Rennie Grove Hospice Care | Peace Hospice Care

Rennie Grove Peace

Patient Safety Incident Response Framework (PSIRF) Policy

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Purpose - This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the approach Rennie Grove Peace Hospice Care (RGP) will take to develop and maintain effective systems and processes in responding to patient safety incidents and concerns 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 issue.
- supportive oversight focused on strengthening response system functioning and improvement.

This policy should read in conjunction with our current Patient Safety Incident Response Plan (PSIRP) - RGP-700, which is a separate document setting out how this policy will be implemented.

Scope - This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across RGP.

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.

Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes as those listed below and are therefore outside of the scope this policy.

1. claims handling,
2. human resources investigations into employment concerns,
3. professional standards investigations,
4. information governance concerns
5. estates and facilities concern
6. financial investigations and audits
7. safeguarding concerns
8. coronial inquests and criminal investigations
9. complaints (except where a significant patient safety concern is highlighted)

For clarity, RGP considers these processes as separate from any patient safety investigation. 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.

Acronyms

PSIRF: Patient Safety Incident Response Framework
PSIRP: Patient Safety Incident Response Plan
RGP: Rennie Grove Peace Hospice Care
H&WE ICB: Herts & West Essex Integrated Commissioning Board
BOB ICB: Buckinghamshire, Oxfordshire and Berkshire West Integrated Commissioning Board
PSII: Patient Safety Incident Investigation
PSP: Patient Safety Partners

ICG: Internal Clinical Governance Group
CGC: Clinical Governance Committee
CQC: Care Quality Commission

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Our patient safety culture

In June 2022 RGP was formed to become a new charity after the merger of two existing established organisations, Rennie Grove Hospice Care and Peace Hospice Care. Both organisations had in place a strong focus on patient safety, learning and improvement which is now being strengthened following the merger.

The safety of our patients and service users is paramount to everything we strive to deliver. RGP promotes a positive culture to the reporting of incidents and staff are encouraged and supported to be open and honest about incidents that have or could cause harm to patients, service users and staff. The organisation operates a just culture where fairness, openness and learning are encouraged.

PSIRF will enhance this culture by creating much stronger links between patient safety incidents, learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to achieve learning and improvement within the culture we hope to foster. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight identified when things have gone well and when things have not gone as planned.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame or liability. Our safety culture has also progressed in a positive way with reporting of patient safety incidents improving over time and the introduction of a new incident management system in April 2023 which will simplify internal reporting for staff.

RGP successfully implemented a system of recording accidents and incidents on Vantage to enable speedy reporting and alerting to senior managers and governance leads of any incidents that require immediate attention. Staff are actively encouraged to report all patient safety incidents on Vantage and alert their line manager of any incidents that are rated as medium to high risk so that immediate action can be taken to mitigate further harm.

Monitoring of incidents is undertaken by the governance team in partnership with the clinical leadership team to enable early identification of themes and trends to be actioned and improvements identified. Themes and trends will be reviewed monthly at the Internal Clinical Governance Group to ensure monitoring and scrutiny and provide assurance that appropriate and timely actions are taken when required. The focus is on learning and improvement which is reflected in our Quality Improvement Plan.

RGP Special Interest groups focus on key areas of patient safety, i.e., tissue viability, falls, safeguarding etc and are responsible for actively addressing any concerns raised to improve practice. The role of the Patient Safety Group (PSG) is to seek assurance that safety concerns are being addressed effectively and ensure learning, and improvement is taking place across the organisation. The PSG will also be responsible for instigating and overseeing the process and completion of a Patient Safety Incident Investigation if required.

RGP Clinical Governance Committee is a subcommittee of the board with overall accountability for ensuring RGP is delivering high quality, safe and effective care for the people we serve. The committee

meets quarterly to scrutinise patient safety data and ensure compliance with quality and safety standards.

