Circle Health Group

Incident Management Policy

02 Nov 2023

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Summary of key policy requirements

1.
This policy describes Circle Health Group's (Circle's) and Circle Integrated Care's arrangements for reporting incidents/events of all types, and of any significance, and the actions expected to manage and follow-up such incidents. This policy relates to any incidents involving staff, patients and others. NB: references to Circle are inclusive of Circle Integrated Care.

2.
This policy is fundamental to the Circle governance and assurance framework to support the promotion of the incident/event reporting culture of Circle.

3.
It utilises the patient safety incident response framework (PSIRF) and Circle's patient safety incident response plan (PSIRP) to provide proportionate responses to incidents/events.

4.
Circle's PSIRP was created following a review of historical data and uses this data to inform a proportionate response to incidents/events based on an understanding of contributing factors, and previous or current quality improvement projects. The PSIRP is a living document that will be regularly reviewed.

5.
All incidents/events must be posted on the governance IT system within 1 working day

6.
When an incident/event that has a defined response in the PSIRP has occurred, this must be escalated within the site to the Executive Director/Functional Lead and Director of Clinical Services, where appropriate.

7.
Where an incident/event is externally reportable or is felt to require escalation to the patient safety incident review group (PSIRG) (formerly the significant incident multidisciplinary review panel) (SIMRP)), a significant incident brief, accessible in the governance IT system documents module, should be completed and escalated to the relevant head of the central function, as described in section 9.2, appendix 5 and the PSIRP.

8.
Where an incident/event involves a patient, the relevant individuals must be informed about the incident/event, providing reasonable support, providing truthful information and an apology when things go wrong. Section 6.0 provides the details and process of being open, the professional and statutory duty of candour.

9.
Response reports should be written in a way that is accessible and understandable to all readers (which will include the patient and/or family in most cases). The report must not contain any staff or Consultant names and the content should be clear and concise. Where referring to a patient, the patient, carer or family should be consulted as to how the patient is named, i.e. anonymised (Patient A), formal name (Mr, Mrs, Ms surname), or by forename and/or surname.

10.
All incidents/events must be investigated. Patient safety incident investigation (PSII) reports and other significant incidents/events (i.e. a fire or where moderate/severe harm was caused) require formal sign-off before they can be internally closed. This formal sign-off process ensures the quality and proportionality of the response and that the accuracy of the learning and improvement proposals are identified.

11.
The robustness of the safety actions, safety improvement plans and after-action reviews designed to address any causative or contributory factors will be assessed using audit methodology.

Definitions

Term	Explanation
Incident/event	Any event, accident or circumstance that led to harm, loss or damage to people, property, reputation, personal data or other occurrence that could impact on the organisation's ability to achieve its objectives, including near miss events.
Patient safety incident response framework (PSIRF)	***The patient safety incident response framework*** sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Patient safety incident investigation (PSII)	A patient safety incident investigation is undertaken when an incident/event or near miss indicates significant patient safety risks and potential for new learning. A PSII offers an in-depth review of a single patient safety incident/event or cluster of incidents/events to understand what happened and how. This replaces root cause analysis (RCA) investigations and reports.
No harm/near miss event	An event which could have, but did not, lead to harm, loss or damage.
Harm	Harm is defined as injury, suffering, disability or death.
Low harm/impact	Requiring extra observations or minor treatment. Further details can be found within appendix 2 of the incident management policy.
Moderate harm/ impact	Resulting in moderate increase in treatment; significant but not permanent. Further details can be found within appendix 2 of the incident management policy.
Severe harm/ impact	Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons. Further details can be found within appendix 2 of the incident management policy.
Death	Any unexpected or unintended incident that directly resulted in the death of one or more persons. Further details can be found within appendix 2 of the incident management policy.
LFD	Learning from deaths.
Child death overview panel	Child death overview panels are locally formed panels who conduct case reviews to help prevent further child deaths. You can find out more about their responsibilities in the ***working together to safeguard children*** guidance.
Never event	A sub-set of incidents defined as serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. Please refer to ***NHS England's never event list***
Patient safety learning response toolkit	The PSIRF promotes a range of system-based approaches for learning from patient safety incidents. These are defined at section 8.2.3 of the incident management policy and their use described throughout the PSIRP. The Circle Operating System (COS) advocates the use of Stop the Line and Swarm. These are defined at section 3.3 of the incident management policy.
LFPSE	Learning from patient safety events.
Independent investigation	A small number of events externally investigated by a nominated professional.
Patient safety incident response group (PSIRG)	The patient safety incident response group (PSIRG) is a multidisciplinary group commissioned to advise, review and approve patient safety investigations/learning responses and event data. Trained in learning response and oversight.

1.0
Purpose

1.1
This policy supports the requirements of the PSIRF and sets out Circle's commitment to minimising risks to patients, visitors, staff, volunteers and contractors as far as is reasonably practicable. This policy is Circle's approach to developing and maintaining effective systems and processes for responding to incidents/events and issues for the purpose of learning and improving patient, staff, and others, safety. It also set out Circle's approach to provide a safe environment, supporting the delivery of excellent care, in which there is an open culture of reporting and a learning approach to improving services based on incident/event analysis.

1.2
The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents/events. It embeds patient safety incident/event response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

1.3
This policy follows the guidance of NHS England's Patient Safety Strategy (2019) to support patients and others involved when care delivery or treatment outcomes may not have gone as expected. Circle's focus is on analysing the contributory factors, including human factors, so that important lessons are learnt and acted upon. This is undertaken within a culture of openness and transparency, supporting patients, family and staff (including bank, locum and agency staff) throughout the process.

1.4
This policy is designed to ensure that clear lines of accountability and responsibility are identified for all elements of incident/event reporting and investigation. This includes ensuring that communication around the reporting and management of all types of incidents/events is effective and that incidents/events are managed in a supportive environment.

1.5
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/events.
- Application of a range of system-based approaches to learning from patient safety incidents/events.
- Considered and proportionate responses to patient safety incidents/events and safety issues.
- Supportive oversight focussed on strengthening response system functioning and improvement.

2.0
Scope

2.1
This policy relates to any incidents/events involving staff, patients, contractors and visitors.

2.2
This policy is specific to incident/event responses conducted solely for the purpose of learning and improvement across all Circle sites in England, regulated by the Care Quality Commission (CQC). It applies to all incident/event types, including near misses, encompassing patient clinical, health and safety, facilities, security (including information security), information governance, radiation, safeguarding and violence/abuse and harassment.

