PHOENIX HEALTH SOLUTIONS LTD

PATIENT SAFETY INCIDENT RESPONSE POLICY & PLAN

	PSIRF Policy & Plan Phoenix Health Solutions Ltd
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Introduction

Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework replaces the Serious Incident Framework.

Patient safety is the avoidance of unintended or unexpected harm to people during the provision of health care.

This patient safety incident response plan sets out how Phoenix Health Solutions Ltd intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the circumstances in which patient safety issues and incidents occurred and the needs of those affected. Patient safety investigations are conducted to identify the circumstances and systemic, interconnected casual factors that lead to patient safety incidents. These findings are then targeted with strong systemic improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

Patient safety is about maximising the things that go right and minimising the things that go wrong. Phoenix Health Solutions prioritises compassionate engagement with patients, family and staff affected by incidents. This provides vital insight into how to improve care, ultimately making services safer for patients. The focus is on understanding how incidents happen, including the factors which contribute to them.

Phoenix Health Solutions integrates the four aims of the Patient Safety Incident Response Framework.

Patient Safety four aims:-

- Compassionate, engaging, involvement of all 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
- Supportive oversight focused on strengthening response system functioning and improvement

Our Services

Phoenix Health Solutions Ltd aims to be outstanding by providing well led, safe and effective services responsive to patients needs delivered by caring staff.

Behaviours Phoenix Health Solutions expects:-

1. **We treat people how we would like to be treated ourselves**
    - We will show respect, courtesy and professionalism
    - We will treat patients with kindness, compassion and dignity
    - We will communicate in a clear, honest and responsible manner
2. **We work together to provide the best quality care we can**
    - Sharing the same goals: sharing answers together
    - Recognising contributions by treating everyone fairly and equally
    - Constantly learning so we share and develop together
3. **We focus on individual and diverse needs**
    - We will personalise the care we give
    - We will keep patients informed and involved in decisions
    - We will take the time to listen to patients

Phoenix Health Solutions Ltd provides NHS patients in Wakefield with adult hearing, ophthalmology, minor hand surgery, gastroenterology and physiotherapy services. We also hold a subcontract with Pioneer Health for a number of services including gynaecology, neurology, haematology, general surgery, colorectal, ophthalmology, urology and ENT.

Patient Safety Incident Profile

We have analysed our incident data over the last 2 years and the common themes that we found are:-

1. Failure to fully complete patient records when seen in theatre
2. Delay of treatment due to clinic cancellations or clinic re-scheduling
3. Patient complaints due to accidents/injuries or unhappiness
4. Staff attitude due to communication of professionalism.

The above patient safety priorities were discussed and agreed at the monthly PSIRF Collaborative Committee meeting in February 2023.

The above priorities will always have a patient safety investigation but there are many more incidents other than the above that also warrant patient safety investigation.

Phoenix Health Solutions Ltd is committed to recording and learning from every patient safety incident to prevent recurrence. All incidents can create opportunities for learning. All incidents are discussed with staff and the learning is shared. We have an open and transparent culture.

PATIENT SAFETY INCIDENT RESPONSE PLAN

Quality and Safety of services and effective learning will remain the focus of Phoenix Health Solutions, improving patient safety outcomes and reducing incidents.

For the last 12 months Phoenix Health Solutions has had one reportable incident to CQC which was investigated appropriately and recorded on LFPSE to maximise opportunities for learning. Duty of candour was undertaken as is with all our incidents.

All staff are required to complete mandatory patient safety training which covers the basic requirements of reporting, investigating and learning from incidents. Our patient safety specialist (Marlene Hayes who is our Lead Endoscopy Nurse and operations manager (Allison Jex) have completed level 2 patient safety training and are working towards completing level 3.

