Patient Safety Incident Response Framework (PSIRF)	

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Owner	**HoCC&E /QIP**

Authored by: R Wilson **Authorised by: Board of Trustees** **Date: 23/9/24**
Review through: Quality & Governance Committee

Evidence Base/ References

Patient Safety Incident Response Framework
https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

NHSE and NHS Improvement patient safety strategy
https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

NHSE Learning From Patient Safety Events (LFPSE)
https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/learn-from-patient-safety-events-service/

NHSE Framework for involving patients in patient safety
https://www.england.nhs.uk/patient-safety/patient-safety-involvement/framework-for-involving-patients-in-patient-safety/

NHSE Engaging and involving patients, families and staff following a patient safety incident.
https://www.england.nhs.uk/publication/framework-for-involving-patients-in-patient-safety/

NHSE guide to responding proportionately to patient safety incidents
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1-FINAL.pdf

NHSE Oversight roles and responsibilities specification
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf

NHSE Safety action development
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Hospice UK Innovations Hub
https://www.hospiceuk.org/innovation-hub/support-for-your-role/examples-of-innovation/transitioning-psirf

NHSE Patient Safety Incident Response Standards
https://www.england.nhs.uk/long-read/patient-safety-incident-response-standards/

St Clare Hospice PSIRF Plan and Policy

Farleigh Hospice PSIRF Plan and Policy

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1. PURPOSE

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out St Mary's Hospice (SMH) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

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

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

This policy should read in conjunction with our current patient safety incident response plan, which is a separate document setting out how this policy will be implemented.

2. SCOPE

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

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. Therefore, these processes as listed below are outside of the scope this policy.

• claims handling,
• human resources investigations into employment concerns,
• professional standards investigations,
• information governance concerns
• estates and facilities concern
• financial investigations and audits
• safeguarding concerns
• coronial inquests and criminal investigations
• complaints (except where a significant patient safety concern is highlighted)

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.

Learning response methods are used to support learning and improvement in relation to patient safety incident types through Vantage, the incident management tool, which is used to effectively record, manage and report SMH incidents. These are reported via the Clinical Governance Group to the Quality and Governance Committee and Board. Other non-patient safety incidents are also recorded within Vantage to collate trends and themed analysis to the Quality and Governance Committee and Board.

3. PATIENT SAFETY CULTURE

SMH as an organisation promotes a culture of maintained and improved safety by acting on and collating datasets, which include, but are not limited to:

- Complaints and compliments
- Freedom to Speak up reports
- Safeguarding cases
- Mortality/case reviews
- Staff survey results
- NHS Learning from Patient Safety Events data
- Risk Assessments
- Data from quality surveillance process
- Inequalities data

SMH is committed to:

- Promoting a fair, open, inclusive and just culture that promotes the belief that incidents cannot simply be linked to the actions of individuals but also focuses on the system in which they were working in order to learn lessons.
- Openness in the handling of patient safety incidents and the application of the Duty of Candour Policy.
- Learning from Incidents
- Disseminating the findings from Incident investigations across the organisation for the purpose of learning and improving safety

4. PATIENT SAFETY PARTNERS

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve safety across healthcare in the UK, including small providers such as SMH. This is part of the new Patient Safety Incident (Event) Response Framework (PSIRF).

At SMH we are committed to offering safe services, we welcome PSPs to work alongside our people (staff), those using our services, and population to influence and improve safety across our services. PSPs can be people, carers, family members or other lay people (including NHS and Social Care staff from another organisation).

PSPs offer a different perspective on safety, one that is not influenced by organisational bias or historical systems, providing insight from a different perspective on safety.

Further development of PSP working with SMH is underway.

5. ADDRESSING HEALTH INEQUALITIES

SMH explore and respond to issues related to health inequalities as part of the development and maintenance of our patient safety incident response plan and policy. Data captured includes age, ethnicity, gender and long-term conditions of those people sharing feedback. The tools we use to respond to patient safety incidents prompt consideration of inequalities, including when developing safety actions.

SMH are starting to use the Hospice UK PopNAT tool to provide more understanding of population and health within our catchment area.

We engage and involve patients, family and staff following a patient safety incident with consideration of their different needs. (See Duty of Candour policy). We uphold a system-based approach (not a 'person focused' approach) and ensure staff have the relevant training and skill development to support this approach as detailed in this policy. This supports the development of a just culture.

Equality and diversity and Learning Disability and Autism training are part of our mandatory training.

All SMH policies are screened for the impact of equality as standard.

6. ENGAGING AND INVOLVING PATIENTS, FAMILIES AND STAFF FOLLOWING A PATIENT SAFETY INCIDENT

Engagement principles
Nine principles inform the design of SMH's systems and processes for engaging and involving those affected by patient safety incidents. Due to the range of incidents that can occur, and the different needs of individuals affected, the principles are be flexibly applied when engaging with or involving those affected by patient safety incidents in an investigation

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 adapt to 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 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 people, families, and healthcare staff) and the organisation.