To enhance our patient safety culture, all incidents are reviewed daily/weekly by the Heads of Service/Assistant Director and Governance Team to ensure early identification of themes and trends so that immediate actions can be taken to mitigate risks if required.

We will also utilise findings from our staff survey metrics based on specific patient (and staff) safety questions and staff feedback including exit interviews to assess if we are sustaining our ongoing progress in improving our safety culture.

RGP is reliant on staff recording incidents and raising concerns about safety as this allows us to deal with issues that affect our patients, carers, staff and volunteers. Staff who feel patient safety concerns are not being addressed through our processes can access the Freedom to Speak up Policy to ensure their concerns are investigated without fear of victimisation, discrimination, or disadvantage. RGP is committed to fostering a culture in which all staff feel safe to raise any concern – a reporting culture is a safe culture.

Patient safety partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England / Improvement to help improve patient safety across the NHS in the UK.

In RGP we have a high number of volunteers who have either been patients or cared for someone who has accessed our services. We are confident that we can enlist carers to join our Patient Safety Group when it is established. Volunteers will offer support alongside our staff, patients, families and carers to influence and improve safety across our range of services. This process offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

PSPs will communicate rational and objective feedback focused on ensuring that patient safety is maintained and improved, this may include attendance at our Internal Clinical Governance meetings, reviewing patient safety, risk and quality and being involved with contributing to documentation including policies, investigations, and reports. This information may be complex, and the PSPs will provide feedback to ensure that patient safety is our priority. As the role evolves, we may ask PSPs to participate in the investigation of patient safety events, assist in the implementation of patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support specific to this new role in collaboration with the patient safety team to ensure PSPs have the essential tools and advice they need.

PSPs will have regular scheduled reviews and regular one-to-one sessions with our Patient Safety Team and training needs will be agreed together based on the experience and knowledge of each PSP.

Addressing health inequalities

RGP recognises the need to reduce inequalities in health by improving access to palliative care services and tailoring our services around the needs of the local population in an inclusive way.

RGP carries out an annual profiling report of people who access our services to ensure we provide accessible services for all those with protected characteristics. This work is further supported by service evaluations as well as active involvement in benchmarking with Hospice UK and our two Integrated Care Boards to ensure the services we provide remain fit for purpose and accessible to all.

RGP is committed to complying with the Equality Act (2010) and will use data intelligently to identify any disproportionate patient safety risk to patients from across the range of protected characteristics and take action. Our incident management system allows us to monitor the demographics of our patients and link them to the SystmOne health record to monitor and analyse protected characteristics which will provide us with themes and trends regarding any emerging inequalities.

Within our patient safety response toolkit, we will directly address any particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

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

RGP endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/service users, carers and families. All staff, including volunteers who work for RGP are monitored to ensure completion of mandatory training in patient safety, delivery of care and compassion, recognising inequalities and meeting the needs of individuals with protected characteristics. RGP will continue to use this approach to implement the system-based approach to patient safety responses which is at the heart of PSIRF best practice.

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.

RGP is firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, service users, their families, or carers to prevent recurrence. We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide. Part of this involves our key principle of being open and honest whenever there is a concern about care not being delivered as planned or expected or when a mistake has been made.

As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident.

RGP Bereavement, Listening and Talking Therapies are available to provide support to families and carers affected by loss. RGP staff can access support and counselling through our Employee Assistance Programme and Occupational Health Services. Clinical staff also have access to a range of reflective supervision, coaching and action learning opportunities.

When a member of the family, carer or a staff personnel informs us that something has gone wrong we will acknowledge their concerns and treat them with compassion and understanding. Aligned with the RGP policy on Duty of Candour, we will use the four steps of engagement framework described below to engage compassionately with those affected by patient safety incidents.

Steps of Engagement

Not all steps of the framework may be required, some steps may need to be repeated and the process may not be as linear as implied. Our approach will be adapted to meet the circumstances of each patient safety incident and the individuals affected. For example, careful consideration must be given to the sequence (including timing in relation to the incident, such as avoiding the anniversary of a death) and complexity of what is being asked of those being engaged and involved, remembering that this can be emotionally demanding for them.

