Patient safety incident response policy and plan

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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Spring North's 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.

Scope

This policy is specific to client safety incident responses conducted solely for the purpose of learning and improvement across **Spring North health contracts.**

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.

Roles and Responsibilities within Spring North

CEO and Board	Have ultimate responsibility for all aspects of patient safety
Deputy CEO and appointed Board member for Safeguarding	Responsible for policy setting and implementation
PSI Lead (Contracts Manager)	Responsible for embedding policy and reporting mechanisms
Investigation team	Representative from all of the above

Our patient safety culture

At Spring North, we aim to promote a just culture for safety of all of our clients whilst within a clinical setting, or in the community. All of our own staff, and subcontracted teams are equipped to a mandatory level of training for the position, or duty delegated to them through each contract.

Our systems have been developed to record every engagement from initial contact to post-engagement/discharge of support, we have a robust method of support in place to assure a safe service to all patients and client contact, and care.

All of our induction processes embed patient safety at the core of the organisation, all staff follow a matrix of training within our organisation which ensures there is the minimum level of competency and structure to the work carried out for and on behalf of Spring North. Our structured staff supervision, appraisal and team meeting processes aim to discuss case level, development of support and best practice to ascertain emerging or any gaps in training needs of our employees. We regularly highlight the importance of safeguarding all of our clients throughout their support and step-down to ensure a robust patient safety culture is fostered by all employed through our organisation.

Feedback of relevant concerns, complaints and compliments are welcomed from our clients, service users, partners and commissioners. We have processes to ensure these are invited, logged and acknowledged, and contribute to our consistent approaches to ongoing service design and development.

If an investigation raises concerns about a child or YP, SN will use the Just Culture Guide (NHS England) to support the organisation through the process

Patient safety partners

All of our work is dependent on strong collaborations and partnerships, for each project area, we have a steering group who act as overall oversight and support. Incidents and safeguarding is an itemised agenda point, and our project team aim to discuss any incidents, reviews, improvement work plans and post action reviews undertaken.

Our steering groups involve representation from many levels of management and expertise. We always aim to have a minimum of commissioning lead to projects officers who are ascertained to oversee work carried out either by Spring North employees or our subcontracted partners.

Our internal policy review team meet annually to check all of our policies, systems therein and that our risk register is meeting contractual requirements across all of our commitments and services.

Membership of our policy review team includes our Chief Executive Officer, Head of Operations, our Safeguarding lead and a nominated Trustee for this workstream.

Our patient involvement lead sits within our projects team and actively promotes the involvement of patients, families, and carers as partners both in their own care and in the wider oversight of healthcare. Such involvement in oversight is of specific value in the development of an organisation's patient safety incident response policy and plan. Patient safety partners should also play an important role on incident response oversight committees. More information is provided in the framework for involving patients in patient safety.

Addressing health inequalities

Spring North recognises the health inequalities faced by population groups/communities and individuals are unfair and that these differences in health across the population, and between different groups within society are avoidable.

Most of our delivery is with people living in areas of high deprivation, and facing these inequities - for example those from Black, Asian and minority ethnic communities, the homeless population in urban areas, LGBTQ population etc

Spring North recognises that at both a national and local level we have a role to play in reducing and removing health inequalities, which impact on people's outcomes and experiences, and across all our services (in line with the Equality Act 2010) we ensure that no one is disproportionately impacted on the grounds of their specific characteristic.

Our focus is to provide (via our delivery partners) the best care to our service users, regardless of, their skin colour, culture, ethnicity or faith, gender or sexuality, age or if they have a disability and do not tolerate, under any circumstances, any form of racial abuse or discrimination. As part of the patient safety incident response framework (PSIRF) our delivery partner will utilise the available protected characteristic datasets held to allow for incidents and intelligence to be analysed by protected characteristics, providing insight into any apparent inequalities.

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.

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.

Spring North will take a proportionate approach to its response to patient safety events to ensure that the focus is on maximising improvement. Our approach will align to the principles in the documents "Guide to responding proportionately to patient safety incidents" and the "Patient safety Incident response standards".

Resources and training to support patient safety incident response.