2.3
Differences in national policy for Wales, regulated by Healthcare Inspectorate Wales (HIW), and Scotland, regulated by Healthcare Improvement Scotland (HIS), are integral to Circle's incident management policy and are described, where appropriate. Both regulatory bodies are aware of PSIRF and acknowledge that this will be the main framework used by Circle.

2.4
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/event.

2.5
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.

2.6
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/event response.

2.7
The following procedural documents are not included in this policy:

- Clinical/restorative supervision and clinical advocacy.
- Freedom to speak up: raising concerns.
- Fraud, bribery and corruption.
- Disciplinary.
- Responding to concerns about medical practice.
- Risk management and risk register.
- Being open and duty of candour.
- Complaints.
- Patient safety incident response plan.
- Management of the deceased patient and reporting requirements.

3.0
Our patient safety culture

3.1
As a learning organisation, Circle understands that healthcare systems and processes can have weaknesses that may lead to errors, and that these errors can sometimes have serious consequences for our patients, staff, Consultants, those performing tasks on behalf of Circle, service users and/or the reputation of the organisation itself. When errors occur, the organisation actively encourages reporting of such incidents/events so that action can be taken to manage the incident/event through a process that is:

- Fair and equitable.
- Open and transparent.
- Focussed on identifying learning responses.
- Dedicated to embedding learning, change and improvement.

All healthcare organisations have legal and contractual requirements in relation to the management of incidents/events and adherence to this policy will ensure that Circle is compliant with these requirements.

3.2
Governance and assurance framework

Circle's governance and assurance framework (GAF) supports the organisation's commitment to compliance and transparency. The GAF demonstrates each governance area of the business and those charged with ultimate responsibility.

The elements of the GAF and its component parts are represented by a circle that effectively illustrates the cyclical interconnectivity of accountability, information and continuous improvement – from department, then site, then region, then board, then back again.

3.3
Circle Operating System

People who work at Circle are empowered to make the best decisions for patients, colleagues and others. This means that our approach to leadership and decision-making is devolved and inclusive to ensure that everyone takes ownership and accountability. We do not expect our people to work around a problem; we want everyone to be empowered to understand and solve the problem.

The Circle Operating System (COS) details the methodology and tools such as Stop the Line and Swarm to support the empowerment of staff to improve their service.

3.3.1
Stop the Line

Anyone who encounters a situation that may cause harm, or requires support to continue an activity safely, is empowered to immediately make a report to the person in charge and 'stop the line'. This activates a collective problem-solving process called a Swarm.

3.3.2
Swarm

Problems are 'swarmed' at the time and place of where they occur by the people who are affected. A Swarm will always happen following a Stop the Line but can also be called anytime an issue or opportunity needs to be worked through collectively.

3.4
Quality and safety improvement programmes

Circle has a quality and improvement strategy from which areas of focus and opportunities to make improvements are identified and used to inform group improvement initiatives. These are made up of group quality improvement programmes (group QIPs) and group safety improvement programmes (group SIPs).

The decision-making process surrounding which improvements to introduce focuses on feedback from a variety of sources, including inquests, incident/event investigations, complaints and patient feedback.

The existence of such improvement projects is noted in the PSIRP, and related incidents/events are measured against these to establish if any new themes or trends emerge. New themes and trends are noted in the governance IT system for ongoing analysis and shared with sites to support learning and prevent future similar incidents/events occurring.

3.5
Just culture charter

The ***NHS England*** webpage states that:

"Safety culture is one of the two key foundations of the ***NHS patient safety strategy***. We define a positive safety culture as one where the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families and carers) can flourish to ensure brilliant, safe care by:

- Continuous learning and improvement of safety risks.
- Supportive, psychologically safe teamwork.
- Enabling and empowering speaking up by all".

Furthermore that:

"With the introduction of the ***patient safety incident response framework*** there is continued emphasis on ***engaging and involving patients, families and staff following a patient safety incident***. This supports the ***just culture guide*** which encourages managers to treat staff involved in a patient safety incident/event in a consistent, constructive, and fair way".

Circle recognises that the vast majority of healthcare workers, at all levels and grades, have no intention of causing harm to any patients under their care. Circle also recognises that incidents and events that cause harm and/or distress do occur and is committed, through its implementation of PSIRF, to ensuring that such incidents/events are reviewed, and that any learning is established and shared to aid the prevention of similar incidents/events in the future.

This assertion is aligned to Circle's philosophy, which encompasses:

- Our purpose: to provide the high quality, safe and compassionate care our patients need and expect.
- Our principles: we believe that patients come first, we believe in our people, we believe 'good enough, never is, and we believe in being open minded and innovative.
- Our values: we value people who are selfless and compassionate, collaborative and committed, agile and brave and tenacious and creative.

Where incidents/events are thought to have an element of malicious or harmful intent, the expectation is that appropriate escalation in the management structures will occur and the incident/event will be managed in a separate structure. ***The just culture*** guide will be available for use by management teams to aid decision making.

4.0
Patient Safety Partners

4.1
The ***NHS patient safety strategy*** 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/event response oversight committees. More information is provided in the ***framework for involving patients in patient safety.***

The Patient Safety Partner role is a new and innovative role within Circle and the wider NHS. The purpose of the role is to develop safer organisations by ensuring the voice of the patient/family is appropriately represented and to provide a questioning approach. The role of the Patient Safety Partner is likely to evolve as PSIRF becomes embedded.

5.0
Addressing health inequalities

5.1
Circle recognises that health and care organisations, including those providing NHS services, have a core role to play in reducing health inequalities, such as by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

Circle is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. Circle is also committed to the accessible information standard, as referenced in the accessible information standards policy.

The governance IT system will allow for the details of patients to be drawn directly from associated patient administration and electronic health record systems, and incidents/events can then be analysed by protected characteristics to give insight into any apparent inequalities.

Any indication of health inequalities can then be reflected in the learning response outputs, allowing direct correlation and action to be taken to address these issues.

Engagement of patients, families and staff following a patient safety incident/event is an integral part of Circle's PSIRF implementation, ensuring that tools are available, such as easy read, translation and interpretation services and other methods, as appropriate, to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident/event response.

6.0
Engaging and involving patients, families and staff following an incident/event addressing health inequalities

6.1
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/events to improve understanding of an incident/event, to understand and answer any questions they have in relation to the incident/event, and to signpost them to available support to prevent compounded harm.

6.2
Where an incident/event is not directly related to patient safety but involves members of staff, Consultants, visitors or contactors, the same principles of engagement are adhered to and individuals should be supported to prevent compounded harm.

