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Patient safety incident response policy

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Contents page

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Community Health and Eyecare Limited's (CHEC) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

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

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

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

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Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Community Health and Eyecare Limited (CHEC).

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

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

CHEC Background

We have worked to strengthen all our clinical services and provide expert scrutiny through our independent Clinical Advisory Boards. CHEC continued with its commitment to drive quality improvement and assurance through the annual data submission to the National Ophthalmology Database (NOD) and National Endoscopy Database (NED). The strengthened clinical governance framework has supported the delivery of excellent patient outcomes in Ophthalmology and Endoscopy. We have seen a progressive increase in clinical incident reporting, representing a good safety culture. Improved monitoring of clinical incidents by type of incident has allowed us to act quickly on any emerging patient safety concerns or trends and to tailor clinical audits to understand identified trends.

Improved monitoring of clinical incidents has allowed Community Health and Eyecare Limited (CHEC) to act quickly on any emerging patient safety concerns or trends and to tailor clinical audits to understand better the trends we have seen. 2022/2023 saw the introduction of PSIRF, with Community Health and Eyecare Limited (CHEC) engaging with independent healthcare providers and the NHS to build their PSIRF implementation plan which is on track and expected to be complete during Autumn 2023.

Our dedicated IT team have spent much of 2022/23 significantly developing the incident reporting system which is being trialled at one of our sites with full roll out expected over quarters one and two in 2023/24. Our new incident reporting system will fully support our plans for PSIRF and the introduction of Learning from Patient Safety Events (LFPSE) Community Health and Eyecare Limited (CHEC) has continued to see low numbers of patient complaints. Across 2022/2023 we received 97 complaints with an average complaint rate of 0.03% based on all clinical activity. Once again, with our increased focus on data related to activity over time, we see a continued trend in decreasing complaints over time.

This is mainly related to our continued focus on an instant process for managing patient concerns, including speaking directly with patients to understand concerns at the time they raise them and apply a rapid response process. The success of this approach has led to the incidence of formal complaints in March 2023 being the lowest ever recorded by Community Health and Eyecare Limited (CHEC). We actively encourage learning and driving improvement for patients from complaints and feedback directly to the patient about improvements and changes we have made because of their feedback. Community Health and Eyecare Limited (CHEC) has introduced a complaint and feedback oversight group that agrees on actions, learning and overall outcomes from complaints, which in turn reports to the Clinical Governance Steering Group.

Our patient safety culture

An environment where staff feel valued, well supported, and enjoy and understand their work is most likely to lead to one where patient safety is of the highest importance. There have been many well-known court cases in healthcare in the last few decades that have highlighted the failure of some organisations to be open and honest with patients and their families in response to patient safety incidents that have caused harm. Examples of these include:

- The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Enquiry, Feb 2013) available at: Easy read Francis report 2013
- The Report of the Morecombe Bay Investigation (March 2015) available at: Kirkup Report 2025
- The Ockenden Review (March 2022) available at: Easy Read Ockenden Report 2022

Community Health and Eyecare Limited (CHEC) recognises the importance of creating an environment for staff and patients which encourages them to feel safe to speak out if they are worried about or involved in anything which impacts the safety of the patients. What is a Just Culture: A 'just culture' is 'one that balances fairness, learning and accountability.' (Nursing and Midwifery Council (NMC), 2021). Accountability means a person taking responsibility for their own decisions and actions. The success of PSIRF will rely on a just culture where staff, patients and their families can expect to be:

- Treated with kindness when a patient safety incident occurs
- Told the truth about what is known at the time the incident is recognised
- Asked what they would like to find out during the learning response (investigation) to the incident
- Involved in the response process if they choose to be
- Allowed to read, in full, the written response to the incident
- Asked to contribute to any actions which could improve safety where the learning response shows that these are required.

What is psychological safety?

Psychological safety is created in an environment where there is openness and trust that allows team members to feel comfortable taking risks and making mistakes. To be able to work in a psychologically safe environment, it is vital for healthcare professionals and patients to feel comfortable in sharing their concerns, fears or any other issues that might hinder (reduce) the quality of patient care.' (Psychological Safety Academy, 2022)

Developing a Just Culture:

Community Health and Eyecare Limited (CHEC) has reviewed its structure to support the progression of a just culture and to further develop its "freedom to speak up function". Advances in this area include.