Early adopters' evaluation

- Example patient safety incident response plans – produced by PSIRF early adopters while testing the introductory framework, March 2020-April 2022
- PSIRF Pilot Evaluation Report – December 21 and Evaluation report annexes – This report sets out findings from the evaluation of the pilot implementation of the PSIRF with 25 'early adopter' organisations, made up of 18 healthcare providers and seven commissioning organisations in England.
- Early adopter interviews – series of short film clips

Training

- Overview of PSIRF training requirements – NHS podcast which focuses on the training NHS organisations should ensure staff undertake as part of their preparation for implementing the PSIRF by Autumn 2023
- Healthcare Safety Investigation Branch (HSIB) courses – range of training to support NHS trusts to implement and use PSIRF and general safety investigation courses
- User guide – Training and development services – information about the training and development services framework and practical support to contracting authorities wishing to access and procure services. Includes these courses:
    - Systems Approach to Learning from Patient Safety Incidents Oversight Training
    - Systems Approach to Learning from Patient Safety Incidents Training
    - Patient and Staff Involvement in Learning from Patient Safety Incidents Training

OxSTaR Patient Safety Academy – courses relating to human factors and incident analysis

Safety culture

Patient safety culture toolkit – March 2023

- NHS England – Safety culture: learning from best practice
- NHS Employers – Safety culture
- NHS Scotland – Safety culture discussion cards

Our patient safety incident response plan

Our plan sets out how **Spring North** 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.

The aim of this plan is to:

- To ensure staff and contracted partners are aware of their obligation to report significant events
- To create an open and transparent environment where staff feel supported in reporting
- To facilitate learning and improvement from reported events
- To ensure patients, friends and families feel listened to, supported and incidents dealt with robustly at all times

Initial Report: Staff should fill out a Patient Safety Incident Report Form, available from the internal network, and submit it to their line manager within 24 hours of identifying the event.

Escalation: Line managers are responsible for escalating the report to the CEO and PSI lead Trustee within 48 hours of receiving it.

Investigating the Incident

Initial Review: The CEO will conduct an initial review of the report to determine the severity and impact of the incident.

Investigation Team: For major events, an investigation team will be assembled to conduct a more in-depth analysis.

Employee Interviews: Staff involved may be asked to participate in interviews or provide additional information.

Learning and Improvement

CEO Review: Following the investigation, the CEO will review the findings and identify opportunities for learning and improvement.

Learning and Improvement

6.2 Feedback: Feedback will be provided to all staff involved in the incident as well as the wider organisation, as appropriate.

Training and Development: Where necessary, additional training sessions will be scheduled to address any skills or knowledge gaps identified.

Supporting Staff & Contracting Partners

Confidentiality: All reports will be treated with utmost confidentiality

Supporting Resources: Staff involved in a significant event will have access to counselling and other support resources.

No Blame Culture: The focus of reporting and investigating significant events is learning and improvement, not assigning blame.

Monitoring and Review

This policy and plan will be reviewed annually by the CEO and board of trustees to ensure its effectiveness and relevance. Changes will be communicated to all staff members

Concluding Remarks

The effectiveness of this policy relies on the willingness of all staff and contracting partners to report significant events and to engage in subsequent learning and improvement processes

Your cooperation is not just encouraged; it is essential for the betterment of our charitable operations and commitments

Patient Safety Incident report template

PSIR reference	
Date of PSI	
Date of PSI meeting	
Title of PSI	
Staff present at meeting	
PSIR raised by	

What happened?
Describe in detail what actually happened. It is pertinent to include where the incident happened, those involved, how it happened and the consequences of the event.

Why did it happen?
What were the root causes that led to the event happening (both positive and negative)?

What could have been done differently?
Consider what, if anything, could have been done differently, which would have led to a more positive outcome or experience.

What has been learned?
Describe in detail lessons learned. Include information about whole-team and individual learning post-event, including reflection.

What are the requirements for change?
Describe in detail the agreed requirements for change and how the change will be implemented and subsequently monitored. Where applicable, hyperlink updated policies or protocols to reflect and evidence change.

What is the overall outcome?
State the outcome of the PSI, which can include: no further action required, training identified, a requirement to audit, best practice identified, etc.

Outstanding actions?
State any outstanding actions, who is to complete the action/s and the agreed date for completion.