6.3.1
Four steps of engagement

1. Before contact	2. Initial contact	3. Continued contact (as per agreed update frequency)	4. Closing contact

• Identify contact
Patient, family member or advocate
• Assess inclusivity needs
Additional communication or inclusivity needs
• Assess potential support needs for patient/family/staff (emotional, practical, information and psychological)
e.g. family, advocacy, specialist support organisations (bereavement support etc.) For staff, including manager, management, supervision, Employee Assist
• Ensure familiarity with the incident
Facts to date, who you are talking about and to
• Assess potential for parallel response and prepare guidance
e.g. complaint process, Coroner's inquest
	• Provide a clear introduction
	Who you are: name, role, engagement role
	• Offer a meaningful apology
	For the circumstances/ incident, noting duty of candour requirements (statutory and professional)
	• Identify key point of contact
	You or someone else
	• Explore patient/family/staff support needs
	• Discuss the incident
	What has happened, in plain language
	• Explain what happens next
	Immediate action taken, review of circumstances, planned investigation
	• Address questions
	• Schedule or discuss next contact
	When and how you/key point of contact will next be in touch
		• Agree timeframe for responding to questions
		• Revisit support needs
		• Check for additional questions
		Clarify and signpost, where not in scope
		• Share experience of the incident
		Empathetic, compassionate conversation - how would you?
		  • *Be clear how will be recorded/ used*
		  • *Relaxed setting (away from work/incident environment)*
		  • *Thank patient/family/staff member for sharing their experience - acknowledge difficulty of doing so and value of contribution*
		  • *24-48 hour check - is any additional support required?*
			• Address questions
			• Reiterate meaningful apology
			• Final contact (formal end)
			• Ongoing support
			Review support already signposted to and consider any additional support needs.

	For investigations	**For investigations**	**For investigations**
	• Confirm involvement preferences *Timing and structure of investigation, engagement and input, preferred contact method (including for investigation process leaflet), dates to avoid, potential disruption (planned leave etc.) Respective input deadlines and involvement preferences for terms of reference, information gathering, draft and final report*	• Define/discuss terms of reference *Scope of investigation and discussion around report format* • Agree timeframe for completion of investigation • Revisit involvement preferences • Discuss report preferences *Including personalisation* • Share the draft report *Attempt verbal discussion prior to sending and arrange a time to discuss.*	• Final report *Give advance notice; offer face-to-face discussion, ask if they would like someone with them* • Discuss any further investigations *Complaints, Coroner's inquest etc.* • Opportunities for further involvement *Patient participation groups etc.*
Complete:	**Complete:**	**Complete:**	**Complete:**

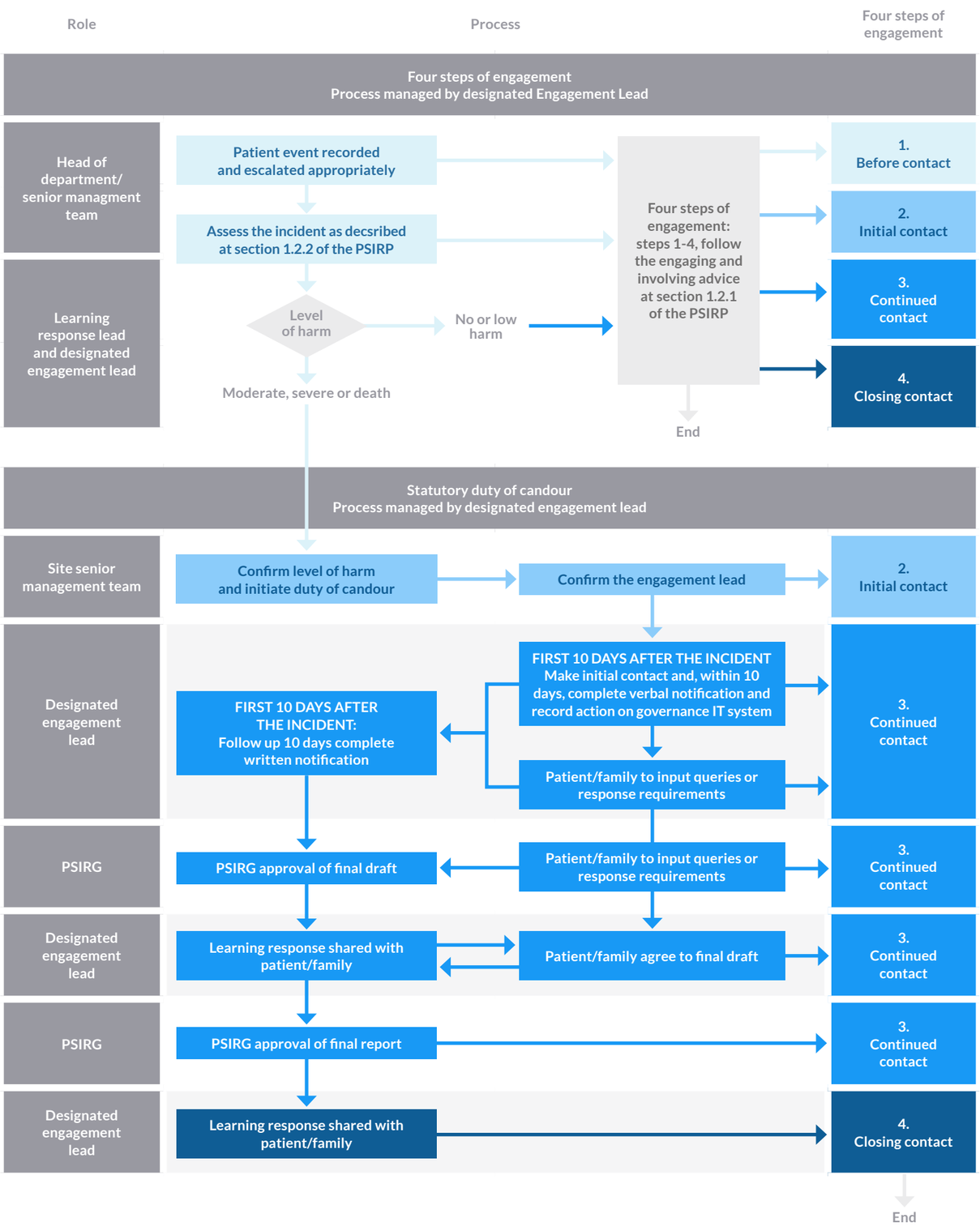
6.3.2
Duty of candour, being open and engaging and involving those affected is further detailed in the Circle's being open and duty of candour policy, which:

> *'Sets out how Circle Health Group implements the statutory Regulation 20: Duty of Candour, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 20 is about the statutory duty of candour, which is regulated by the CQC/HIW/HIS, while the professional duty of candour is overseen by regulators of specific healthcare professions such as the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and the General Dental Council (GDC).'*