- The appointment of a patient safety manager who has developed a detailed plan which includes how patient safety can be reported and escalated to senior managers at CHEC.
- A reviewed freedom to speak up policy mirroring that recommended by NHSE.
- The introduction of 3 freedom to speak up guardians based regionally to cover all our clinical sites and freedom to speak champions at each site around the country.
- The roll out an education to ensure all staff receive training in speaking out, listening, and following up on patient safety concerns.

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 Community Health and Eyecare Limited (CHEC), we will utilise our chosen ICB's patient safety partners who will offer support alongside our staff, patients, families/carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills.

We will look to appoint our own PSP once our processes are embedded.

Addressing health inequalities

Community Health and Eyecare Limited (CHEC) recognises that the independent sector has a vital role to play 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.

Community Health and Eyecare Limited (CHEC) is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. The introduction of a new incident management system will allow for the details of patients to be directly drawn from the healthcare record and incidents can then be analysed by protected characteristics to give insight into any apparent inequalities.

Within our patient safety response toolkit, we will directly address if there are any 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.

We will also address apparent health inequalities as part of our safety improvement work. We understand that our services provide care to significant numbers of the Core20PLUS5 population cohort identified by NHS England and Improvement (2021).

In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy. We consider this as an integral part of the future development process.

Engagement of patient, families and staff following a patient safety incident is critical to review of patient safety incidents and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

Community Health and Eyecare Limited's (CHEC) commitment to transforming organisational culture to that of restorative justice has already been outlined. Further to this, the organisation has affirmed that it endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and towards our workforce and our patients/service users, carers, and families.

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.

We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence.

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 want 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 this process, we will work with patients, families and carers to identify areas of focus as part of the investigation process specifically if they have any questions in relation to the incident or any focus areas, they would like us to address as part of the investigation.

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.

Community Health and Eyecare Limited's (CHEC) 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 the organisation will meet both national and local focus for patient safety incident responses.

Resources and training to support patient safety incident response.

Community Health and Eyecare Limited's (CHEC) has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

Community Health and Eyecare Limited's (CHEC) 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. Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the organisation. A learning response lead will be nominated, and the individual should have an appropriate level of seniority and influence within the Community Health and Eyecare Limited's (CHEC).

Community Health and Eyecare Limited's (CHEC) will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. The Clinical Governance Team including the designated member of the senior leadership team and the Head of Quality Governance, Risk and Patient Safety will manage the selection of an appropriate learning response led to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation. The Patient Safety Manager will support learning responses wherever possible and can provide advice where this is required.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses.

Community Health and Eyecare Limited's (CHEC) 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

Community Health and Eyecare Limited's (CHEC) 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**
  National – E-Learning for Health patient safety syllabus module.
  All staff, clinical and non-clinical are expected to undertake these on induction and to repeat each three years.

  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 as eLearning via ESR access.
  National – Health Education England patient safety syllabus module (Essentials of patient safety for boards and senior leadership teams
  This module can be accessed directly from the Health Education England eLearning for healthcare platform or ESR.
- **Level two**
  National – Health Education England patient safety syllabus module (Access to Practice). This is to be undertaken by all members of the senior management team who have the potential to support or lead patient safety incident management.

  This module is available as eLearning via ESR access.

Learning response leads training and competencies.

Training

Community Health and Eyecare Limited's (CHEC) 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 syllabuses. Learning response leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the organisation will undertake an annual networking event for all learning response leads via our clinical governance framework. Learning response leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Patient Safety Manager and supported by the Clinical Governance team.

Competencies

Community Health and Eyecare Limited's (CHEC) 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 the Clinical Governance Team, Patient Safety Manager and Line Managers.

