Patient Safety Incident Response Framework (PSIRF) Policy
Western Medical Services

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1 Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Western Medical Services 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.

2 Review of Policy

This policy will be reviewed regularly, at least once every year, and amended as considered necessary by the Organisations Senior Management Team in the event of changing circumstances or regulations.

3 Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the ambulance and medical services provided by Western Medical Services

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.

4 Our Patient Safety Culture

Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of blame, is essential to improving safety. Psychological safety underpins openness and transparency, and Western Medical Services actively encourages and supports incident reporting and raising concerns where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). We promote a just culture approach in line with the NHS Just Culture Guide to any work planned or underway to improve safety culture.

Leadership is a key influencer of safety culture and the management team within Western Medical Services proactively embrace this approach. The goals of just culture include:
A balance of fairness, learning and accountability (individual and organisational)
Moral engagement
Reintegration of the practitioner
We are clear that patient safety event responses should be conducted for the sole purpose of learning and identifying system wide improvements; they are not to apportion blame, liability or define preventability or cause of death. The PSIRF will create stronger links between patient safety events and learning for improvement. We will work collaboratively with those affected including patients and their families, and our colleagues. This will continue to increase transparency and openness amongst our colleagues to report events and allow for wider engagement.

Our safety culture within Western Medical Services will always remain an organisational priority embedded into the core values of the service. We have programmes of work in place to improve this including:

- Integrated accessible incident reporting processes
- Refreshed and supportive approach to potential patient safety incidents
- Encouraging freedom to speak up
- Increasing awareness of Duty of Candour
- Refining our governance framework
- Encouragement to receive patient feedback via various channels.

5 Patient Safety Partners

The Patient Safety Partner (PSP) role is a new and evolving role developed by NHS England to help improve patient safety across the NHS. Patient Safety Partners (PSP) have a vital role in supporting our response to incidents and service improvements by providing a patient perspective for developments and innovations to drive continuous improvement. We welcome the introduction of PSPs who will use their lived experience as a patient, carer, family member or a member of the local community to support and advise on activities, policies and procedures that will improve patient safety and help us to deliver high quality care.

PSPs will work with staff, volunteers and patients, attend meetings (face-to-face and online), be involved in projects to co-design developments of patient safety initiatives, and join (and participate in) key conversations and meetings in the Trust focusing on patient safety. They will assist in the formulation of improvement outcomes, representing the patient, carer, family views.

We will aim to utilise Patient Safety Partners in line with the NHSE guidance ‘Framework for involving patients in patient safety.’ PSPs will be adopted in line with our contracted stakeholders in the event

of a patient safety incident. Western Medical Services have a system in place for PSP's and will utilise this in conjunction with NHS Devon or other stakeholders if required. Western Medical Services will ensure inclusivity of the views and opinions of PSPs when managing a patient safety incident.

6 Addressing health inequalities

The NHS and its subcontracted providers have a duty to reduce inequalities in health by improving access to services and tailoring those around the needs of the local population in an inclusive way. Western Medical Services has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. However, most of the major factors driving inequalities in health are beyond the responsibility of the health care system alone and are driven by several socio-economic factors. We recognise there are areas within our region that have high levels ethnicity diversity and of deprivation.

The all-inclusive, joined approach to patient safety under the PSIRF will require us to be more collaborative with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and society agenda. In preparation for PSIRF, we have reviewed and strengthened our incident reporting system to facilitate the collection of key data sets to inform our future improvement works. We will use data captured by our Electronic Patient Report Form (EPRF) and internal incident reporting system intelligently to assess actual and potential health inequalities and safety risks to patients from across the range of protected characteristics.

Our engagement with patients, families and carers following a patient safety investigation must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues will be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process. We will use easy read, translation, and interpretation services alongside any other method appropriate to meet their needs and maximise the potential of being involved.