Signature of PSI lead	
Name	
Date	
Signature of CEO/ Trustee lead	
Name	
Date	

Our services

Spring North is a dynamic charity with 190 VCFSE members across Lancashire and South Cumbria. We strive for community health and wellbeing. Our focus is on reshaping support and services to meet evolving health and social care needs of vulnerable children, young people, adults and their communities, tackling disadvantage and inequality, we enhance local resilience, through our collaborative, innovative approach delivering significant impact.

Currently we manage and coordinate several contracts aimed at reducing health inequalities and vulnerabilities across our communities; this may through our champions work (Diabetes support, Asthma and respiratory infections family information and advice, Covid and Flu awareness raising, Blood pressure case finding, and Child safety intervention work). Some of our contracts require us to work on and within wards across the ICB footprint, this may include children's or adults mental health wards support to clinical teams with therapeutic interventions, whilst also providing step-down support across place based venues within our communities.

We pride ourselves on working flexibly and adapting to each environment and placing a patient/clients care at the centre of all of our casework and support.

Defining our patient safety incident profile

At Spring North, we considered that despite our robust serious incident processes and management, our commitment to patient safety would need new enhanced elements of patient engagement involvement and learning to accommodate our increasing presence on clinical wards. We have seen an increase in vulnerabilities of our client groups and ascertained that the potential for a patient safety incident to be increasingly likely, and we need to be equipped with a consistent model for continuing assessment of need and incident.

Through active stakeholder engagement, we will continue to collaborate with a mixture of patients (former and current), family members of and professionals to ascertain the patient safety issues most pertinent to include in our planning structures.

We continue to engage with local patient forums, Healthwatch, our parent peer support network and community groups that we have access to attend including our network of holiday activity and food partners and families who attend each scheme we coordinate for.

We use all relevant date available to us to assess likelihood and consequence of low to high-risk incidents to patient to safety. We currently we have zero patient safety incidents on our records from a Spring North and subcontracted partner point of view, however this policy and plan will enable us to embed, capture, respond and learn from any incidents that we may encounter going forward.

Consultation

Regular consultation with our commissioners and commissioned partners will enable us to keep abreast of needs and priorities of our Patient safety Incident response policy, both on a local and national level. We are committed to ensuring maximum safety and risk assessment assurance for all patients to our services, as well as the follow-up incident review processes.

PATIENT SAFETY INCIDENT RESPONSE PLAN: NATIONAL REQUIREMENTS

Spring North will support Acute and Mental Trust through cross working when complying with the following national event response requirements:

Event	Action Requires	Lead Body for Response
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally-led PSII	The Trust
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally-led PSII	The Trust
Incidents meeting the Never Events criteria 2018, or its replacement	Locally-led PSII	The Trust
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	As decided by the RIIT
Maternity and neonatal incidents meeting Healthcare Services Safety Investigation Branch (HSSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSSIB or SpHA for independent PSII	HSSIB (or SpHA)
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent	Refer to your local designated professionals for child and adult safeguarding

support needs from their local authority • the incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery • and human trafficking or domestic abuse/violence	inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	

Our patient safety incident response plan: local focus

Spring North will be flexible with its investigative approach, informed by the national and local priorities detailed within this plan and agree the most appropriate response based on the potential for learning, improvement and systemic risk.

Patient safety incident type or issue	Planned response	Anticipated improvement route
IG/Information Sharing breach within core team and/or across delivery partners	Immediate action to mitigate impact Discussion within SN and across all delivery partners to learn from event and plan for strengthening process After action review	Robust measures in place Identify greatest potential for learning
Safeguarding children/adults	Referral to LA Safeguarding lead Reporting into SN Board (and Safeguarding lead)	Update of safeguarding training and governance as required through the identification of greatest potential for learning
Inappropriate or delays in referrals to support services	Review of internal processes as well as those with partners (including service users) After action review	Reduction in delays Appropriate support for clients Learning identified

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 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 website, replacing the previous version.

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

Investigation Reference: Date started:

Stakeholder			
Organisation	**Role**	**Name**	**Contact details**
	eg patient, GP, ward nurse		*eg email, phone, address*

Italic

After action review

An After Action Review (AAR) is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.

Tool	Time	Resources	Physicality	Interactivity
After action review	★★☆☆☆	★★☆☆☆	☆☆☆☆☆	★★★★★

When?
An AAR should be used at any point where there has been an unexpected outcome – whether it be positive or negative. It is usually focused on task-based events during a project.

