitioners to receive responses to any unanswered questions. A 'patient voice' story is presented to the Board, and the wider organisation, each quarter and allows us to maintain a patient focused response seeking both staff and patient voices along the pathway of continuous improvement.

PSIRF will enhance these by creating much stronger links between a patient safety incident and learning and improvement. We aim to continue to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at such learning and improvement within the culture we have begun to foster. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoidability or cause of death.

Our safety culture has also progressed in a positive way with reporting of patient safety incidents improving over time, we now achieve a reporting rate equivalent to approximately 9% of all treatments. Our Clinical Quality team are now leading a review of the information captured through reporting to identify where improvements can be made to what incidents we capture, to ensure we are identifying the most important risks.

To enhance our safety culture, we are rolling out safety culture training to all patient facing elements of the organisation. All staff within BPAS will undertake patient safety level 1 training and all staff who are involved in investigating incidents will be required to complete patient safety level 2 training and the two day equivalent HSIB level 2 training, as detailed in the BPAS Incident Management Training Needs Analysis. Patient Safety ergonomics training is already available on the electronic BPAS Learn system accessible for all staff.

We will utilise findings from our staff survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture. We will also act on feedback gained through the PMA/PNA team, to ensure that our response to incidents is supportive of staff.

Towards the end of the financial year 2024/2025 BPAS will be transitioning to the InPhase incident reporting system. This system is interphases with the Learning From Patient Safety Events (LFPSE) system which will allow access to data that has been submitted by units, in order to better understand local recording practices and culture, and to support safety improvement work.

4. Patient safety partners

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

At BPAS, we are excited to work alongside our PSP who will offer support alongside our staff, patients, families/carers to influence and improve safety across our range of services. PSPs are lay people from outside reproductive health care who represent the patient, carer and family member perspective. This perspective enables them to challenge established ways of thinking.

Our approach to Patient Safety Partners, their recruitment and their role is outlined in our Patient Safety Partner policy. Their contract with BPAS is managed through the Nursing, Midwifery and Quality Directorate and they work closely with the Clinical Director and their deputies.

We recognise the value of the work our PSP does and the experience they bring to us. We also wish to remove barriers which would prevent those most likely to represent our patient group (adults of reproductive age) from being involved in this work. Therefore, BPAS has opted to make an honorarium payment to our PSP. To comply with employment law our PSP is a technical employee of BPAS but with a contract that defines their independence.

Input form our PSP was sought in the development of our Patient Safety Incident Reporting Plan (PSIRP) to ensure that it met the needs and expectations of service users. It is recognised that some of the incidents encountered can provoke an emotive response. Our PSP will have regular contact with senior clinical staff to allow space for debriefs or questions. Additional support is provided by means of the PMA/PNA as well as the EAP.

5. Addressing health inequalities

BPAS recognises the role of all providers of NHS care in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

BPAS will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. Where identified, actions will be taken to mitigate and ensure equity of care. The introduction of InPhase will give access to the protected characteristic datasets held on the LFPSE system which will allow for incidents and intelligence to be analysed, providing insight into any apparent inequalities. BPAS are committed to our legal and moral responsibility set out in the Equality Act 2010 to ensure that all our services uses receive an equally safe service free from discrimination.

Within our patient safety response toolkit, we will directly address if there are any particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

6. 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.

6.1 Engagement with patients and families

We are firmly committed to continuously improving the care and services we provide. We want to learn from incidents where care does not go as planned or expected by our patients, their families and carers.
We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made. As well as meeting our regulatory and professional requirements for Duty of Candour, we strive to be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident. As part of preparing for PSIRF our Duty of Candour policy has been redeveloped and will form part of the incident response framework.

We will support our patients in engaging with the incident process however the incident is identified. Our learning response leads will work closely with the complaints team to ensure that patients involved in an incident which is identified through a complaint are engaged in the incident process.

As with all health care provision, patient information and details of care remain confidential. The views of their family may be different to those of the patient. This applies both to the termination of pregnancy and vasectomy pathways. BPAS will always ensure that the patients consent is obtained prior to sharing any information parts of which can be redacted upon request. In addition, redacted information may relate to organisational information. BPAS are committed to ensuring that the reason

for redacted information will be explained and steps taken to ensure that this does not detract from the quality of the information.