6.3.3

Engagement and involvement of individuals affected by patient safety incidents, using the four steps of engagement model and the statutory duty of candour processes, are mapped in the flowchart:

Involvement and engagement
Duty of candour



6.4

Supporting staff

- To support healthcare staff involved in patient safety incidents, Circle will actively promote an open and fair culture that fosters peer support and discourages attribution of blame.
- All staff affected by an incident will receive support and advice from their line manager.
- Formal and informal debriefing of the clinical team involved in the patient safety incident should be arranged. It is the responsibility of the line manager to ensure appropriate debriefing is undertaken to ensure all those involved in the investigation or learning response receive feedback of the outcome. This is key in ensuring a good incident reporting and learning culture, helping staff to see the value of reporting incidents, and organisational change. The outcome is logged onto the SHARE debrief (see section 8.2.3.).
- Information on support systems available for staff should also be shared after a patient safety incident. This should include occupational health services, counselling services (e.g. Employee Assist), clinical supervision arrangements and support available from relevant professional bodies.
- Staff involved in patient safety incidents should also be supported to record their recollections/ statements of the incident in a timely manner through statements, interviews and debriefs.
  NB: the reference to recollections as 'statements' is recognised as a barrier to a creating an environment or culture for learning. This process of recording recollections in a written format, known as a statement, is important to the process of ascertaining 'what' happened. Recollections should be factual and not an analysis of causation. Staff should be fully informed of the purpose of completing statements to reduce the impact of the negative connotation.

Based on the application of ***The just culture guide***, referral of individual staff to their regulatory professional body may be identified as a required response to an event. In such instances, the individual will be provided with appropriate information on the process and access to support.

6.5

Freedom to Speak Up Guardians, Professional Nurse Advocates and Clinical Supervision Advocates

To underpin the support mechanisms described above, Circle has associated policies which detail the roles of Freedom to Speak Up Guardians (freedom to speak up: raising concerns), and of Professional Nurse Advocates and Clinical Supervision Advocates, in supporting staff (clinical/restorative supervision and clinical advocacy)

The freedom to speak up policy supports staff to raise a concern and states, at section 2.2, that:

> *'So long as the individual is troubled by an issue, there is no need to wait for proof and it does not matter if the individual turns out to be mistaken about the situation. If in doubt, individuals should speak up.'*

The clinical/restorative supervision policy states its purpose and values as:

> *'2.1 For Circle to ensure each of its registered practitioners is supported through restorative clinical supervision and advocacy to carry out their roles and responsibilities (CQC Regulation 18: Staffing 2002), improve patient care and/or staff wellbeing and contribute to continuous quality/service improvement and professional development.*
>
> *2.3 For supervisees to enhance self-awareness, their professional practice, knowledge and skills within a safe and supportive environment that promotes personal accountability for standards and quality of improvement and practice'.*

7.0

Patient safety incident response planning

PSIRF supports organisations to respond to incidents/events 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. This principle is reflected in the PSIRP.

7.1

Resources and training to support patient safety incident/event response. The resources and training that Circle provides to support effective systems and processes for responding to patient safety incidents are outlined below.

PSIRF role	Training requirements	Circle role	Courses recommended by NHSE (patient safety syllabus)
All staff	E-learning - level 1	All staff	Level 1: essentials for patient safety (e-learning)
	E-learning - level 2	All staff, excluding: • Chief Commercial Officer's team • Chief Financial Officer's team • Chief Information Officer's team • Chief People Officer's team NB: members of the executive team remain included	Level 2: access to practice (e-learning)
Board and senior leadership	E-learning - board-specific level 1 & 2	Members of the Operating Board	Level 1: essentials of patient safety for boards and senior leadership teams (e-learning) Level 2: access to practice (e-learning)
Learning response leads	• Learning responses are led by those with at least two days' formal training and skills development in learning from patient safety incidents and experience of patient safety incident response • Learning response leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus • Learning response leads undertake continuous professional development in incident response skills and knowledge, and network with other leads at least annually to build and maintain their expertise • Learning response leads contribute to a minimum of two learning responses per year	PSIRG members Directors of Clinical Services Associate Directors of Clinical Services Quality and Risk Managers	Initial training: systems approach to learning from PSII – two days (face-to-face) **Healthcare Safety Investigation Branch level 2** Post-initial roll-out: in-house training can be offered by staff meeting requirements of *5.1 in PSIRF standards*
Oversight	• All patient safety incident response oversight is led/conducted by those with at least two days' formal training and skills development in learning from patient safety incidents, and one day training in oversight of learning from patient safety incidents • Those with an oversight role on a provider board or leadership team (e.g. an executive lead) have completed level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the patient safety syllabus • All individuals in oversight roles in relation to PSIRF undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise	These should be people leading in system oversight roles as outlined in the *NHSE roles and responsibilities guide* (i.e. provider board PSIRF lead(s)) and must have knowledge of effective oversight and supporting processes, including effective use of data for assurance and patient safety incident/event response system development: • Group Clinical Director • Group Medical Director • Director of Clinical Governance and Improvement • Director of Clinical Practice and Specialist Services • Patient Safety Lead • PSIRF Lead • Head of Regulatory	Initial training: oversight learning from PSII – six hours (face-to-face) Procure training from a *NHS training and procurement framework* Post-initial roll-out: in-house training can be offered by staff meeting requirements of *5.1 in PSIRF standards*
Engagement leads	• Engagement and involvement with those affected is led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process • Engagement leads have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus • Engagement leads undertake continuous professional development in engagement and communication skills and knowledge, and network with other leads at least annually to build and maintain their expertise • Engagement leads contribute to a minimum of two learning responses per year	These should be people leading on engagement with those affected by patient safety incidents/events: • PSIRG members • Directors of Clinical Services • Associate Directors of Clinical Services • Quality and Risk Managers	Initial training: Involving those affected by PSII - six hours (face-to-face) Procure training from a *NHS training and procurement framework* Post initial roll-out: In house training can be offered by staff meeting requirements of *5.1 in PSIRF standards*

7.2
Circle's PSIRP

Circle's PSIRP sets out how the organisation 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.

7.3
Review of the PSIRP

The PSIRP will be reviewed regularly to ensure our focus remains up to date; reflecting that with ongoing improvement work, the organisation's 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 during the previous PSIRP period. Updated plans will be published on Circle's website, replacing the previous version.