We will continue to address health inequalities in our safety improvement work. We strive to improve the service we provide for our local community and provide better working environments, free of discrimination. We endorse zero tolerance of racism, discrimination, and unacceptable behaviours from and towards our people, our patients, carers, and families

7 Engaging and Involving Patients, Families and 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 committed to continuous improvement for the services we provide, and we will be open and transparent regardless of the level of harm caused by an event. We know patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents, and / or may have different questions or needs to that of the organisation. We want to learn from any event where care does not go as planned or expected by our people, patients, their families, carers, and other organisations.

This policy reinforces existing guidance relating to the duty of candour and 'being open' and recognises the need to involve patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved. We will signpost patients/ families and carers to the appropriate agencies for support as required.

We recognise colleagues can also be affected by their involvement in an incident, and that this can have an impact on staff retention and performance, and therefore patient care. We offer colleagues support when they are involved in a patient safety event. Colleagues are encouraged to access our dedicate Staff Welfare Lead for support if required.

8 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.

As an organisation we welcome this approach so we can focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improving safety. We recognised that our planning needed to account for other sources of feedback and intelligence such as complaints, risks and other forms of direct feedback from staff and patients.

9 Resources and training to support patient safety incident response

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. We have evaluated our capacity and resources to deliver our plan. We are committed to ensuring that we fully embed PSIRF and meet the national training requirements as far as possible being a subcontracted provider to the NHS. We have utilised NHS England Patient Safety Response Standards (2022), to provide resources and the training required for this to happen.

Western Medical Services will utilise members of the senior management team to manage and investigate patient safety incidents. Western Medical Services will engage fully with our contract stakeholders to support investigations. Responsibility for patient safety learning responses sits with the oversight of the senior management team.

Our colleagues affected by patient safety events will be provided with support and given time to participate in patient safety learning responses. Investigating managers will work within our just culture principles and signpost our colleagues to the appropriate support.
Western Medical Services will be putting forward a dedicated group of staff to achieve compliance with the standards outlined in the Patient Safety Syllabus, supporting a transition to enhanced

patient safety practices. Western Medical Services will collaborate with NHS Devon, being our local integrated care board and main commissioner. Western Medical Services commits to having a group of management staff compliant with this training by Q2 2025 using approved NHSE training courses and content

Core Modules of the Patient Safety Syllabus:

- **Patient Safety Syllabus Level 1:** Essentials for patient safety.
- **Patient Safety Syllabus Level 2:** Access to practice.
- **Involving Those Affected:** Engaging patients, families, and staff in the learning process.
- **System Approach:** Adopting a system-wide perspective to learning from patient safety incidents.
- **Oversight of Learning:** Ensuring effective evaluation and integration of lessons learned.

The PSIRP provides more specific details in relation to this.

10 Our Patient Safety Incident Response Plan

Our plan sets out how Western Medical Services 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.

Western Medical Services is a new organisation, only providing regulated activities since 10th October 2023. Since this time due to limited exposure, we have not experienced any patient safety incidents and so are unable to currently build a full internal safety profile.

However, our plan was consulted internally via our senior leadership team meetings, clinical governance review meetings identifying the following priority areas based on industry experience.

1. Harm identified during patient transport
2. Delays in scheduled inter-facility transfers
3. Risks associated with manual handling during patient movement
4. Equipment reliability and readiness
5. Delays in accessing definitive care

11 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.

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

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate 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

12 Patient Safety Incident Reporting Arrangements

It is recognised that staff must continue to feel supported and able to report any incidents, or concerns in relation to patient safety, to promote a system of continuous improvement and a just and open culture. We will continue to promote, support and encourage our colleagues and partners to report any incident or near-misses, with a shift in focus to incidents, or groups of incidents, which provide the greatest opportunities for learning and improvement.

Although our investigation process has changed incident reporting and local incident management remains the same. There is still a requirement to report incidents regardless of whether they are incidents that feature on the national priorities list or within our local priorities in our PSIRP.