We recognise that there might be other forms of support that can help those affected by a Patient Safety incident and will work with patients, families, and carers to signpost to their preferred source for this, including signposting to charities like Sands and Tommy's for pregnancy / infant loss support, or to GP's or private organisations for counselling.

7. 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.

BPAS will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our patient safety incident response plan will detail how this has been achieved as well as how BPAS will meet both national and local focus for patient safety incident responses.

7.1 Resources and training to support patient safety incident response

BPAS has committed to ensuring that we fully embed PSIRF, we have used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

BPAS will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff. BPAS operates a matrix management approach with clinical leadership being provided by Quality Matrons who do not directly line manage nursing staff at units. The Clinical Director will ensure that Quality Matrons are not involved in investigations which would conflict with their professional leadership responsibilities in the division or their ability to support staff outside of the incident process.

Responsibility for the proposal to designate leadership of any learning response sits within the Executive Leadership Team (ELT), with lead responsibility delegated to the Clinical Director. The incident procedure sets the standard subject matter expertise to be involved in incidents in different categories. The Executive Director for each function, or their nominated deputy, will be responsible for nominating subject matter experts from their area.

BPAS will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. The standard learning response lead for different incident types is outlined in the PSIRP. BPAS recognises the requirement within PSIRF to ensure that the Learning Response Lead has sufficient recognised authority within the organisation to deliver an impactful report. For clinical incidents the learning response lead will normally be a Quality Matron, with the support of a Clinical Risk and Quality Governance Lead who will provide in-depth investigative knowledge and act as a critical friend to ensure the focus of the investigation is on systems. All Quality Matrons will comply with the training and development requirements for a Learning Response Lead.

Patient Safety level 2 training is also a requirement for for all clinical unit leads to ensure that they are equipped with the necessary skills to identify and initiate incident management pathways. This will include carrying out Swarms following within the unit. This will provide setting for a blame free discussion to be held with the staff involved as soon as possible after the incident while it is still fresh in everyone’s mind and to determine the cause and identify preventative measures. A Swarm will allow for a more accurate picture of any contributory organisational or human factors and involve staff in improvements that can be implemented quickly.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. BPAS Managers will be responsible for ensuring access to PMA/PNAs is available to all staff, regardless of professional group, for restorative support following incidents.

BPAS will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

Training

BPAS has implemented a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows

- Level one

Internal - This comprises a local incident e-learning module setting out the BPAS' expectations of staff for reporting and responding to incidents, including an outline of staff responsibility for Duty of Candour. All staff also receive a one day training course on safety culture, which provides an introduction to Human Factors.

National – Health Education England patient safety syllabus module (Essentials for patient safety)

All staff, clinical and non-clinical are expected to undertake these on induction and to repeat each three years

These modules are available via BPAS Learn.

- Level two

National – Health Education England patient safety syllabus module (Access to Practice). This is initially being rolled out to all Quality Matrons, Lead Nurse/Midwives, Operational Managers and Regional Clinical Directors as well as the senior leadership in these teams and the Governance Directorate, where these staff members have the potential to be involved in incident investigation.

Learning response leads training and competencies

- Training

Any BPAS learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response. Records of such training will be maintained

by the Learning and Development team as part of their general education governance processes.

Learning response leads must have complete Level one and two of the national patient safety syllabus.

Learning response leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise BPAS will work with NUPAS and MSI Choices to provide annual networking in incident response.

Learning response leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Corporate Governance team.

- Competencies

We expect that those staff leading learning responses can

a. Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
b. Summarise and present complex information in a clear and logical manner and in report form.
c. Manage conflicting information from different internal and external sources.
d. Communicate highly complex matters and in difficult situations.

Support for those new to this role will be offered from Directorate senior managers and the Governance team

Engagement and involvement training and competencies

- Training

Engagement and involvement with those affected by a patient will be undertaken by those who have undergone a minimum of six hours training.

Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.

Engagement leads must have completed level one and two of the national patient safety syllabus.

Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise BPAS will undertake an annual networking event for all engagement leads.