Compassionate engagement and involvement of those affected by patient safety incidents is demanding but incredibly important. Engagement and involvement needs to be tailored to the particular circumstances of a patient safety incident response and to each individual affected, so preparation for initial conversations with those involved is crucial. Further information and guidance are set out in **Appendix 1**.

We recognise that some families, carers may not want to be involved in this process but may wish to access other forms of support that can help those affected by a Patient Safety incident. These resources offer to work with patients, families, and carers to signpost to their preferred source for support and include:

National guidance for NHS trusts engaging with bereaved families.
https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

Learning from deaths – Information for families
https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/ explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Child death support

https://www.childbereavementuk.org/grieving-for-a-child-of-any-age

https://www.lullabytrust.org.uk/bereavement-support/

Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

Complaint's advocacy

https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints.

Healthwatch

https://www.healthwatch.co.uk/ Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters.

You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site.

https://www.healthwatch.co.uk/your-local-healthwatch/list

Parliamentary and Health Service Ombudsman

https://www.ombudsman.org.uk/ makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau

https://www.citizensadvice.org.uk/ provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

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.

RGP will take a proportionate approach when responding to patient safety incidents to ensure the focus is on maximising improvement. We have identified insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our patient safety incident response plan details how this has been achieved as well as how RGP will meet both national and local focus for patient safety incident responses Patient Safety Incident Framework Incident Response Plan.docx

Resources and training to support patient safety incident response

RGP has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to support this approach.

RGP has governance arrangements in place to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

The Head of Governance or a suitably trained senior manager will be the learning response lead. This may depend on the nature and complexity of the incident and response required, but learning responses are led by staff at Band 8a and above or those that have completed suitable training.

RGP will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation and the Patient Safety Lead will support learning responses where possible.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All managers will work within an open and just culture of no blame and ensure staff have access to support services if required.

RGP will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

Training

RGP has implemented a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with NHS England Health Education England Patient Safety Training Syllabus as detailed below:

- *Level one*
- National – Health Education England patient safety syllabus module (Essentials for patient safety)
- All staff, clinical and non-clinical are expected to undertake these on induction and to repeat each module every three years.
- National – Health Education England patient safety syllabus module (Essentials of patient safety for boards and senior leadership teams.
- *Level two*
- National – Health Education England patient safety syllabus module (Access to Practice) – this is to be undertaken by all clinical staff.

All training modules are available as eLearning and completion of modules will be recorded on the organisations blue stream training system.

Learning response leads training and competencies.

- Training
- The learning response lead will be undertaken by the Patient Safety lead for RGP supported by the Head of Governance. Training will consist of two formal days and skills development in learning from patient safety incidents and experience of patient safety response. Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.
- The learning response leads will also complete level one and two of the national patient safety syllabus and be required to undertake appropriate continuous professional development on incident response skills and knowledge.
- Learning response leads will need to contribute to a minimum of two learning responses per year. Records of all learning responses will be maintained by the Governance team.
- Competencies
- RGP expects all staff responsible for leading learning responses to be competent in:

a. Applying human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
b. Summarising and presenting complex information in a clear and logical manner and in report form.
c. Managing conflicting information from different internal and external sources.
d. Communicating highly complex matters, often in difficult situations.

Support for those new to this role will be offered from the Executive Lead for Patient Safety and the Governance team.

Engagement and involvement training and competencies

- Training
  Engagement leads must have completed Level one and two of the national patient safety syllabus.

  Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge.

  Engagement leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Governance Team.

- Competencies
  RGP expects staff who are engagement leads to be able to:

1. Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
2. Listen and hear the distress of others in a measured and supportive way.
3. Maintain clear records of information gathered and contact those affected.
4. Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation.
5. Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

Oversight roles training and competencies

- Training
  The Chief Clinical Officer is the designated Executive Patient Safety Lead for the board and has completed the appropriate modules from the national patient safety syllabus - Level one - essentials of patient safety and essentials of patient safety for boards and senior leadership teams.