Patient safety incident reporting will remain in line with our internal Incident Reporting, Quality Improvement and Complaints policies. The importance of daily incident reporting, review and local management remains. All our staff members are responsible for recording and reporting potential or actual patient safety events on the internal incident forms. The reporter will record the level of harm they believe to have been experienced by those affected. Every incident report is reviewed by the Compliance & Quality team with appropriate action taken in relation to our policies and NHS recommendations.

We also recognise that a proportionate response is required to incidents with multiple different learning models available if appropriate. These can be chosen, based on the severity of the incident. On occasion informal team huddles can be a way to promptly resolve a minor concern followed up with an after action review (AAR).

We recognise the value of local learning, ensuring an incident has been appropriately dealt with and that mitigating actions have been immediately introduced and shared as necessary to help prevent reoccurrence. Patient safety incidents will be reviewed and assigned an appropriate response by the senior management team. Each patient safety incident record will be reviewed by the senior management team to ensure appropriate learning response and relevant service lines are included in response, feedback to the reporter and closure.

Most events will require a local review and learning response (if necessary), undertaken by the management team. Those events where the opportunity to learning and improvement would be of greatest value, will be led by the Directors.

The organisation has corporate oversight of all patient safety events and service lines will have their own mechanisms in place to ensure patient safety events are responded to proportionately and in a timely manner. This will include consideration of Duty of Candour.

Operational managers will ensure any incidents that require cross system or partnership engagement are identified and shared with the senior management team, and that partnership colleagues are fully engaged in investigations and learning as required. Likewise, the senior management team will ensure we are responsive to incidents reported by partner colleagues that require input from Western Medical Services, by directing enquires to the relevant clinical teams or colleagues and seeking assurance that engagement, information sharing and learning has been achieved, or taken forward.

Events and/or incidents highlighted that appear to meet requirements for reporting externally to national bodies such as Health Safety Investigation Branch (HSIB), Health & Safety Executive (HSE), Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and Medicines and Healthcare products Regulatory Agency (MHRA) will be overseen by the Directors.

There will be occasions where events require the efforts of cross-system working with relevant partners, the Integrated Care Board (ICB) will support a collaborative approach with these arrangements if required. We will ensure regular communication and involvement through our communication framework and our wider organisational governance structures.

13 Patient Safety Incident Response Decision-Making

Reporting of incidents should continue in line with existing company policy and guidance. We have arrangements in place to meet the requirement to review patient safety events under PSIRF. The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning are central to decision making under our PSIRP. This, however, will now include a wider range of options for further investigation outlined in the PSIRF. This may often mean no further investigation is required, especially where the incident falls within one of the improvement themes identified in the PSIRP. Some of these will require a mandatory response, others will require review or referral to another body and/or team; these are set out in the PSIRF plan.

Western Medical Services are registered on the LfPSE reporting system and are aware of how to use this system as required.

The Directors will provide support to operational managers to ensure the following arrangements are in place to assist with:

- Identification and escalation of any incidents that have, or may have caused significant harm or death

- Identification of any incidents requiring external reporting or scrutiny (e.g., Maternity and neonatal deaths, RIDDOR, safeguarding and domestic homicide)

- Identification of any other incidents of concern, such as near-misses, non-patient safety incidents that could lead to potential patient harm or significant failures in established safety procedures

- Identification of themes, trends or clusters of incidents within a specific service

- Identification of themes, trends or clusters of incidents relating to specific types of incidents

- Identification of any incidents relating to local risks and issues (e.g., CQC concerns)

We have revised our governance processes to ensure there is a clear set of mechanisms allowing for oversight of our learning responses. The Senior Management Team will hold a weekly meeting to review incidents and escalation to ensure an appropriate level of response has been allocated and to identify those events that appear to meet the need for further exploration due to the possibility of meeting the criteria for a full review.

The responsibility for identifying appropriate panel members for completion of a Patient Safety Incident rapid review for incidents requiring further investigation or escalation will be discussed by the Directors and external NHS contract holders.