Engagement leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by Corporate Governance team.

- Competencies

We expect that those staff who are engagement leads to be able to

a. Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
b. Listen and hear the distress of others in a measured and supportive way.
c. Maintain clear records of information gathered and contact those affected.
d. Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation.
e. Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

Oversight roles training and competencies

- Training

Training requirements for those in oversight roles are now as follows:

- 'Oversight of learning from safety incidents' course (6 hours)
- Level 1 Essentials of Patient Safety for all staff (e-learning)
- Level 1 Essentials of patient safety for Boards and senior leadership teams, (e-learning plus new resources are now available to support patient safety specialists to facilitate as face to face training)
- Level 2 Access to Practice (e-learning; these modules cover systems thinking, human factors, risk expertise and safety culture, which form the basis required to undertake the additional PSIRF specific oversight training)

Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.

Those with an oversight role on our Board and leadership team (i.e., executive leads) must have completed the appropriate modules from the national patient safety syllabus - Level one - essentials of patient safety and essentials of patient safety for boards and senior leadership teams.

All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

- Competency

We expect staff with oversight roles to be able to

a. Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
b. Apply human factors and systems thinking principles.
c. Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
d. Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
e. Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
f. Summarise and present complex information in a clear and logical manner and in report form.

7.2. Our patient safety incident response plan

Our plan sets out how BPAS intends to respond to patient safety events over a period of 12-18 months. The plan is not a permanent set of rules that cannot be changed. As we will focus our improvement activities around the learning from our incident responses, we anticipate that our need for learning responses will change over time and we will remain flexible to emerging trends and to identify new priorities.

7.3. Reviewing our patient safety incident response policy and plan

BPAS's 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. Alongside the transition to PSIRF, BPAS' Clinical Director has taken responsibility for Clinical Risk. Therefore, the PSIRP is intended to be reviewed in 12-18 months to assess how the plan is working and to review whether the ongoing improvement work has changed our patient safety profile. The plan will then be reviewed every 12-18 months. Each review will include engagement with stakeholders.

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

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our nominated lead integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our 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.

8. Responding to patient safety incidents

8.1. Safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incident on a BPAS incident reporting system, and will record the level of harm they believe has been experienced by the person affected.

The Clinical Quality Team have established a daily review mechanisms to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This includes consideration and prompting to service teams where Duty of Candour applies. Most incidents will only require local review within the service, however, for some, where it is felt that the opportunity for learning and improvement is significant, these will be escalated by the Clinical Quality Team to the Event Response Group for senior input.

Where incidents require external reporting the Corporate Governance Team and Clinical Quality Teams will work together to ensure close, collaborative, working with partners such as ICBs.

The Clinical Governance Team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for BPAS.

Interwoven throughout BPAS and coinciding with the openness and transparency of PSIRF is the Freedom to Speak Up Policy and Procedure. This is designed to support a positive culture where people are able to speak up and know that their voice will be heard. The policy can be utilised for anything that an individual may feel could compromise good care or place a service user at risk. The policy can be accessed by all personnel from BPAS Internet.

8.2. Patient safety incident response decision-making

PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. BPAS has developed its own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work. In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety incidents.

All incidents reported by the person closest to the incident, with support from their local managers if needed. The incident management pathway includes a daily review by a Quality Matron. This means that all incidents are reviewed within one working day of being reported. This is followed by weekly, twice weekly or daily meetings at the Divisional level. These meetings are attended by the lead nurses/midwife, unit managers for the area and clinical staff, chaired by the Quality Matron. Where possible, the Regional Clinical Director, Clinical Risk and Quality Governance Lead and Safeguarding Lead will also attend. The purpose of these meetings is to ensure that:

- There is multi-disciplinary collaboration and local engagement at every stage
- Support for those involved is discussed and put into place as soon as possible
- Incidents are reviewed from a system and learning perspective – with incidents that do not offer an opportunity for learning being closed and resources focused on those with the potential for learning
- A fair and just approach is taken
- Incidents which meet the criteria for a designated event response under PSIRF are identified early and managed appropriately
- All staff have the opportunity to raise concerns about risks which are not identified within PSIRP and have these escalated appropriately

Where an incident is identified as needing a learning response defined by PSIRP, this will be brought by the Quality Matron to the Event Response Group within 3 working days. The purpose of this group is to identify the appropriate people to be involved in the response, including nominating a learning response lead and to ensure the appropriate support and engagement for those involved. The group will also consider cases that do not meet the PSIRF plan requirements but where there is an identified opportunity for learning.