Who?
Everyone who was involved in the particular task / activity / event which is to be reviewed, has a role to play.

Developed by the US Army, the AAR should be carried out with the intent of 'leaving the stripes at the door' so everyone has an equal opportunity to input and learn. The AAR focuses not on accountability but on learning.

A facilitator is also required to introduce the task and assist participants.

How?
The overall time required for the session is around 30 minutes to an hour.

A facilitator should introduce the session and aim to create a space everyone feels comfortable in to openly and honestly share their views and experiences. A prerequisite of an AAR is that everyone feels they can equally contribute without fear of blame or retribution.

Firstly, the group should define together what the intended outcome was as 'what was meant to happen'.

Then, the group should define what actually happened and whether this contributed to either the success of failure of the task – again, this is about identifying unexpected events both positive and negative, not those who are responsible for them.

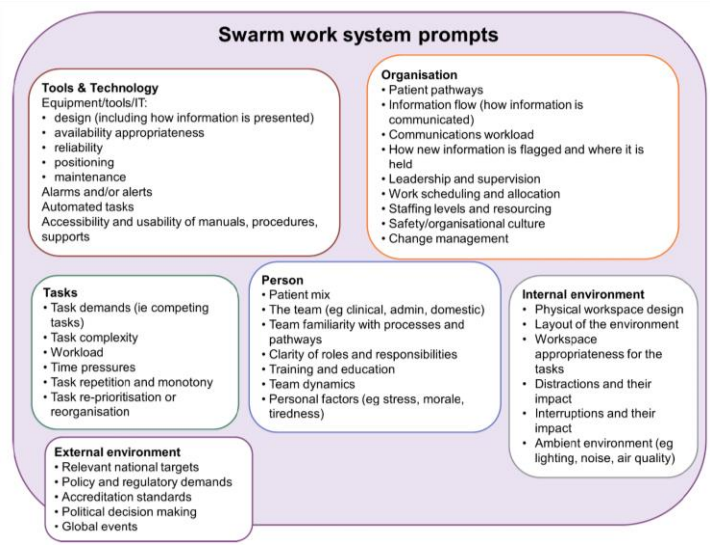
Then the group should aim to understand the differences between the intended and actual outcomes and what can be learned – should the outcomes be avoided or aimed for in the future?

The facilitator keeps track of time and can play a role in recording centrally what emerged from the activity. Review of the notes / key points is completed at the end for further discussion. The

notes should then be captured by the team as part of a knowledge asset for the project to be shared within the wider organisation.

Things you need:

- Facilitator
- An open, safe space for discussion and movement
- Flipcharts/sticky notes and pens



Pros/cons	How	Tips
Can be used to: • inform the design of work procedures • identify hazards in existing procedures or tasks • identify everyday work hassles, frustrations and irritations. **Pros** • Process can be stopped at any time to ask questions, review documentation, devices or decisions being made, seek more detailed clarity. • Quick and low cost – all that may be need is pen and paper • Flexible approach that can be used as part of any learning response method. **Cons** • Not observing 'real' behaviour, but can be combined with observation data to further contextualise understanding of the process. • Requires access to team member(s) experienced in the process. • Best applied 'in situ', which may limit when you can access certain environments (eg may not be usable this method during busy periods).	Four steps: 1. Define the process: walkthrough analysis begins by defining the process under evaluation. 2. Describe the process: divide the process into component parts (tasks) that are clearer/simpler to understand. 3. Perform a walkthrough of the process with a user representative of the workforce. Ask representative users to 'think out loud' (ie verbalise their thoughts) as they simulate going through their tasks (either in situ or in a simulated environment). Example questions to ask: • "I noticed that you did _____. Can you tell me why?" Follow-up on any interesting behaviour you observe to get a better idea of the thought process behind the actions: • "Is there another way to complete that task?" (try to determine why they did one thing instead of another) 4. Summarise re-design opportunities and examples of good practice identified. This can be used to define potential areas for improvement.	If the process is too complex to describe in list format, a diagram can be used instead. Hierarchical task analysis can help to unpick complex processes. Record the walkthrough (sound or video where feasible) and/or contemporaneous notes taken by the learning response lead. Use prompts from the 'systems considerations' below. Learning response leads may wish to seek multiple perspectives from team members to understand how tasks are performed. General questions to consider: • What makes tasks difficult? • What surprises you? • What can go wrong? • What can be improved and how? Use the task and tool matrix table below to generate further detail as part of your analysis.