This group will have responsibility for the retrospective consideration of events for PSII (Patient Safety Incident Investigation) or a patient safety learning response for oversight of outcomes.

Quality assurance, oversight and sign-off of incident investigations and reviews will feature as a high priority risk on the company risk register until PSIRF is fully embedded within the organisation and assurances learning responses result in the desired system improvements are evidenced.

14 Responding to cross-system incidents/issues

The senior management team will assist in the coordination of these events identified to other providers directly, via each organisations reporting processes. We will work with organisational partners and relevant ICBs to establish and maintain robust procedures to facilitate flow of information and minimise delays to joint working on cross-system events.

We will provide summary reporting to share insights with other providers about their patient safety profile. If a complex cross-system event is identified, we will refer to the NHS contract providers and ICBs to assist with the coordination. We anticipate the ICB and NHS contract providers will provide support and advice with identifying a suitable reviewer, should this circumstance arise.

15 Timeframes for learning responses

The impact extended timescales can have on those involved and the risk of delaying findings may adversely affect safety and must be always considered. Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

Timeframe for completion will be agreed with those affected, as part of setting the terms of reference; this remains subject to them willing and able to be involved in that decision.

- Where a full PSII is indicated, this will be started as soon as practically possible following the identification and completed within three months.

- Locally led PSII involving partner organisations should not exceed six months in duration.

- Locally led responses that are taking more than 6 months or exceeding timeframes set with those affected will be reviewed to understand how timeliness can be improved.

Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the Directors and Senior Management Team will work with all the information they have to complete the response to the best of their ability. We will consider whether new information would indicate the need for further review once this is received. The decision for further review would be made by the PSIRF/ LFPSE group.

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

Safety Action Development and Monitoring Improvement

16 Development of Safety Actions

We will use the principles outlined in the NHS England Safety Action Development Guide (2022) to develop our safety actions. We will have systems and processes in place to design, implement and monitor safety actions using an integrated approach of reducing risk and limit the potential for future harm. All action plans must be developed with and agreed by the staff that will implement the change.

Safety actions arising from learning responses must incorporate means of monitoring completion and sustained effectiveness.

Action plans should:

- Follow SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and have designated owners to monitor and measure of success.

- Be concise, consisting of a small number of action points that have been prioritised based on impact.

- Agree areas for improvement: specify where improvement is needed, without defining solutions.

- Define safety actions to address areas of improvement focuses on systems in collaboration with those teams involved.

- Define safety measures to demonstrate if actions are influencing what is intended.

- Allow staff to focus resource on those actions that are likely to result in sustained beneficial change.

- Actions reminding staff of policies or procedures should not be included.

- Actions for sharing reports in various forums should not be included.

The Management Team will be available to assist with the improvement plan development stage to help support defining and implementing impactful and informed change ensuring the issues raised have been fully explored. Improvement plans will be centrally documented.

17 Safety Action Monitoring

Each planned response detailed in our PSIRP has defined improvement routes and oversight. Safety actions must continue to be monitored within organisational governance arrangements to ensure any actions put in place remain impactful and sustainable.

Monitoring of completion and effectiveness of safety actions will be through regular senior management meetings. It is important that monitoring of completion of safety actions does not become an end in and of itself, but rather a means to improve safety and quality outcomes and reduce risk.

The Senior Management Team will maintain an overview across the organisation to identify themes, trends and triangulation with other sources of information that may reflect improvements and reduction of risk. Monitoring of themes and trends will be through the PSIRF/ LFPSE group.

We recognise that recommendations may be made following responses that may not be achievable at that time in the context of current finances or resources. It's important to still consider and document these improvement ideas. Over time an evidence base may then build which in turn may influence future safety improvement plans, business cases, developments and financing options.