  All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

- Competency
  RGP expects the lead with an oversight role to:

1. Demonstrate an inquisitive approach with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
2. Apply human factors and systems thinking principles.
3. Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
4. Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
5. Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
6. Summarise and present complex information in a clear and logical manner and in report form.

Our patient safety incident response plan

Our Patient Safety Incident Response Plan sets out how RGP 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 but acts as a guide to help us focus on patient safety. RGP 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.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our 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

Patient safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incident on Vantage, our incident reporting system. Entries on the system will include recording of the level of harm they know has been experienced by the person affected.

Vantage is monitored by the Governance team and any harm defined as moderate and severe are escalated automatically to the appropriate Assistant Director, Executive lead for patient safety and the governance team for immediate review. This will include consideration and prompting to service teams where Duty of Candour applies. Most incidents will only require local review within the service, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated by the Assistant Director to the Governance Team for monitoring and ensuring improvement is implemented. (Appendix 2. / Patient safety incident response decision-making).

The Governance Team and Patient Safety Executive Lead will highlight to the Patient Safety Group any incident which appears to meet the requirement for reporting externally. This enables RGP to work in a transparent and collaborative way with our ICB or local NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

The Governance team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for RGP.

Patient safety incident response decision-making

RGP will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan.

PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. RGP has developed its own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work. In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our response to other patient safety incidents.

We have established a process for our response to incidents which allows for a clear “Floor to Board’ set of mechanisms allowing oversight of incident management and our PSIRF response.

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

The Patient Safety Group and the internal Clinical Governance Group will have delegated responsibility for the consideration of incidents for PSII and for oversight of the outcomes of such reviews to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required.

The Clinical Governance Committee will have overall oversight of such processes and will challenge decision making of the Patient Safety Group and Internal Clinical Governance Group to ensure the Board are assured that the true intent of PSIRF is being implemented within RGP and we are meeting the national patient safety incident response standards.

Any incident highlighted will follow the process outlined below which can be seen in diagram form in **Appendix 2**.

Local level incidents – Assistant Directors, Heads Of and other managers of service areas must have arrangements in place to ensure that incidents can be reported and responded to within their area. Incident responses should include immediate actions taken to ensure safety of patients, public and staff, as well the measures needed to mitigate a problem until further review is possible. This may include for example, withdrawing equipment or monitoring a procedure. Any response to an incident should be fed back to those involved or affected and appropriate support offered. Where Duty of Candour applies this must be carried out according to RGP guidance.

Incidents with positive or unclear potential for PSII – all staff (directly or through their line manager) must ensure notification of incidents that may require a higher level of response as soon as practicable after the event through internal escalation processes (including out of hours). Duty of Candour disclosure should take place according to RGP guidance. Where it is clear that a PSII is required (for example, for a Never Event) the Assistant Director should notify the Executive Lead for Patient Safety immediately to ensure the incident is shared with the executive team and the Governance Team. A rapid review will be undertaken by the Assistant Director & Patient Safety Lead to inform decision making at the Patient Safety Group.

Other incidents with unclear potential for PSII, must also be reported to the Patient Safety Group and Governance Team. Decision making with regard to escalation to the Clinical Governance Committee can be considered by the Patient Safety Group. A rapid review will be undertaken by the Assistant Director and Patient Safety Lead to inform this decision making. Significant incidents which may require consideration for ad-hoc PSII due to an unexpected level of risk and/or potential for learning should be included in this category.

RGP Patient Safety Group will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), any mitigation identified by the rapid review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met. The Patient Safety group will define terms of reference for a PSII to be undertaken by an appropriate member of the Patient Safety team. The group will also designate subject matter expert input required for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared.