5. **Guidance and clarity are provided**: People, families, and healthcare staff can find the processes that follow a safety incident confusing. Those outside the health service, and even some within it, may not know what a safety incident is, why the incident they were involved in is being investigated or what the learning response entails. People, families, and healthcare staff can feel powerless and ill-equipped for the processes following a 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 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, people, 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 people, families, and healthcare staff are all viewed as credible sources of information in response to a safety incident.

9. **Strive for equity**: Organisations may differ from people, families, and healthcare staff in what they consider is the appropriate response to a safety incident. 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 events and be aware of the risk of introducing inequity into the process of safety responses.

SMH consider PSIRF guidance in line with the following guidance.
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

The PSIRF recognises that learning and improvement following a safety event 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 people, 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.
Engagement and level of involvement will be in keeping with the wishes of those affected as far as possible, using the four steps of engagement process. (Appendix 1)

Managers and/or leaders should demonstrate their commitment to compassionate engagement and

involvement in their words and actions. Engagement and involvement must be communicated as a genuine priority and not a formality.

When the expectations of those affected are not met, families and staff will be given meaningful, truthful and clear explanations as to why this was not possible. People and families will be offered the opportunity to complain in line with St Mary's Hospice complaints procedure. If the complainant is in agreement, the complaint analysis and individual safety incident analysis will be combined together so that the individual/family get all the answers they are seeking.

<u>Supporting families and staff</u>
Families and staff will be signposted for support during engagement or involvement in a learning response. Sources of support for families will include St Mary's Family Bereavement Support Service together with external bereavement and mental health services as well as independent advocacy services.

Staff are also able to access support from their manager and occupational health service.

<u>Working with system partners</u>
The Hospice will engage with partners organisations that provide care to the individual(s) involved where that care may have played a role in the incident being examined e.g. Districts Nurses, GPs

We will work together and co-operate with any learning responses that crosses organisational boundaries.

<u>Duty of Candour</u>
St Mary's Hospice believes that the organisation and its staff should be open and candid about any and all events involving the health, safety and clinical care of individuals. Being Open is part of a 'no blame' culture, which is striven for at SMH, and this culture is fundamental to learning.

The hospice recognises that as part of Care Quality Commission Regulations, it is a requirement to ensure that people and/or their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences. An individual affected by an incident should be notified (their nominated significant other if capacity concerns, or at request of the person) at the earliest opportunity.

CQC clearly identifies within Regulation 20:

- The duty of candour is a general duty to be open and transparent with people receiving care from you.
- It applies to every health and social care provider that CQC regulates.
- The duty of candour requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines 'notifiable safety events' and specifies how registered persons must apply the duty of candour if these events occur

7. PATIENT SAFETY INCIDENT RESPONSE PLANNING

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement. 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.

8. RESOURCES AND TRAINING TO SUPPORT SAFETY INCIDENT RESPONSE

The Hospice 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 allow for this to happen.

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 our just culture principles and will have processes in place to ensure psychological safety.

The hospice 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
All staff and trustees are required to complete the Patient Safety Syllabus Training - Essentials of Patient Safety on E-Learning for health. All Senior Management Team and Trustees should also complete Patient Safety Syllabus Training – Essentials of patient safety for boards and SLT.

All staff will receive training in accordance with NHS England Health Education England Patient Safety Training as below:

- Patient Safety Syllabus Level 1 (Essentials of Patient Safety) – All Staff and Trustees
- Patient Safety Syllabus Level 2 (Access to Practice) – All Clinical Staff, CEO, Facilities and QIP
- Patient Safety Syllabus - Essentials of individual safety for Boards and Senior Leadership Teams -Senior Management Team and Trustees
- System approach to learning – Learning Response Lead
- Involving those affected by patient safety incidents – Engagement lead
- VANTAGE incident reporting – All staff

Competencies
As a hospice we would expect those in Learning Response Lead and Engagement Lead roles are able to:

<u>Learning Response Lead</u>

- Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
- Summarise and present complex information in a clear and logical manner and in report form.
- Manage conflicting information from different internal and external sources.
- Communicate highly complex matters and in difficult situations.
- Support for those in this role will be offered from the CEO and ICB Patient Safety Team.

<u>Engagement Lead</u>

- Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
- Listen and hear the distress of others in a measured and supportive way.
- Maintain clear records of information gathered and contact those affected.
- 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.
- Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

9. OUR PATIENT SAFETY INCIDENT PLAN

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.

The Hospice will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify 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 will detail current arrangement and future plans for patient safety investigations, including the benchmarking of SMH data with that of Hospice UK.

Our plan sets out how St Mary's Hospice intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

10. REVIEWING OUR 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.

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.

11. SAFETY INCIDENT REPORTING ARRANGEMENTS

All staff are responsible for reporting any potential or actual patient safety incident via our electronic internal reporting system, 'Vantage'.