Please see table below of patient safety incident's themes for investigation:-

Patient Safety Incident Type	**Planned Response**	**Anticipated Improvement Route**
Failure to fully complete patient records when seen in theatre	Audit undertaken and incident report written	Audits Team meetings with staff to stress importance of fully completing documentation and staff training
Delay of treatment due to clinic cancellations or clinic re-scheduling	Incident report written	Key themes looked at to see if there are recurring patterns and to identify areas for improvement
Patient complaints due to accidents/injuries or unhappiness	Incident report written Clinical review Discussions undertaken with the patient. Statements taken from staff. Concerns responded to and opportunities given to both the patient and staff for feedback	Review and discussion to determine whether outcomes were as expected/intended Clinical audits To look at areas for improvement and share any learning with staff in team meetings
Staff attitude due to communication of professionalism.	Incident report to be written Discussions undertaken with the patient. Statements taken from staff. Concerns responded to and opportunities given to both the patient and staff for feedback	To look at areas for improvement and share any learning with staff in team meetings

Example of Using PSIRF

Patient Safety Incident Type	Planned Response	Improvement Route
Failure to fully complete patient records when seen in theatre	Audit undertaken and incident report written	Following discussions with staff it was found that the save button was not being pressed when exiting the patients records and the discard button was being pressed therefore the completed documents were not saved. We therefore removed the discard button from staff's toolbars so that when patients records are exited only the saved button can be pressed ensuring that no data is lost. Following this a repeat audit was done and all documentation is now completed.

GOVERNANCE

Regular bi-monthly governance meetings are held to discuss and review performance and identify areas for improvement and we learn from patient safety incidents to improve safety.

Following this meeting a staff meeting is then held monthly to feedback to staff on incidents, the learning that has occurred following these incidents and the actions that have been put in place. Staff are invited to input their feedback regarding the incidents and asked for suggestions if they have any improvements that they feel would be suitable to be put into place.

Phoenix Health Solutions attends a quarterly collaborative committee patient safety partner meeting with Novus Health and the Grange Medical Centre. At this meeting incidents and outcomes are discussed and shared. The main aim of this meeting is to assist each other with learning and improvements.

Incidents are shared on the LFPSE platform to develop learning opportunities. Incidents at Phoenix Health Solutions mainly fall under the category of `low patient harm' or `no harm' but if a serious incident occurs this is reported to the CQC and the ICB.

PHS holds regular governance meetings with Pioneer for each service to discuss incidents and outcomes. Learning is shared at these meetings and plans are implemented and the learning is shared with PHS staff and the plans are put into place.

This policy has been shared and signed off in the Phoenix Audit and Governance Group Meeting in January 2024

INCIDENT INVESTIGATION TECHNIQUES

TECHNIQUE	METHOD	OBJECTIVE
Incident Report	Disclosure of an incident	To provide a written overview of the incident
`Being Open' Conversations	Open disclosure	To provide the opportunity for verbal discussion about the incident and to respond to any concerns
Safety Huddle	Briefing	To improve awareness of safety concerns To focus on patient's most at risk To share understanding on the day's priorities To agree actions To enhance teamwork through communication and collaborative problem solving Celebrate success in reducing harm
After Action Review	A structured discussion after an event	To discuss the day's events Identify the groups strengths' weaknesses, areas for improvement and capture learning to share with others
Clinical Review	Care and treatment review	To determine and describe how the care provided compared with the accepted standards
Outcome Audit	Audit	To determine whether the outcome was as expected/intended
Clinical Audit	Outcome Audit	Quality improvement cycle to measure effectiveness of healthcare against proven standards for high quality
Risk Assessment	Proactive hazard identification and risk analysis	To determine likelihood of an identified risk and its potential severity

PATIENT SAFETY INCIDENT REPORTING ARRANGEMENTS

All staff have a duty of care to report all patient safety incidents to the operations manager and or Medical Director. Serious Incidents must be declared as soon as possible and immediate action is undertaken to establish the facts, ensure the safety of the patient, other service users and staff and to secure all relevant evidence to support further investigation. Serious incidents should be disclosed as soon as possible to any affected patient, their family (including victims' families where applicable) or carers.

Objectives of Significant/Critical Event Reporting

- To record adverse incidents affecting, or with the potential to affect, patients or staff
- To record "near misses" so that steps may be taken to prevent a recurrence
- To learn from the event as a team, discuss, and put changes or procedures in place to improve
- To commend and acknowledge good practice
- To provide a permanent record of events and evidence of remedial steps taken
- To satisfy the requirements of nationally required incident reporting standards.
- To operate and discuss incidents in an open environment and within the safety of a "blame-free culture"

Recording of the event

Every person who played a significant part in an incident or witnessed it should each complete a Significant Event Report Form independently and without conferring as soon as possible after the incident. This will ensure that each account of the proceedings is, as far as possible, as accurate as it can be and without the influence of a third party. Each statement will form part of the incident record.