Specific staff who have undertaken the essentials of patient safety training will be released from their regular role to be actively involved in PSI investigations under the direct supervision of the Patient Safety Lead. As PSIRF is a new process, it is difficult to clarify the resource and commitment required but RGP will ensure that sufficient expertise and resource is made available to undertake any such investigations.

Incidents not requiring PSII - Where an incident does not meet the requirement for PSII, the Patient Safety Group may request a further investigative review or closure of the incident at a local level, with due consideration of any Duty of Candour requirement being met. The Patient Safety group will also indicate how immediate learning is to be shared.

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

The Patient Safety Group will have arrangements in place to record safety actions arising from any further investigations requested and ensure learning is used to inform potential safety improvement plans.

The Patient Safety Group will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the CQC according to accepted reporting requirements. Whilst this will include some incidents escalated as PSII, the Patient Safety Group will work with the Assistant Directors/Senior managers to ensure that any incidents meeting external reporting needs are appropriately escalated.

Patient Safety Group

RGP will establish and maintain a clinical Executive-led Patient Safety Group to oversee the operation and decision-making of all incident responses. This group will support the final sign off process for all PSIIs and report outcomes to the Internal Clinical Governance Group and the Clinical Governance Committee. Through this mechanism the Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety and improvement profile within the organisation.

The Patient Safety Lead and staff who have worked on the PSII will provide a report to the Patient Safety Group following completion of the investigation. Learning and Improvements will be identified and agreed by the Patient Safety Group and a robust action plan will be developed to ensure learning and improvement is embedded.

The investigation and action plan will be presented to the Internal Clinical Governance Group who are accountable for seeking assurance that outcomes to improve patient and service user care are achieved.

Responding to cross-system incidents/issue

The Governance team or Assistant Director will forward incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety

team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

RGP 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. The Governance team will act as the liaison point and will have supportive operating procedures to ensure that this is effectively managed.

RGP will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

Timeframes for learning responses

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No local PSII should take longer than six months.

The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) RGP can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the Patient Safety Group and Executive Lead.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between RGP and those affected.

Timescales for other forms of learning response

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete.

Safety action development and monitoring improvement

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

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

Learning response should not describe recommendations as this can lead to premature attempts to devise a solution. Safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from the Executive Patient Safety Lead, Patient Safety Group and the Governance Team.

Safety Action development

RGP will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

1. Agree areas for improvement – specify where improvement is needed, without defining solutions
2. Define the context – this will allow agreement on the approach to be taken to safety action development
3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved
4. Prioritise safety actions to decide on testing for implementation
5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics
6. Safety actions will be clearly written and follow SMART principles and have a designated owner

Safety Action Monitoring

Safety actions must continue to be monitored within the governance arrangements to ensure that any actions put in place remain impactful and sustainable. Reporting on the progress with safety actions

including the outcomes of any measurements will be made to the Patient Safety Group with overview by the Internal Clinical Governance Group.

For some safety actions with wider significance, this may require oversight by the Clinical Governance Committee which reports directly to the Board.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. RGP has several overarching safety improvement plans in place which are adapted to respond to the outcomes of quality improvement efforts and other external influences such as national safety improvement programmes.

RGP patient safety incident response plan has outlined the local priorities for the focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

RGP will use the outcomes from existing patient safety incident reviews where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work. The Assistant Directors, Senior Managers and Governance team will work collaboratively with the Patient Safety Group to ensure there is an aligned approach to the development of plans and resultant improvement efforts.

Where overarching systems issues are identified by learning responses outside of RGP, a safety improvement plan will be developed. These will be identified through governance processes and reported to the Patient Safety Group who may recommend a safety improvement plan. The Assistant Directors, Senior Managers and Governance team will work collaboratively with the Patient Safety Group to ensure there is an aligned approach to development of the plan and clear improvement efforts.

Monitoring of progress with regard to safety improvement plans will be overseen by the Patient Safety Group and reporting to the Internal Clinical Governance Group on a monthly basis.