Engagement and involvement training and competencies

Training

Engagement and involvement with those affected by a patient will be undertaken those who have undergone a minimum of six hours training (such as the Duty of Candour training provided via the Patient Safety team from 2021). 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 complete Level one and two of the national patient safety syllabuses. Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the Community Health and Eyecare Limited's (CHEC) will undertake an annual networking event for all engagement leads via our Community Health and Eyecare Limited's (CHEC) clinical governance framework. Engagement leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Patient Safety Manager and supported by the Head of Quality Governance, Risk and Patient Safety.

Competencies

As an organisation 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

All patient safety response oversight will be led/conducted by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents. Records of such training will be maintained by the Learning and Development team as part of their general education governance processes. 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

As an organisation 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.

Our patient safety incident response plan

Our plan sets out how Community Health and Eyecare Limited's (CHEC) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

These are shown in the table below:

Type	Descriptor
Refferal to secondary care	All incidents reported through the refferal to secondary care.
Incidents	All incidents not falling into the other categories
Complaints	All incidents reported through the complaints process.
Freedom to Speak Up (previously whistleblowing)	All incidents reported through the Freedom to Speak up/Whistleblowing process
Never Event	All incidents meeting the NHSE Never Event criteria
Safeguarding	All incidents where it has been reported or noted that a patient requires safeguarding
Significant Event	All incidents that meet the SI Framework criteria
Other	All incidents that do not fall into the other categories.

Reviewing our patient safety incident response policy and plan

Our 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. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our 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.

Responding to patient safety incidents

Patient safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incidents on our internal organisational incident reporting system via EPR and will record the level of harm they know has been experienced by the person affected.

Hospitals will have daily safety huddle in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include 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 should be escalated to the Patient Safety Manager (see Patient safety incident response decision-making below).

The quality team will highlight to the Patient Safety Manager any incident which appears to meet the requirement for reporting externally. This may be to allow the organisation to work in a transparent and collaborative way with our ICB or regional teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

The Patient Safety Manager will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the organisation

Patient safety incident response decision-making

Community Health and Eyecare Limited's (CHEC) will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan.

PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Community Health and Eyecare Limited's (CHEC) 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.

Departments will have escalation arrangements in place for the monitoring of patient safety incidents and this includes daily escalation of incidents which appear to meet the need for further exploration as a rapid review due to possibly meeting the criteria as PSII or PSR or due to the potential for learning and improvement or an unexpected level of risk.

The senior leadership team will have overall oversight of such processes and will challenge decision making of the Patient Safety panels to ensure that the Board can be assured that the true intent of PSIRF is being implemented within our organisation and we are meeting the national patient safety incident response standards.

Local level incidents – managers of all service areas must have arrangements in place to ensure that incidents can be reported and responded to within their area. Incident responses should include immediate actions taken to ensure safety of patients, public and staff, as well as indication of any measures needed to mitigate a problem until further review is possible. This may include for example, withdrawing equipment or monitoring a procedure. Any response to an incident should be fed back to those involved or affected and appropriate support offered.

Incidents with positive or unclear potential for PSII – all staff (directly or through their line manager) must ensure notification of incidents that may require a higher level of response as soon as practicable after the event through appropriate escalation processes (including out of hours) and this must include the patient safety manager.

Duty of Candour disclosure should take place according to organisation policy. Where a PSII is required (for example, for a Never Event) the Division should notify the Patient Safety Manager as soon as practicable so that the incident can be shared to executive level staff. The incident will be escalated to the department. A rapid review will be undertaken by the relevant department to inform decision making and onward escalation following this.

Other incidents with unclear potential for PSII, must also be reported to the Patient Safety Manager. A rapid review will be undertaken by the department to inform this decision making. Significant incidents which may require consideration for ad-hoc PSII due to an unexpected level of risk and/or potential for learning should be included in this category. The senior leadership team will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), any mitigation identified by the rapid review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met.

The senior leadership team will define terms of reference for a PSII to be undertaken by an appropriate member of staff. The senior leadership team will also designate a subject matter expert input required for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared.

Where an incident does not meet the requirement for PSII, the senior leadership team may request a patient safety review (PSR) or closure of the incident at a department level, with due consideration of any Duty of Candour requirement being met. The senior leadership team will also indicate how immediate learning is to be shared.