System considerations

Person(s)	Tasks	Tools and technology	Environment	Organisation at work	External
• Who are the people doing the work? Are they familiar with it? • Height and physical strength requirements • Are roles defined? • Are people trained to complete the task? • Team dynamics (team structure/skill mix) • Explore impact of personal factors (eg stress, morale) • Fatigue influence (distances travelled, cognitive fatigue, reliance on short-term memory) • Communication barriers • Influence of inequalities	• Complexity/ demands of the task • Are tasks repetitive (variety, monotony)? • Are tasks conducted in a particular order (sequence)? • Workload • Workarounds • Time pressure	• Usability: are there 'supports' (eg signs of poor design such as sticky notes to guide use)? • Presentation of information • Quality of alarm design (eg recognition and response) • Positioning of equipment – how is it grouped (eg in relation to task requirements)? • Level of automation • Reliability of equipment • Appropriateness of equipment for the task • Are tools/technology maintained/updated? • Maintenance requirements • Availability (eg is there an adequate supply)	• Distractions • Interruptions • Business • Ambient environment, including lighting, noise, air quality • Environment layout • Where are tasks completed? • Is this space appropriate for the task? • Visibility of patients, staff, equipment	• Information flow (eg high communications workload, poor phrasing or low communication standards) • How is new information flagged? • Where is this information held? • Leadership and supervision • Inadequately defined roles and responsibilities • Work scheduling • Staffing levels, resourcing • Safety culture • Change management	• National targets • Policy and regulatory demands • Accreditation standards • Political decision-making • Global events

External environment
Societal, economic, regulatory and policy factors outside an organisation

Organisation
- Work schedules and assignments
- Management and incentive systems
Organisational culture
- Training
- Policies
- Resource availability

Internal/physical environment
- Lighting
- Noise
- Vibration
- Temperature
- Air quality
- Physical layout and available space

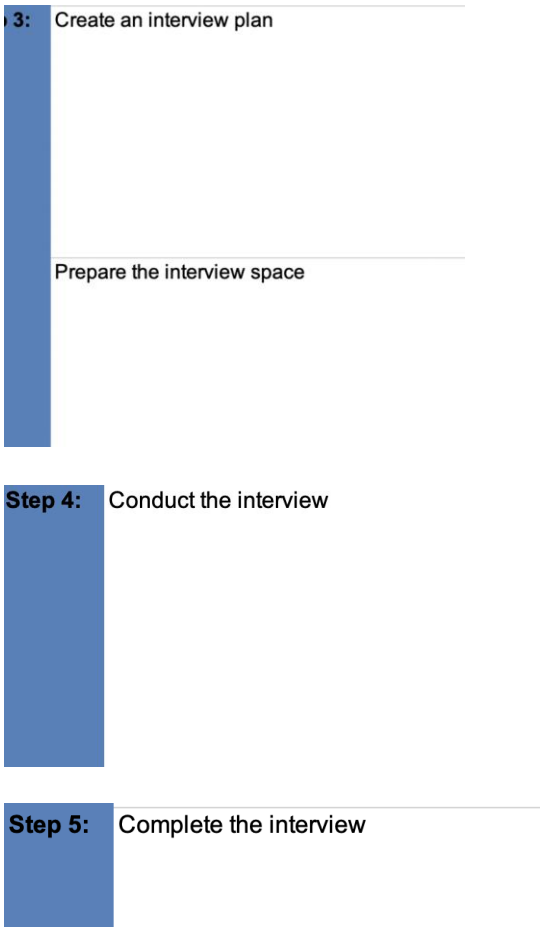
Tools and technology:
Characteristics such as:
- Usability
- Accessibility
- Familiarity
- Level of automation
- Portability and functionality

Tasks
Specific actions within larger work processes
Includes task attributes such as:
- Difficulty
- Complexity
- Variety
- Ambiguity
- Sequence

Person
Individual characteristics: age, preferences, goals, knowledge, physical strength and needs

Collective characteristics: team, cohesiveness, structure

	Description
Step 1:	Determine who to interview
Step 2:	Invite participants to attend for an interview



Patient safety incident reporting arrangements

Spring North will report all patient safety incidence on our own risk management framework n - these reports will be regularly reported to the SN Board and into ICB system partners via LFPSE.