Oversight roles and responsibilities

Principles of oversight

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

RGP follows the ‘mindset’ principles to underpin the processes we have put in place to allow us to implement PSIRF as set out in the supporting document (NHS England (2022).

Responsibilities

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission and the Charity Commission, we have specific organisational responsibilities with the Framework including a robust process in place to notify the CQC of all serious patient safety incidents.

To meet these responsibilities, RGP has designated the Chief Clinical Officer to support PSIRF as the Patient Safety Executive Lead whose duties include:

1. *Ensuring the organisation meets the national patient safety standards.*

The Executive Lead will oversee the development, review and approval of RGP's policy and plan ensuring they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the restorative just working culture that RGP aspires to achieve.

To define its patient safety and safety improvement profile, RGP will carry out a thorough review of available patient safety incident insight and engagement with internal and external stakeholders.

2. *Ensuring that PSIRF is central to overarching safety governance arrangements.*

RGP Board will receive assurance regarding the implementation of PSIRF and associated standards via the Clinical Governance Committee. Quarterly reporting to the board will ensure the Trust Board has a formative and continuous understanding of organisational safety and any PSII investigations.

The Patient Safety Group and Internal Clinical Governance Group will provide assurance to the Clinical Governance Committee that PSIRF and related workstreams have been implemented to the highest standards. Assistant Directors and Service Managers will be expected to report on their patient safety incident learning responses and outcomes. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.

Assistant Directors and Service Managers will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

RGP will source appropriate expertise, when necessary, from across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years, alongside a review of all safety actions.

3. *Quality assuring learning response outputs.*

RGP will implement a central Patient Safety Group to ensure that PSIIs are conducted to the highest standards and to support the executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed.

Complaints and appeals

RGP recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided.

It is important to understand that there is a distinction made between complaints and concerns as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process.

The first point of contact is with the Assistant Director or Service Manager who will support the resolution of any concerns raised. It is important to address any issue raised at the earliest opportunity to reduce the risk of escalation and increase the possibility of finding a satisfactory resolution to the problem. It may be more appropriate to deal with and resolve in a more immediate and timely manner as long as this is with the agreement of the person raising the concern.

Complaints are defined as expressions of dissatisfaction from a patient, service user, their family or carer, a person acting as their representative, or any person who is affected or likely to be affected by the action, omission or decision of RGP staff. Complaints will be investigated according to RGP Complaints & Concerns policy, and all complainants are offered a formal response.

RGP is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

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

Complaints can be valuable aids in developing and maintaining standards of care and lessons learnt can be used positively to improve services.

Outcomes and recommendations from a complaint will be shared with the services to ensure that changes can be considered and implemented where appropriate.

Equality Impact Assessment

a. The Hospice aims to design and implement services, policies, procedures, and measures that meet the diverse needs of their service, population, and workforce, ensuring that none are placed at a disadvantage over others. The Equality Assessment tool is designed to help staff consider the needs and assess the impact of the policy in this light.

b. Appropriate adjustments will be made to accommodate individual communications needs.

		Yes/No	Comments
1.	**Does the policy/procedure/guidance affect one group less or more favourably than another based on:**	No	
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment, and mental health problems	No	
	Marriage & Civil partnership	No	
	Pregnancy & maternity	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/procedure/guidance likely to be negative?**	N/a	
	If so, can the impact be avoided?	N/a	
5.	**What alternatives are there to achieving the policy/procedure/guidance without the impact?**	N/a	

6.	**Can we reduce the impact by taking different action?**	N/a	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Department Director together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact the HR Team.

Appendix 1

Compassionate engagement and involvement of those affected by patient safety incidents is demanding but incredibly important. Engagement and involvement need to be tailored to the particular circumstances of a patient safety incident response and to each individual affected, therefore preparation for initial conversations with those involved is crucial. Set out below are the key steps to consider when engaging with patients, families, carers and those affected by a patient safety incident.