The Clinical Quality Team will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the CQC according to accepted reporting requirements. Whilst this will include some incidents escalated as PSII, the Corporate Governance Team and Clinical Quality Team will work

together to have effective processes in place to ensure that any incidents meeting external reporting needs are appropriately escalated.

Sign-off of PSIIs

BPAS will establish and maintain an Incident Review meeting, chaired by the Clinical Director or their deputy to oversee the operation and decision-making of the incident response process. This will support the final sign off process for all PSIIs.

8.3. Responding to cross-system incidents/issues

The Clinical Risk and Quality Governance Leads will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

BPAS will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Clinical Quality team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

BPAS will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

8.4. Timeframes for learning responses

Timescales for patient safety PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No local PSII should take longer than six months.

The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) BPAS can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the Event Response Group

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between BPAS and those affected.

Timescales for other forms of learning response

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

8.5. Safety action development and monitoring improvement

One of the core aspects of the PSIRF is to ensure that there is focus on the delivery of improvements to care as a result of learning from incidents. Therefore, any form of patient safety learning response (PSII or review) is only the beginning of the process, and the development of effective safety actions will be given equal attention.

BPAS will have systems and processes in place to ensure that our actions are:

- Developed collaboratively with subject matter experts, including those who are experts in work as done and those with specific areas of expertise such as training and Human Factors.
- Are system focused, rather than behaviourally focused. Learning Response actions will not produce actions that are focused on individuals.
- Reflect a PDSA approach
- Are focused on reducing the identified risks

Safety Action development

BPAS will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows

1. Agree areas for improvement – specify where improvement is needed, without defining solutions

2. Define the context – this will allow agreement on the approach to be taken to safety action development

3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved

4. Prioritise safety actions to decide on testing for implementation

5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics

6. Safety actions will be clearly written and follow SMART principles and have a designated owner

Safety Action Monitoring

Safety actions will be monitored through the Integrated Governance structure.

The corporate governance team will monitor safety actions to provide assurance to the Board that:

- Safety actions are appropriately designed, meeting the guidance provided by BPAS for system safety actions.
- Safety actions realistic and sustainable.
- Safety actions are completed on time or barriers to completion are appropriately escalated through the integrated governance system
- Those completing actions provide evidence of completion that would be acceptable to external stakeholders.
- Have plans in place to measure impact and inform future safety improvements

For some safety actions with wider significance, this may require oversight by the Executive Leadership Team.

8.6. Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. BPAS has several overarching safety improvement plans in place which are adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes.

BPAS' patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

BPAS will use the outcomes from existing patient safety incident reviews (Serious Incident and Root Cause Analysis reports) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work.

Where overarching systems issues are identified by learning responses outside of BPAS, a safety improvement plan will be developed. These will be identified through Clinical Quality Team processes and reporting to the Clinical Quality Committee who may commission a safety improvement plan.

Monitoring of progress to safety improvement plans will be overseen by reporting by the Clinical Director to the Executive Leadership team. Assurance testing on these processes will be provided by the Corporate Governance team.

9. Oversight roles and responsibilities

Principles of oversight

Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement.

BPAS followed the 'mindset' principles to underpin the processes we have put in place to allow us to implement PSIRF as set out in the supporting document (NHS England (2022), p 3).

Responsibilities

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission, we have specific organisational responsibilities with the Framework.

In order to meet these responsibilities, BPAS has designated the Clinical Director as the Executive responsible for the implementation of Clinical Risk processes, in consultation with the Deputy Medical Director. This will cover the following areas:

1. Ensuring that the organisation meets the national patient safety standards

The Clinical Director will oversee the development, review and approval of the BPAS' policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the restorative just working culture that the BPAS aspires to.

The Clinical Director will ensure that the Deputy Medical Director and their team are consulted on the Policy and Plan, to ensure the defined patient safety and safety improvement profiles are reflective of both directorates.