Patient safety incident response decision-making

Describe the processes in place locally to decide how to respond to patient safety incidents as they arise, including how decisions take into account your patient safety incident response plan.

Planning supports proactive allocation of patient safety incident response resources, but there will always need to be a reactive element in responding to incidents. A response should always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's plan.

Describe the following:

- process for identifying emergent issues
- method for agreeing a proportionate response
- how resources will be allocated to support responses to emergent issues not included in your patient safety incident response plan.

Responding to cross-system incidents/issues

Describe your process to recognise incidents or issues that require a cross-system learning response, including how you will seek the views of local partners to ensure learning responses are co-ordinated at the most appropriate level of the system.

Spring North 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.

Timeframes for learning responses

A learning response will be started as soon as possible after the patient safety incident is identified and will be be completed within one to three months of their start date. (we will ensure that no learning response will take longer than six months to complete).

Describe your process for agreeing how timeframes for different response types will be set.

See Guide to responding proportionately to patient safety incidents for more information

Safety action development and monitoring improvement

Following a patient safety event, we will agree and generate safety actions in relation to defined areas for improvement. Following this, the organisation will have measures to monitor any safety action and set out review steps. These actions will be overseen by the Operations Manager and Safeguarding Lead

Describe how you use learning from incident responses to inform improvements (see the Safety action development guide).

Explain how safety actions will be monitored.

Note whether quality improvement and patient safety approaches are aligned (or you are working towards alignment).

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. They can take different forms. For example, organisations might consider:

- creating an organisation-wide safety improvement plan summarising improvement work
- creating individual safety improvement plans that focus on a specific service, pathway or location
- collectively reviewing output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues
- creating a safety improvement plan to tackle broad areas for improvement (ie overarching system issues).

Describe the approach best suited to your organisation (it may be a mixture of the above). The key is to demonstrate why a specific safety improvement plan approach is the right one for your organisation based on available data, stakeholder views, improvement priorities, patient safety incident profile and insight from patient safety incident responses.

There are no thresholds for when a safety improvement plan should be developed; for example, after completing a certain number of learning responses. The decision to do so must be based on knowledge gained through the learning response process and other relevant data.

Describe how you will support alignment of improvement efforts across the organisation.

As a consortium, we take an active role and responsibility in supporting our members and external partners with all elements of operational and strategy tasks. We intend to set up a network of peer support across the Voluntary, community and faith sector to discuss patient safety, share resources and best practice and possibly become a voice to influence across all sectors engaging with patients.

Our network will aim to:

- To support patient safety lead roles
- To support the role of learning from patient safety incidents
- To offer peer support to patient safety educators
- To share experience with the network

- To collaborate on new projects and ideas that enhance the learning from incidents and review training of new staff
- To provide a pool of shared resources within the network
- To create a community of assets who are experts in the field of patient safety, and make a positive difference in the lives of all stakeholders of patient safety

Oversight roles and responsibilities

Our PSIR oversight team aims to:

- Ensure the organisation meets national patient safety incident response standards
- Ensure PSIRF is central to overarching safety governance arrangements
- Quality assure learning response outputs

Our lead officer will ensure that:

- Patient safety incident reporting and response date, learning response findings, safety actions, safety improvement plans, and progress are discussed at senior leadership meetings, and board where relevant.
- Roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to incidents.

All co-design sessions with stakeholders will aim to provide:

- Engagement and involvement of those affected by patient safety incidents
- Policy, planning and governance
- Competence and capacity
- Proportionate responses
- Safety actions and improvement

Spring North consortium responsibilities to our members and sub-contracted partners:

- To collaborate with our providers in the development, maintenance and review of provider patient safety incident response policies and plans
- Agree provider patient safety incident response policies and plans
- Oversee and support effectiveness of systems to achieve improvement following patient safety incidents
- Support coordination of cross-system learning responses
- Share insights and information across organisations / services to improve safety
- Help improve Incident response through collaborative external review

An essential part of improving how organisations learn from patient safety incidents is external peer review of a sample of learning. External review improves quality and reduces siloed approaches to learning that can embed unintentional bias. It can also anticipate future problems by reflecting on systems in place and risks that they carry. Reviewing incident findings, areas for improvement and safety actions developed in other organisations, providers can review their own practice to ascertain if ‘this will happen here’.