1. Apologies are meaningful

Apologies need to demonstrate understanding of the potential impact of the incident on those involved, and a commitment to address their questions and concerns. Ideally, an apology communicates a sense of accountability for the harm experienced, but not responsibility for it ahead of investigation. Getting an apology right is important – it sets the tone for everything that follows. Apologising is also a crucial part of the Duty of Candour.

2. Approach is individualised

Engagement and involvement should be flexible and adapted to the individual and changing needs. These needs could be practical, physical, or emotional. Engagement leads should recognise that every response might need to be different, based on an understanding of the different needs and circumstances of those affected by an incident.

3. Timing is sensitive

Some people can feel they are being engaged and involved too slowly or too quickly, or at insensitive times. Engagement leads need to talk to those affected about the timing and structure of engagement and involvement, and any key dates to avoid (e.g., birthdays, funeral dates, anniversaries), particularly where someone has lost a loved one.

4. Those affected are treated with respect and compassion

Everyone involved in a learning response should be treated respectfully. There should be a duty of care to everyone involved in the patient safety incident and subsequent response, and opportunities provided for open communication and support through the process. Overlooking the relational elements of a learning response can lead to a breakdown of trust between those involved (including patients, families, and healthcare staff) and the organisation.

5. Guidance and clarity are provided

Patients, families, and healthcare staff can find the processes that follow a patient safety incident confusing. Those outside the health service, and even some within it, may not know what a patient safety incident is, why the incident they were involved in is being investigated or what the learning response entails. Patients, families, and healthcare staff can feel powerless and ill-equipped for the processes following a patient safety incident. Therefore, all communications and materials need to clearly describe the process and its purpose, and not assume any prior understanding.

6. Those affected are 'heard'.

Everyone affected by a patient safety incident should have the opportunity to be listened to and share their experience. They will all have their individual perspective on what happened and each one is valid in building a comprehensive picture to support learning. Importantly, the opportunity to be listened to is also part of restoring trust and repairing relationships between organisations and staff, patients, and families.

7. Approach is collaborative and open

An investigation process that is collaborative and open with information, and provides answers, can reduce the chance litigation will be used as a route for being heard. The decision to litigate is a difficult one. Organisations must not assume that litigation is always about establishing blame – some feel it is the only way to get answers to their questions.