Incidents requiring possible patient safety review (PSR) – all staff (directly or through their line manager) must ensure notification of incidents that may require a patient safety review response as soon as practicable after the event through our internal EPR reporting processes (including out of hours) and this must include the patient safety manager and clinical governance team. A rapid review will be undertaken by the department manager and patient safety manager to inform decision making following this.

The department manager and patient safety manager will meet at the earliest opportunity to discuss the nature of the incident, immediate learning (which should share via an appropriate platform), any mitigation that is needed to prevent recurrence and whether the Duty of Candour requirement has been met.

Where a PSII is not required, the Divisional Patient Safety panel will consider any incident as having potential for PSR. The tool to be utilised for the review will be specified and a suitable member of the divisional team to undertake the review will be allocated. This will not be any staff involved in the incident or by those who directly manage the staff. The department will also specify any subject matter expert input required. There will be clear records maintained regarding this decision-making process.

Arrangements will include the recording of safety action arising from any PSR or other learning response and these details will be used to inform potential safety improvement plans.

The patient safety manager 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 patient safety manager will work with the departments to have effective processes in place to ensure that any incidents meeting external reporting needs are appropriately escalated.

Responding to cross-system incidents/issues

The patient safety manager 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. Community Health and Eyecare Limited's (CHEC) will attempt to 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 patient safety manager will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

Community Health and Eyecare Limited's (CHEC) 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.

Timeframes for learning responses

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.

Safety action development and monitoring improvement

Community Health and Eyecare Limited's (CHEC) acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed.

Community Health and Eyecare Limited's (CHEC) will have systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the organisations working systems where change could reduce risk and potential for harm – areas for improvement. Community Health and Eyecare Limited's (CHEC) will generate safety actions in relation to each of these defined areas for improvement. Following this, the organisation will have measures to monitor any safety action and set out review steps.

Safety Action development

Community Health and Eyecare Limited's (CHEC) 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 must continue to be monitored within the clinical governance arrangements and discussed at our clinical governance steering group to ensure that any actions put in place remain impactful and sustainable.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. Community Health and Eyecare Limited's (CHEC) 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.

Community Health and Eyecare Limited's (CHEC) will use the outcomes from existing patient safety incident reviews (SI RCA reports) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work.

Monitoring of progress regarding safety improvement plans will be overseen by reporting by the patient safety manager to the Board of Directors and CEO.

Safety improvement plans

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Oversight roles and responsibilities

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

Alongside our NHS regional and local ICB structures and our providers regulator, the Care Quality Commission, we have specific organisational responsibilities with the Framework.
To meet these responsibilities, Community Health and Eyecare Limited's (CHEC) has designated the Medical Director to support PSIRF as the executive lead.

1. Ensuring that the organisation meets the national patient safety standards
The Medical Director will oversee the development, review, and approval of Community Health and Eyecare Limited's (CHEC) 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 Community Health and Eyecare Limited's (CHEC) aspires to. To define its patient safety and safety improvement profile, Community Health and Eyecare Limited's (CHEC) 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
Community Health and Eyecare Limited's (CHEC) Board will receive assurance regarding the implementation of PSIRF and associated standards to ensure that the Board has a formative and continuous understanding of organisational safety. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.

Community Health and Eyecare Limited's (CHEC) will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents. Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years to comply with Community Health and Eyecare Limited's (CHEC) guidance on policy development, alongside a review of all safety actions.

Complaints and appeals

Community Health and Eyecare Limited's (CHEC) recognises that there will be occasion when the patients, families or carers are dissatisfied with aspects of the care provided. It is important to understand that there is a distinction made between complaints and concerns as the use of the word concern should not automatically mean that someone expressing a concern enters the complaints process.

Complaints are defined as expressions of dissatisfaction from a patient, family or carer, a person acting as their representative or any person who is affected or likely to be affected by the action, omission, or decision of Community Health and Eyecare Limited's (CHEC) or our providers and requires a formal review. The organisation is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

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

Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services. Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.
If a concern cannot be resolved and the complaints team are undertaking a formal review the complaints team will contact the complainant and can be contacted 0344 264 4160 or email CHEC Quality **chec.quality@communityeyecare.org.uk.**

References

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

CHEC

www.chec.uk