A rigorous planning exercise will also be undertaken every four years, and more frequently if appropriate (as agreed with Circle's lead Integrated Care Board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing Circle's response capacity, mapping the organisation's services, a wide review of organisational data (e.g. PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

8.0
Responding to incidents/events

8.1
Incident/event reporting arrangements

8.1.1
What is an incident/event?

For the purpose of this policy an 'incident/event' includes any unintended or unexpected event which caused, or may have caused (e.g. a near miss):

- Harm/injury to patient(s), staff and/or visitors.
- Damage to property or equipment.
- Damage to the reputation of the organisation.
- Financial loss to an individual or the organisation.
- Disruption to services.
- Death.

The policy applies to all incidents/events, including staff/patient and others harm, health and safety, fire, theft, fraud, incidents/events of violence and aggression, significant loss or damage, assault, breaches in information governance, employee accidents/incidents and near misses. Incidents/events provide the organisation with opportunities for learning which can result in improved safety and quality of both clinical and non-clinical services.

8.1.2
How are incidents/events identified?

Incidents/events can be identified through various routes including:

- During the provision of healthcare e.g. patient safety incidents/events or adverse clinical outcomes, allegations made against, or concerns expressed about, the organisation by a patient or third party.
- Near miss events.
- Incident/events/accidents involving staff, visitors or contractors.
- Through the initiation of other investigations/learning response.
- During, or on completion of, an internal mortality review or structured judgement review, e.g. if the reviewers identify that harm has occurred, which had not been previously reported.
- Through complaints, claims, grievances and inquest processes.
- During audit, walk-rounds, peer review or third parties, e.g. the CQC or health and safety inspections.
- Via the freedom to speak up route and/or whistleblowing.
- Through other routes such as medical records review, identification by other patient's visitors, clinical audit etc.

8.1.3

Immediate actions following identification of an incident/event

When an incident/event is identified, immediate action must be taken by staff to ensure that:

- The priority for anyone who has witnessed, or was involved in, an incident is to ensure the needs of individual(s) affected are attended to, including any clinical care needs.
- The area and any persons (including patients, staff and the public) affected by the incident are safe.
- The local management team are verbally informed of the incident (except where not appropriate, e.g. if potentially implicated in a suspected fraud).
- Prompt and appropriate clinical care provision is provided to prevent further harm.
- Any immediate safety concerns are shared across other areas of the organisation, as needed, to minimise risk at the earliest opportunity.
- In the event of a significant data breach, the Head of Information Governance is contacted immediately by telephone or email.
- In the event of the onsite death of a patient, the management of the deceased patient and reporting requirements policy should be followed in the first instance. This details the process for reporting and notification of deaths.
- In the event of an unexpected patient death a scoping meeting (see section 9.3) will be undertaken with the site. This will review the circumstances of the patient's death, ensure notifications and duty of candour with the relevant person(s) has been undertaken, and to provide support and agree the next steps, including whether any equipment needs quarantining/ isolating (if a medical device was involved in the incident/event, please refer to guidance within the management of medical devices policy).
- Obtaining photographs of the area, if appropriate (if photos are taken this must be in accordance with Circle's IT acceptable use policy).
- If there has been a death or serious injury, the most senior person on duty in the area must be informed immediately and, if a patient is affected, the patient's Consultant must be contacted to advise on optimising immediate care.
- If there is a suggestion that a criminal offence has been committed then this should be escalated immediately to director/manager on call who will make arrangements to contact the police, and the scene and evidence must be secured.
- If there are suspicions or allegations of fraud then the fraud response plan documented in the fraud, bribery and corruption policy must be followed.
- In the event that abuse or neglect is suspected, the relevant child or adult safeguarding policy will be implemented.
- Requesting and obtaining initial written recollections/statements from staff involved in the incident/event, or witnesses to the incident/event, in order to gather immediate recollections (a template is available in the governance IT system documents module).

The director/manager on call must be informed immediately if access to any area of the organisation is restricted due to the need to preserve evidence. In addition, no evidence, e.g. equipment, CCTV footage etc. should leave Circle premises without the explicit approval of the Executive Director or Regional Director.

8.1.4

Reporting an incident/event onto the governance IT system

The organisation's central repository for reporting and managing all incidents/ events is the governance IT system. The governance IT system can be accessed via Circle's Support Portal. Incidents/events should be reported immediately and must be reported within 24 hours of knowledge that they have occurred. In some situations, staff may not be aware that an incident/event has occurred until an unexpected outcome is detected sometime later. In such cases the incidents/events should be reported retrospectively.

The incident/event report should be completed by a member of staff who was involved in, witnessed, or notified of the incident/event, as appropriate. It is the responsibility of all staff to ensure that incidents/events are reported in order to enable timely learning and to prevent recurrence. If in doubt, an incident/ event should be logged. Incidents/events may be reviewed and de-escalated, however staff should always be appreciated for reporting, and over-reporting internally is not of concern.

If an incident/event is identified by Circle but, as an organisation, we have not been involved in the delivery of care or the circumstances within which the incident/event occurred, Circle has a duty to ensure that the relevant organisation(s), provider(s) and/or commissioner(s) are informed to ensure the incident is reported, investigated and learnt from to prevent future risk of reoccurrence.

If the harm has been caused solely by the external organisation then the incident/event should be recorded as 'no harm' on Circle's governance IT system.

Where an incident/event requires the input of a specialist subject matter expert (SME), the governance IT system will automatically notify the appropriate SME, subject to the appropriate category selection.

8.2
Incident response decision making

8.1.5
Reporting timeframe

Within the first 24 hours post-incident/event identification, the ongoing management of an incident/event requires:

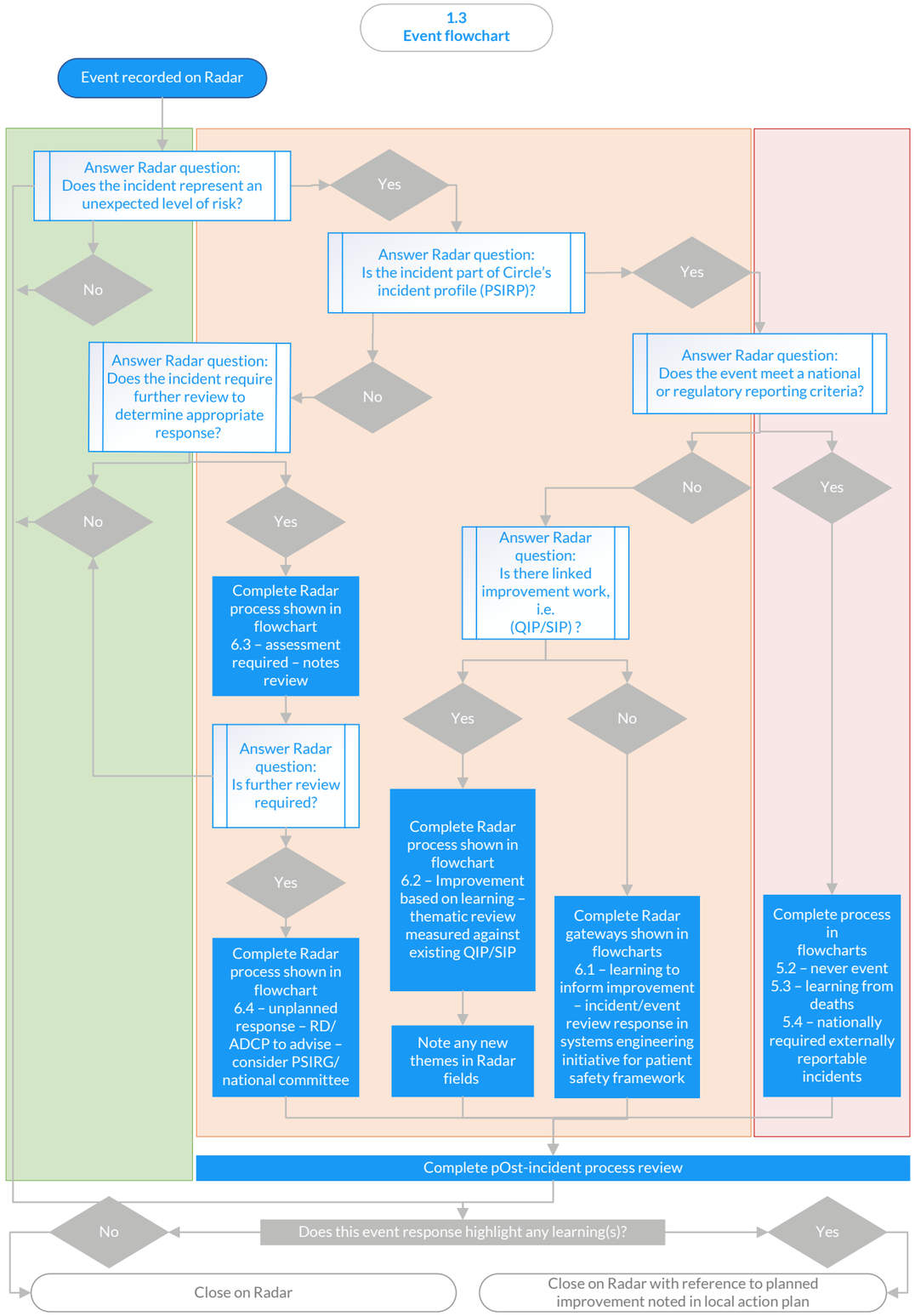
- Reporting of the incident/event on the governance IT system.
- Site triage.

Within the first 72 hours post-incident/event identification, where applicable in the PSIRP, or for consideration of reporting to an external body, the ongoing management of an incident/event requires:

- Regional consideration.

Pre-investigation/learning response approval is from the PSIRG or the equivalent committee.

8.2.1
Patient safety incidents/events – defined in the PSIRF/PSIRP. The flowchart shows the basic process for decision-making. The PSIRP will further inform the type of response required.



8.2.3
Choice of tools

As defined in the PSIRP, there are several tools which can be used for completing and recording the incident/event response. Those chosen for use by Circle are defined below.

8.2.2
The PSIRF incident/event-specific activity is detailed in the PSIRP, which is divided into three overarching categories:

- Learning to inform improvement - where contributory factors are not well understood and no SIPs/QIPs exist.
- Improvements based on learning – where contributory factors are well understood and QIPS/SIP exist.
- Assessment required to determine response – where the learning response required is unclear.

Overarching category	PSIRF Circle tool	Description
Learning to inform improvement: An investigation tool is used and supplemented with tools for capturing everyday work and tools for mapping and synthesising information to understand the required process improvement: Referred to at Section 6.1 of the PSIRP	**Tools for learning to inform improvement - investigation**	
	PSII – full investigation	A PSII is undertaken when an incident/event or near miss indicates significant patient safety risks and potential for new learning.
	Swarm	Can take place immediately after an incident/event. Staff 'swarm' to the site to quickly analyse what happened and how it happened, and decide what needs to be done to reduce risk. Swarms enable insights and reflections to be quickly sought and generate prompt learning.
	Tools for capturing everyday work	
	Incident event review (MDT)	A multidisciplinary (MDT) review, where a wide range of stakeholders share their perspective on 'work as done' in the health or social care system being analysed.
	Tools for mapping and synthesising information gathered	
	System engineering initiative for patient safety (SEIPS)	SEIPS is a framework for understanding outcomes within complex socio-technical systems. SEIPS examines the different components of work systems (person(s), tools and technology, tasks, internal environment, organisation and external environment) and their interactions.
	Post-incident event process review (AAR)	A review of the process of investigation, based on after-action review (AAR) is a method of evaluation that is used when outcomes of the investigative process have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.
Improvements based on learning: referred to at Section 6.2 of the PSIRP	Thematic review	A thematic review can identify patterns in data to help answer questions, show links or identify issues. They are typically used with qualitative data (incident reports and information sourced through interviews etc.)
Assessment required to determine response: referred to at Section 6.3 of the PSIRP	Case record/notes review	Review of incident/event and associated documentation to establish any issue within care or service delivery to inform appropriate investigation/learning response.
Unplanned Response: referred to at Section 6.4 of the PSIRP	Case record/notes review and significant incident brief (SIB)	Review of incident/event and associated documentation to establish any issue within care or service delivery to inform appropriate investigation/learning response. Escalated to the SME/ Area Director of Clinical Performance (ADCP) for the attention of the PSIRG.
Action planning		
Safety action development	Identifying and agreeing those aspects of the work system where change could: • Reduce potential for harm (i.e. 'areas for improvement' or 'system issues'). • Reduce risk of reoccurrence (i.e. safety actions).	

Other tools which can be used as directed by PSIRG	
Observations	Observations help us get a better understanding of 'work as done.'
Walkthrough analysis	Walkthrough analysis is a structured approach to collecting and analysing information about a task or process having 'walked through the steps' with a current representative user to understand everyday 'work as done' and determine any system re-design needs/future development (e.g. designing a new protocol).
Link analysis	Link analysis visualises the frequency of interactions in a specific location or touch points to understand the environment once the common or essential tasks have been described.
Interview tool	An interview contains pre-defined questions and prompts to help support engagement with staff involved in a patient safety incident/event or with patients, families or their carers.
Structured judgement review	Where issues with care or service delivery are identified, the PSIRG will commission a structured judgement review to be completed by a nominated individual.
SHARE debrief	The SHARE debrief tool supports health and social care teams to engage teams and staff who may be affected by the outcome (i.e. safety actions) of a learning response to enable feedback.
AcciMap	The AcciMap approach is a systems-based technique for accident analysis, specifically for analysing the causes of accidents and incidents/events that occur in complex sociotechnical systems. It is similar to the SEIPS model but with a greater focus on external factors.