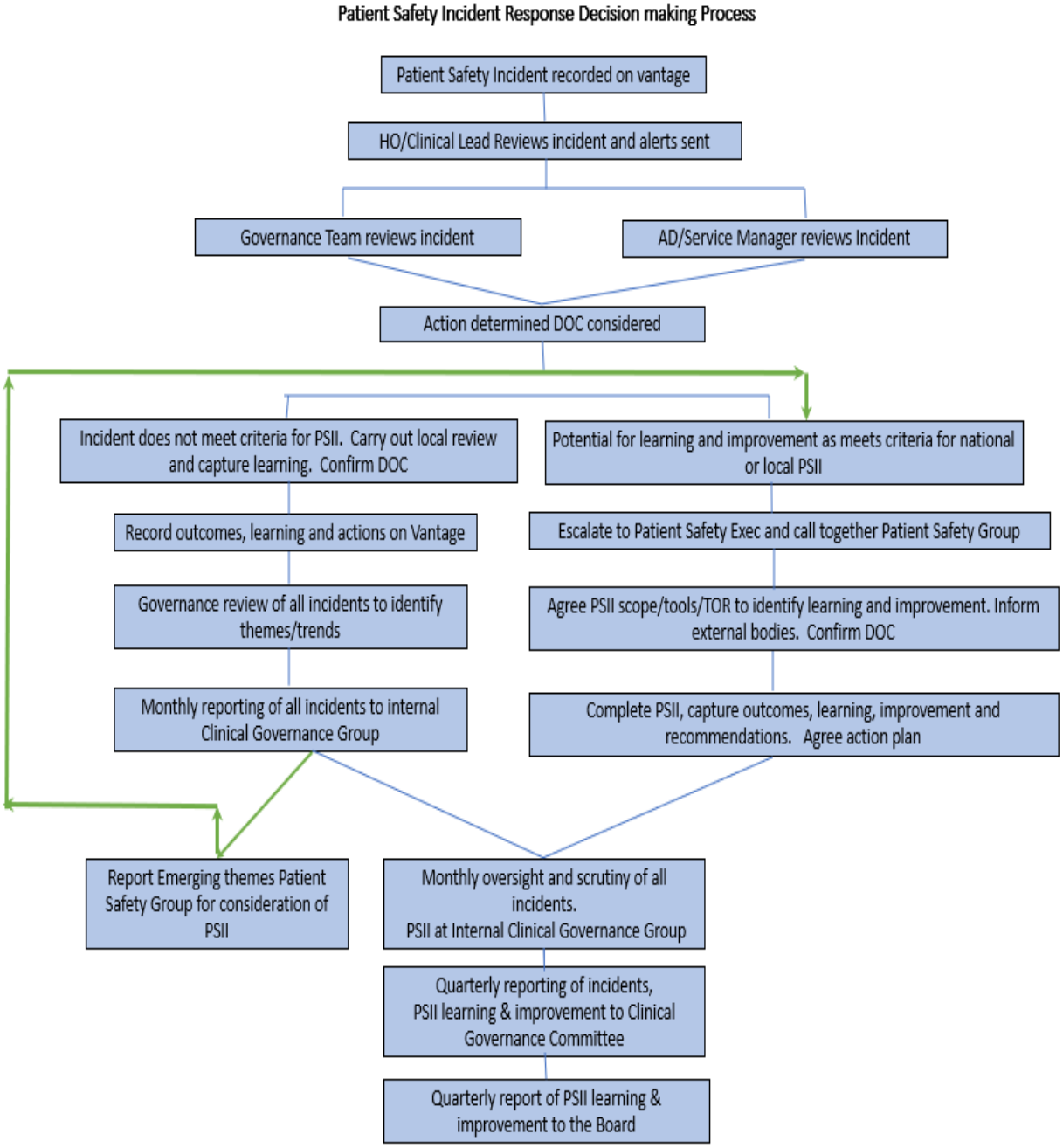
8. Subjectivity is accepted

Everyone will experience the same incident in different ways. No one truth should be prioritised over others. Engagement leads should ensure that patients, families, and healthcare staff are all viewed as credible sources of information in response to a patient.

9. Strive for equity

The opportunity for learning should be weighed against the needs of those affected by the incident. Engagement leads need to understand and seek information on the impact of how they choose response types on those affected by incidents and be aware of the risk of introducing inequity into the process of safety responses. safety incident.

Appendix 2


Patient Safety Incident Response Decision making Process
Patient Safety Incident recorded on vantage
HO/Clinical Lead Reviews incident and alerts sent
Governance Team reviews incident
AD/Service Manager reviews Incident
Action determined DOC considered
Incident does not meet criteria for PSII. Carry out local review and capture learning. Confirm DOC
Potential for learning and improvement as meets criteria for national or local PSII
Record outcomes, learning and actions on Vantage
Escalate to Patient Safety Exec and call together Patient Safety Group
Governance review of all incidents to identify themes/trends
Agree PSII scope/tools/TOR to identify learning and improvement. Inform external bodies. Confirm DOC
Monthly reporting of all incidents to internal Clinical Governance Group
Complete PSII, capture outcomes, learning, improvement and recommendations. Agree action plan
Report Emerging themes Patient Safety Group for consideration of PSII
Monthly oversight and scrutiny of all incidents.
PSII at Internal Clinical Governance Group
Quarterly reporting of incidents, PSII learning & improvement to Clinical Governance Committee
Quarterly report of PSII learning & improvement to the Board

Change Control			
Version	**Date of Change**	**Author**	**Brief Description of updates**
0.65	07 February 2024	Tricia Wren	New Document