The following ‘mindset’ principles should underpin the oversight of patient safety incident response:

1. Improvement is the focus PSIRF oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality.

2. Blame restricts insight Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.

3. Learning from patient safety incidents is a proactive step towards improvement Responding to a patient safety incident for learning is an active strategy towards continuous improvement, not a reflection of an organisation having done something wrong.

4. Collaboration is key A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation – it must be done collaboratively.

5. Psychological safety allows learning to occur Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.

6. Curiosity is powerful Leaders have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge

Complaints and appeals

Basically, we want to receive general feedback on all our services or commissioned contracts. There will be many occasions when members and community members can give the staff valuable feedback or comments on our services. However, a complaint is more serious. The key difference between comment and a complaint is that should anyone make a complaint they will expect the organisation to do something about it, and not just listen.

If you as an organisation member or community member are unhappy with any aspect of the service you receive through Spring North or one of our commissioned services, we want to hear about it as soon as possible.

It is important for us to attempt to respond to any issues or challenges politely and promptly, however we understand there will be occasions when this is not possible, and a more formal response and support is required/sought.

How Spring North will respond to a complaint:

1. A member of staff will listen and take notes of what you are saying. This will be a confidential discussion and will always take place in private.
2. We will take your complaint seriously and respond to it quickly and fairly.
3. All complaints will be treated in confidence and information passed on to others on a strictly “need to know” basis.
4. Where appropriate we will help you with a complaint e.g. a member of staff will help you to record the complaint and give you a copy of what has been recorded.

Staff Issues

If a member of staff is the subject of complaint they will be informed as soon as possible. Before being interviewed they will be given a written copy of the complaint.

It may be difficult making a complaint against a member of staff, but please remember if you think the organisation has a problem we need to know.

This is what we will do if you make a complaint:

1. All complaints will be acknowledged in writing within 7 days.
2. We will inform you of the time scales, what will happen next etc.
3. The organisation will investigate your complaint and let you know in writing, what we think and what our recommendations are within 21 days of acknowledgement.
4. A nominated member of the team will carry out this investigation.

Our subcontracted provider Issues

If a subcontracted provider is the subject of complaint they will be informed as soon as possible. Before being interviewed they will be given a written copy of the complaint, and an initial option of resolving the issue directly with the complainant.

This is what we will do if you make a complaint about a subcontracted provider:

1. All complaints will be acknowledged in writing within 7 days.
2. We will inform you of the time scales, what will happen next etc.
3. The organisation will investigate your complaint and let you know in writing, what we think and what our recommendations as per our contractual obligations with the organisation via our robust performance management framework. This we will inform you of within 21 days of acknowledgement.
4. A nominated member of the team will carry out this investigation.
5.

Appeals

If you are unhappy with the decision, you have the right of appeal to: The Chief Executive Spring North Ltd, 1 Exchange Street, Blackburn. BB1 7JN.

The complaint and resulting recommendations will then be reviewed by a panel of representatives from our Charity board. You will receive the outcome of appeal within 14 days of appeal acknowledgement date.

Monitoring Complaints

The organisation will monitor all complaints and look at the number of complaints, the category of complaints and the outcome of those complaints.

Complaints Policy - Staff Check List

- *If someone wants to complain always see them in a private office. Treat them politely and positively, make them feel comfortable.*
- *Explain that we have a complaints policy and how it works.*
- *Most importantly listen to what they have to say.*
- *Make notes of the complaint.*
- *Help the person to put the complaint in writing if necessary.*
- *Try to pull together the key points and check with the person that you have understood their points.*
- *Try and clarify the complaint. What exactly are the issues involved?*
- *Treat all information in confidence, share only with your line manager.*
- *Try and decide what does the person want to happen as a result of making this complaint.*
- *Record in the complaints log.*
- *Make sure that the person making the complaint receives confirmation in writing and that this letter includes a thank you, a summary of the complaint and informs them what will happen next and when.*
- *Make sure the complaint is investigated fully.*
- *Inform the person making the complaint of our decision and let them know how to appeal if they are not happy with this decision.*