8.2.4
Non-PSIRF/PSIRP defined incidents/events

There are circumstances where an incident response/investigation needs to take place outside of the definitions in the PSIRF/PSIRP. Such incidents are described at section 8.1.1.

Dependent on their severity, some of these incidents may be reportable to external agencies and regulators, such as:

- The Health and Safety Executive (HSE).
- Environmental Health (EHO).
- The Environment Agency (EA).
- The UK Health Security Agency (UKHSA).
- The Information Commissioner's Office (ICO).
- The Human Fertilisation and Embryology Authority (HEFA).
- The Home Office.

The process for escalation of these incidents, in line with the GAF, is detailed in the PSIRP, in the flowchart at section 5.4.

Where an investigation is required by one of these regulatory bodies, Circle advocates the use of the PSII and SEIPS model. These investigations will be supported by those members of staff who have received accredited PSIRF training and will rely heavily on the input from the local or national SMEs.

8.2.5
Choice of tools

As defined at section 8.2.3, there are several tools which are used for completing an incident investigation, all of which can be used to gain insight into incidents outside of the PSIRF/PSIRP. Where an incident is nationally reportable to a regulatory agency, advice should be sought from that agency, via the relevant SME, regarding the format expected for the recording and sharing of investigation findings.

8.3
Responding to cross system incidents/events/issues

8.3.1
Local system issues

Each clinical site (hospitals and Circle Integrated Care facilities) should engage with their local ICB; the overarching PSIRP can be shared within these organisations.

Any joint investigations should be discussed with the clinical site's senior management team and ICB in the first instance and, where in place, local procedures for joint investigation followed. If appropriate, the activity of the joint investigation should be escalated and discussed at a corporate level by the ADCP and PSIRG.

8.4

Timeframes for learning responses

8.4.1

Investigation/learning response timeframes are outlined below, linked to the event flowchart at section 1.3 of the PSIRP.

Reference flowchart	Incident/event/event descriptor	Closure timeframe
Flowchart 1.3 Event flowchart	An incident/event which does not represent an unexpected level of risk, or require a further review to determine an appropriate response, but will be used for future planning	As soon as is practicable
Flowchart 6.1 Learning to inform improvement	Where the learning response completed	As is practicable, within a 20-working day period
Flowchart 6.2 Improvement based on learning	Where the incident/event requires a thematic review against an existing QIP/SIP	As soon as is practicable, within a 20-working day period
Flowchart 6.3 Assessment required	Following assessment, no further review is required	As soon as is practicable, within a 20-working day period
Flowchart 6.4 Unplanned response	Following assessment further review is required	Defined by PSIRG, not exceeding six months
Flowchart 5.2 Never event	An incident/event meeting the never event criteria	Defined by PSIRG, not exceeding six months
Flowchart 5.3 Death	An incident/event meeting the learning from deaths criteria	Defined by PSIRG, not exceeding six months
Flowchart 5.4 Nationally required externally reportable incidents/events	An incident/event meeting a nationally required externally reportable criteria	Defined by PSIRG or other GAF committee, not exceeding six months

8.5

Safety action development and monitoring improvement

8.5.1.

Actions should not focus on individuals but instead focus on system level issues, including interactions between system elements. Guidance can be found in the NHS document: ***safety action development guide.***

From a Circle perspective, these actions should be inclusive of an assessment of the investigative process identified through the application of the post-event process review. In the spirit of the PSIRF, actions should be developed in a collaborative way and should involve people immediately involved in the incident/event as well as those with additional perspectives including, where appropriate, patients, families, carers and other specialists within the system.

8.5.2

Governance IT system/PSIRG

The governance IT system has fields available for the recording of areas for improvement and incident/event safety actions. These will form part of the site's overarching action plans.

PSIRG will have oversight of the incident/event management process through the allocation and approval of nationally required learning responses, the development of safety actions and the development of themes for inclusion in future patient safety and improvement planning.

8.5.3

Oversight

On completion of the investigation/learning response, the following steps should be followed to ensure completeness of oversight processes:

- Post-investigation/learning response sign-off:
  - Site, including staff involved/affected in/by the incident/event.
  - Patient/family affected by the incident/event.
  - Area.
  - Region.
  - Corporate.
- Data mapping for future planning and inclusion in PSIRP

Local oversight of actions should consist of regular update and escalation through the existing GAF mechanisms.

Corporate oversight of actions will be managed through the quantitative analysis of dashboards and data touch points, as contained in the GAF, and from the more qualitative feedback from learning response and engagement leads.

8.6
Safety improvement plans

8.6.1
Data mapping

Data mapping will be a focussed activity that will inform future safety improvement planning, as detailed in section 3.0 of the PSIRP.

8.6.2
Circle Operating System

As detailed in section 3.3, COS is integral to quality improvement throughout Circle. COS provides a framework for expressing Circle's purpose, principles and values objectively in day-to-day business.

Information gathered through the analysis of Stop the Lines and Swarms, will inform national improvement plans.

National improvement plans will be included in future PSIRPs, as illustrated in section 3.0: defining our patient safety incident profile, and section 4.0: defining our patient safety improvement profile.

9.0
Oversight roles and responsibilities

9.1
When an incident/event is reported onto the governance IT system, the system will generate automatic email notifications for new incidents/events as follows:

- Site senior managers will receive all incidents/events reported within their area of responsibility.
- Designated manager(s) will receive notification of all new incidents/events within their department/location.
- Incidents/events for escalation to those with corporate responsibilities, as shown in the incident escalation organisation chart.
- Specialist teams/individuals may also be automatically notified of an incident/event based on a 'trigger' within the reporting form, e.g.
  - Medicine-related incidents/events - pharmacy team.
  - Health and safety incidents/events - health, safety and environment team.
  - Information governance – Data Protection Officer.
  - Financial incidents – local counter fraud specialist.

9.1.1
It is the responsibility of Circle's specialty teams to ensure they are set up to receive notifications applicable to their role. Specialist leads will not lead the investigation but will provide specialist input, where required, to assist the learning response lead. However, where appropriate, the investigation/learning response can be led by a member of a specialist team where they have the relevant expertise to undertake the investigation/learning response.