To define its patient safety and safety improvement profile, BPAS will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders.

2. Ensuring that PSIRF is central to overarching safety governance arrangements

BPAS will receive assurance regarding the implementation of PSIRF and associated standards via its Integrated Governance Framework. The Clinical Director will provide assurance to ELT on the management of patient safety risks.

The Corporate Governance Team will include the Learning Response Leads and Engagement Leads in the named roles register to ensure the appropriate training is sourced and that they receive support and continuous professional development.

Updates will be made to this policy and associated plan as part of regular oversight.

3. Quality assuring learning response outputs

BPAS will implement a PSII Review & Ratification panel to ensure that PSIIs are conducted to the highest standards and to support the executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed. This panel will include senior clinical and governance representatives, including those with expertise in the completion of system based investigations, to provide assurance on the quality of the investigation. BPAS are part of the HSIB/NHS England tool for Learning Response review and intend to incorporate this tool, or is successor, into the review process. BPAS will ensure that sufficient time is given to the panel members to review reports prior to the panel to ensure that quality can be fully assessed.

10. Complaints and appeals

BPAS recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided by BPAS. At times, this will include dissatisfaction with the incident investigation process – whether this is the engagement or the outcome.

Complaints regarding an investigation process will be managed through the standard complaints process. Where a review of the investigation is needed, this will be conducted by a panel including a senior clinician who was not part of the original investigation and a member of the governance team who has expertise in investigation methodology.

Where a complaint relates to an incident which has been signed-off, the panel must be led by an Executive who was not part of the original review process.

Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

Feedback from complaints about incident investigations will be used to inform improvements in the incident process.

Appendix A

Level of Harm

Guidance to categorise levels of harm have been set out in the new Learn from Patient Safety Events service which gives context to reported incidents. The focus is on selecting the appropriate event type for the circumstances, and in selecting the most appropriate Levels of Harm categorisation within Patient Safety Incidents.

A new addition in relation to patient safety incident data in the LFPSE service relates to the capture of information on psychological harm. Previously harm was measured to include both psychological and physical harm as a single aspect. These have now been separated and can now be recorded in the LFPSE service.

In summary harm is defined as follows: (taken from the NHS England Policy guidance on recording patient safety events and levels of harm)

Physical Harm

- No physical harm
  - No physical harm

- Low physical harm is when all of the following apply:
  - Minimal harm occurred – patient(s) required extra observation or minor treatment
  - Did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit
  - Did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication
  - Did not or is unlikely to affect that patient's independence
  - Did not or is unlikely to affect the success of treatment for existing health conditions.

- Moderate harm is when at least one of the following apply:
  - Has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention
  - Has limited or is likely to limit the patient's independence, but for less than 6 months
  - Has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

- Severe harm is when at least one of the following apply:
    - Permanent harm/permanent alteration of the physiology
    - Needed immediate life-saving clinical intervention
    - Is likely to have reduced the patient's life expectancy
    - Needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
    - Has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions
    - Has limited or is likely to limit the patient's independence for 6 months or more.

- Fatal (previously documented as 'Death' in NRLS)
    - You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

Psychological harm

Please note that when recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available.

- No psychological harm
    - Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.

- Low psychological harm is when at least one of the following apply:
    - Distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit
    - Distress that did not or is unlikely to affect the patient's normal activities for more than a few days
    - Distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

- Moderate psychological harm is when at least one of the following apply:
    - Distress that did or is likely to need a course of treatment that extends for less than six months
    - Distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months
    - Distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months

- Severe psychological harm is when at least one of the following apply:
    - Distress that did or is likely to need a course of treatment that continues for more than six months
    - Distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months
    - Distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

The Equality Act, making equality real, Easy Read Document
easy-read.pdf (publishing.service.gov.uk)

NHS England (2021) Core20PLUS5: An Approach to Reducing Health Inequalities
core20plus5-online-engage-survey-supporting-document-v1.pdf (england.nhs.uk)

NHS England (2022) Patient safety incident response standards
B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)

NHS England (2022) Safety action development guide
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

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