Completed forms should be passed to the Operations Manager/Patient Safety Lead (Nominated person) to collate for an initial check. These are then logged onto the Incident Record Log.

Key risk issues

The main elements of the incident will be identified - this will assist in the formulation of specific action points to address each of the risk areas (including actions to prevent recurrence). Also, recorded actions taken during the event which proved to be successful/satisfactory.

Root Cause Analysis

Using guidance identify the root cause; the core issue that sets in motion the entire cause-and-effect reaction that ultimately led to the issue

Specific action required/Learning outcomes

Specific measurable action points should be agreed within a meeting of the clinical / management team, and documented to address the specific risk issues recorded within the form. The action points should be allocated to an individual to oversee and should be time-bound.

Timescales and responsibilities

Record details of who is responsible for each action and the date by which it is to be completed.

Review of actions

This will be carried out at a meeting of the clinical / management team at a later stage in the process after all action points have been completed. The review will focus on the causes of the incident (good or bad) and will focus on the adequacy of the response and the continuity of the learning points (again, good or bad) which have arisen.

Incidents which meet the criteria for an investigation are reported nationally on the LFPSE – Learn for Patient Safety Events System.

PSIRF AND SUB CONTRACTORS

PHS holds a subcontract with Pioneer Healthcare. PHS has an excellent working relationship with Pioneer and has an open culture between the teams and encourages staff to report any incidents. All incidents are dealt with by Pioneer Healthcare and PHS provides the information required and supports Pioneer with any investigations, statements and learning from incidents. The incidents are discussed in the monthly governance meetings between Pioneer and PHS where the learning is shared and action points and plans are put into place.

Engagement and Duty of Candour

Once an incident that meets the statutory duty of candour threshold has been identified, the legal duty, as described in regulation 20 says we must:-

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

PHS recognises the importance of involving patients and families following patient safety incidents, engaging them in the investigation process and to fulfil the duty of candour requirements. PHS is open with patients and recognises the need to involve patient’s and families as soon as possible in an investigation, unless they express not to be involved. We encourage questions from patients and answer and share with them outcomes of investigations.

Similarly the involvement of staff and colleagues is equally as important when responding to patient safety incidents to ensure a holistic and inclusive approach from the outset. PHS continues to promote, support and encourage our colleagues to report any incidents or near misses and to provide opportunities for learning and improvement.

PHS recognises that staff and colleagues need to feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame. We will continue to monitor incident reporting levels and continue to promote an open and just culture to support this.

COMPLAINTS & APPEALS

Phoenix Health Solutions is committed to listening to our patients' comments, feedback and complaints regarding our services. We aim to resolve any issues as quickly as possible and also aim, with the help of patient and staff feedback, to improve the quality of our services. We review our staff surveys and take on board the comments made in these surveys and have displayed in our reception area a "you said we did" to show to our patients we are listening to their feedback which helps us to improve our services.

The general principle of PHS in respect of all complaints will be to regard it first and foremost as a learning process,

There are notices advising on the complaints process conspicuously displayed in all reception/waiting areas and that leaflets containing sufficient details for anyone to make a complaint are

Formal complaints can be made to either to PHS by contacting 01977 655605 or emailing phoenix.patients@nhs.net

In the event of anyone not wishing to complain to PHS they should be directed to make their complaint to NHSE at:

By telephone: 03003 11 22 33

By email: england.contactus@nhs.net

By post: NHS England, PO Box 16738, Redditch, B97 9PT

In those cases where the complaint is made to NHS England, PHS will comply with all appropriate requests for information and co-operate fully in assisting them to investigate and respond to the complaint.

· A statement of the right, if they are not satisfied with the response, to refer the complaint to the Parliamentary and Health Service Ombudsman, Millbank Tower, Millbank, London, SW1P 4QP or visit the 'Making a complaint page' at

http://www.ombudsman.org.uk/make-a-complaint

(to complain online or download a paper form).

Alternatively the complainant may call the PHSO Customer Helpline on 0345 015 4033 from 8:30am to 5:30pm, Monday to Friday or send a text to their 'call back' service: 07624 813 005

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