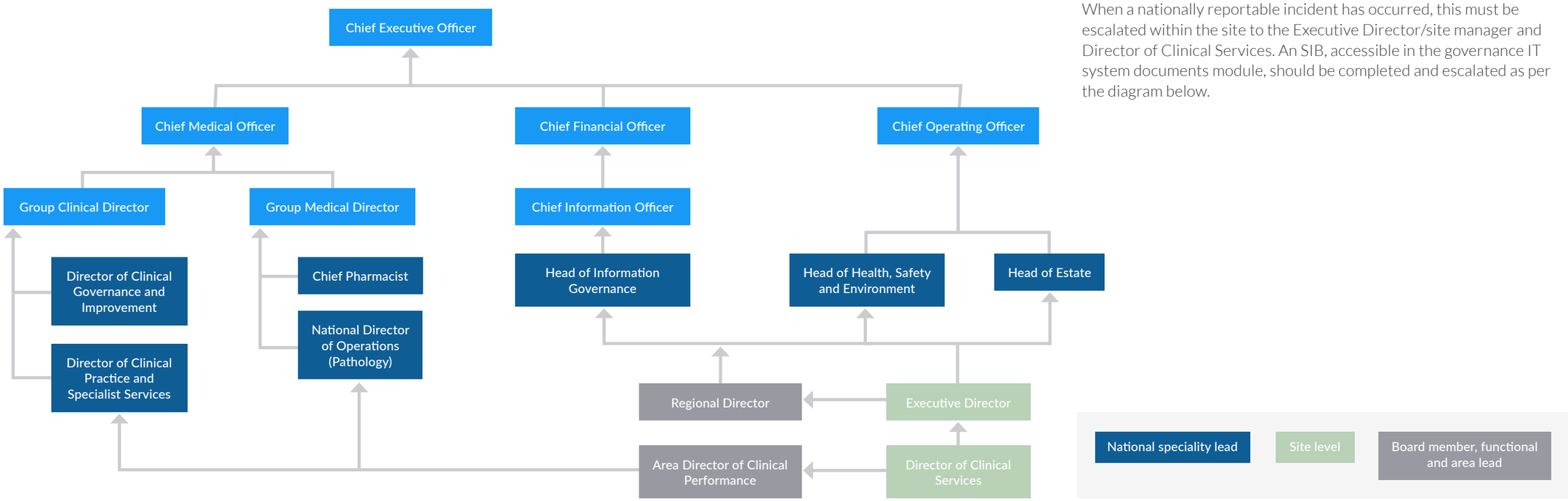
For example, in certain health and safety-related incidents/events, it may be most appropriate for a Health, Safety and Environment Co-ordinator/Lead or, depending on the seriousness of the incident/event, this could be the Regional Health, Safety and Environment Manager or another member of the corporate health, safety and team.

If there is an information governance incident/event, this must be reported on the governance IT system within 24 hours, as per all other incidents/events under the relevant category, and the relevant team will receive notification via the governance IT system.

9.2
Internal escalation of incidents/events in line with the PSIRF

When a nationally reportable incident has occurred, this must be escalated within the site to the Executive Director/site manager and Director of Clinical Services. An SIB, accessible in the governance IT system documents module, should be completed and escalated as per the diagram below.

Incident Escalation Organisation Chart



9.3
Scoping meeting

A scoping meeting is an opportunity for a group to urgently review an incident/event of consequence to assure that all appropriate resource will be deployed and immediate actions are executed with pace and impact. Participants of the meeting will be guided by the type of incident/event but should include both the site and relevant corporate representatives. The purpose of the meeting is to:

- Quickly cascade an understanding of the incident/event.
- Secure support to take all necessary action and ensure appropriate response to the incident/event.
- Agree action and response.
- Determine if there are any associated risks.
- Determine what actions are needed to mitigate any further risks.
- Establish whether there any immediate patient/family/staff or Consultant concerns.
- Assess any support required by colleagues, and who will provide this.
- Decide if the incident/event needs to be reported externally and, if so, to and by whom, e.g. ICB/CQC/HIW/HIS.
- Identify if a learning/regulatory response is required.
- Identify the learning response lead and engagement/duty of candour lead.
- Agree internal and external communications (ICB/CQC/HIW/HIS).

In relation to patient safety incidents, the outcomes of the scoping meeting will be documented on the governance IT system by the Patient Safety Lead or a member of the corporate governance and improvement team.

The Regional Health, Safety and Environment Manager and, where required, additional specialty leads will support this process and advise if the investigation report, once completed, is acceptable. The investigation report will be approved by the Chief Operating Officer or their designated deputy.

Other corporate specialists will advise on the reporting and investigation routes for other types of incidents/events. These outcomes will also be recorded on the governance IT system.

9.4
Reporting incidents/events to external bodies.

Circle has legal and statutory obligations to externally report certain types of incidents/events. These include:

- Deaths thought to be, more likely than not, due to problems in care (incidents/events meeting ***the learning from deaths criteria*** for PSII).
- Incident meeting the ***never events criteria 2018*** or its replacement.

Details of specific reportable criteria can be found in the PSIRP.

Certain health and safety incidents/events must be reported to the HSE under the Reporting of Injuries, Diseases & Dangerous Occurrence Regulations (RIDDOR) 2013, which requires employers to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences.

Not all workplace accidents need to be reported to the HSE under RIDDOR. A RIDDOR report is required only when the accident is work-related ***and*** results in an injury of a type which is reportable.

There are seven different categories of RIDDOR incidents/events and these are:

- Deaths.
- Specified injuries.
- Over seven-day injuries.
- Injuries to people not at work.
- Some work-related diseases.
- Dangerous occurrences.
- Gas incidents/events.

Incidents/events must be reported to the HSE within 10 days of the incident/event occurring. For accidents resulting in the over-seven-day incapacitation of an employee, Circle must notify the enforcing authority within 15 days of the incident/event, using the appropriate online form.

The flowcharts contained in the PSIRP, section 5, detail the external reporting requirements and the individual responsible for undertaking this notification.

All external notification documents must have corporate health, safety and environment team review before they are submitted. Once approved, the appropriate external notifications will be sent by the Registered Manager or deputy, e.g. Director of Clinical Services.

Additional guidance can be accessed via the governance IT system.

10.0
Complaints and appeals

10.1
Circle has well embedded policies and processes to deal with feedback and recognises feedback, including complaints, as an 'early warning of failings in systems and processes which need to be addressed'. Circle's complaints policy is publicly available and aligns to the expectation of third-parties, including the Independent Sector Complaints Adjudication Service (ISCAS), the Parliamentary and Health Service Ombudsman (PHSO), HIS and HIW.

Circle Health Group

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