18 Safety Improvement Plans

Safety improvement plans bring together findings from various responses to patient safety events and issues. Our PSIRP has outlined local priorities for focus or response under the PSIRF, these themes, as detailed in the PSIRP, are based on an extensive analysis of historic data and information from a range of sources (e.g., incident trends, complaints, mortality reviews, risk registers, legal claims and inquests) and feedback from staff and patients. Each theme was developed due to the opportunity they offer for learning an improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by a reduction in risk or harm. Each theme will have its own improvement plan, to determine what the key drivers are to patient safety risks, how improvements can be made and how these can be monitored for completion and effectiveness.

A Quality Improvement (QI) approach is valuable in this aspect of learning and improvement following a patient safety investigation and PSIRF provides an opportunity for the QI and Patient Safety functions to work more closely together. To achieve successful improvement, safety action development will be completed in collaborative way with a flexible approach. We will develop governance systems focused more on measuring and monitoring these outcomes, utilising subjective as well as objective measures. Rather than reporting on action plan completion, we are more focused on measuring and monitoring outcomes. The development of these outcome measures will be defined over the first 12 months of our plan.

We will continue to use the outcomes from patient safety reviews and any relevant learning response conducted under PSIRF to refine and create related improvement plans to assist focus on our improvement work. Whilst the PSIRP identifies our broad organisational priorities, there may be more specific priorities and improvements identified, which although will not form part of the overarching plan, can still be approached utilising the more holistic and inclusive PSIRF approach.

Where overarching systems issues are identified by patient safety learning responses outside of our PSIRP priorities, a safety improvement plan will be developed. These will be identified through the PSIRF governance processes, and the Senior Management Team will provide support and guidance, as required, to services and care groups in this regard.

19 Oversight Roles and Responsibilities

We have reviewed our governance processes in line with the PSIRF guidance so it is clear how the PSIRP improvement priorities will be overseen through our governance structures and processes. Corporate oversight and assurance committees/meetings provide 'floor to board' assurance.

Responsibilities

Our local ICBs, NHS organisations, and our regulator the Care Quality Commission (CQC), have specific responsibilities under PSIRF. We will share our oversight and monitoring reports with our colleagues to provide assurance on the effectiveness of our PSIRP. We will work closely to develop our process and improvement measures collectively as we embed and learn utilising our new response tools and standards.
We will invite our colleagues to join us in our programmes of quality and safety reviews which will support our monitoring improvements in specific services. We will also support ICB led assurance visits. The CQC will closely monitor and test the strength of our application of the PSIRF and associated patient safety incident response standards as part of its assessment approaches. We will work closely with the CQC to ensure timely notification of high profile and complex incidents, as well as providing all statutory notifications as required by the Health and Social Care Act (2008) and set out in CQC's guidance on statutory notifications.

Organisational Board

Our organisational board/Directors have overall responsibility for the oversight of PSIRF and is accountable for effective patient safety incident management across the organisation. This includes supporting and participating in cross-system/ multi-agency responses, and/or independent patient safety incident investigations (PSIIs) where required.
To facilitate appropriate Board oversight of the implementation and effectiveness of our plan and policy, PSIRF is integrated into our organisations governance framework and reporting schedules.

Forums

Western Medical Services will engage in PSIRF forums as relevant and required by our local partners and NHS agencies.

20 Complaints and Appeals

Any concerns relating to this guidance, or its implementation can be raised informally to a Western Medical Services representative who will aim to resolve any concerns as appropriate. We recognised that there will be occasions when patients, services users and carers are dissatisfied with the aspects of care and services provided by the organisation. If patients, relatives and or carers have a concern or complaint in relation to how a patient safety learning response has or is being handled, they should contact their nominated Patient Safety Incident Learning Response Lead or Engagement Lead in the first instance. Every effort will be made to address specific concerns.

We are committed to dealing with any complaints that may arise quickly and as effectively as possible as reflected in the Complaint Standards (2021). We promote a culture that seeks to learn from complaints, treats people fairly, and works to resolve problems in a timely way. Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints and concerns are 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 within the organisation to ensure any necessary changes can be considered and implemented where appropriate

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