All reported patient safety incidents will be monitored daily by the Quality Improvement Practitioner (QIP) and Vantage Administrators to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to teams where Duty of Candour applies. Most incidents will only require local review by the Clinical Governance Group however for some, where it is felt that the opportunity for learning and improvement is significant, or meets the criteria for a Notifiable Incident these should also be reported through The Learning from Patient Safety Events (LFPSE) portal and be considered for a Patient Safety Incident Investigation (PSII).

The QIP will highlight to the Clinical Governance Group any incident which appears to meet the requirement for reporting externally. This may be to allow the hospice to work in a transparent and collaborative way with our ICB or Care Quality Commission if an incident meets the national criteria for PSII or if supportive coordination of a cross system learning response is required.
The QIP will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the hospice.

12. PATIENT SAFETY INCIDENT RESPONSE DECISION-MAKING

PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. SMH 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 toolkit for responding to other patient safety incidents.

We have established a process for our response to incidents which allows for a clear set of mechanisms allowing for oversight of incident management and our PSIRF response. See Appendix 2.

The Clinical Governance Group will have 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 Quality and Clinical Governance Committee will have overall oversight of such processes and will challenge decision making of the Clinical Governance Group to ensure that the Board can be assured that the true intent of PSIRF is being implemented within our organisation 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 our Safety Plan.

<u>Local level incidents</u> – managers of all clinical areas must have arrangements in place to ensure that

incidents can be reported and responded to. Incident responses should include immediate actions taken to ensure safety of patients, public and staff, as well as indication of any measures needed to mitigate a problem until further review is possible. This may include for example, withdrawing equipment or monitoring response. 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 hospice guidance in SMH's Duty of Candour policy.

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 by reporting on Vantage and informing a senior manager. Duty of Candour disclosure should take place according to hospice guidance. Where it is clear that a PSII is required (for example, for a Never Event) the assigned investigator for the raised incident should notify the QIP, HoCC&E and CEO as soon as practicable so that the incident can be shared with the Clinical Governance Team.

A rapid review will be undertaken by the assigned investigator to inform decision making at the Clinical Governance Group and onward escalation following this.
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.

The Clinical Governance Group will meet to discuss the nature of any PSII response incident, any immediate learning (which should be shared to LFPSE), 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 group with support from ICB Patient Safety Team will define terms of reference for a PSII to be undertaken by the response lead. 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.

Where an incident does not meet the requirement for PSII, investigations will be undertaken in accordance with patient safety response plan. The Clinical Governance 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 Clinical Governance Group will also indicate how immediate learning is to be shared.

The Clinical Governance Group will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the Care Quality Commission according to accepted reporting requirements. Whilst this will include some incidents escalated as PSII, the Clinical Governance Group will work together to put in place effective processes that will ensure any incidents requiring external reporting are appropriately escalated.

Quality and Clinical Governance Committee
The Quality and Clinical Governance Committee will oversee the operation and decision-making of the Clinical Governance Group. This will support the final sign off process for all PSIIs. 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 hospice.

13. RESPONDING TO CROSS-SYSTEM INCIDENTS/ISSUES

The Clinical Governance Group will oversee that those incidents identified as presenting potential for significant learning and improvement for another provider will communicate directly with that organisation's patient safety team or equivalent.
The hospice will work with partner providers and the ICB to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The QIP will act as liaison between organisations.

The hospice will defer to the ICB Patient Safety Team 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.

14. 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 setting of 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) the hospice 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 HoCC&E or CEO. In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the hospice and those affected.

Other forms of learning responses (non PSII) must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one month of their start date. No learning response should take longer than six months to complete. Again, timeframe decisions should include input from those affected by the incident.

15. SAFETY ACTION DEVELOPMENT AND MONITORING IMPROVEMENT

The hospice 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 – focused 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 actions must continue to be monitored within governance arrangements to ensure that any actions put in place remain impactful and sustainable. Reporting on the progress of safety actions including the outcomes of any measurements will be made to the Clinical Governance Group. For some safety actions with wider significance, this may require oversight by members of Quality and Clinical Governance Committee.

The hospice will use the outcomes from 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. Monitoring of progress regarding safety improvement plans will be overseen by reporting from the Clinical Governance Group and Hospice Special Interest Teams (SITs) to Quality and Clinical Governance Committee.

16. 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.

The hospice followed 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), p 3).

Responsibilities

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission, we have specific organisational responsibilities with the Framework.

To meet these responsibilities, the hospice has designated the Head of Clinical Care & Education (HoCC&E) to support PSIRF as the executive lead.

1. Ensuring that the organisation meets the national patient safety standards -
The HoCC&E will oversee the development, review and approval of the hospice's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the just working culture that the hospice aspires to.

To define its patient safety and safety improvement profile, the hospice will undertake 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 - The Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Quality and Clinical Governance Committee.
The Committee's quarterly reporting will comprise oversight question responses to ensure that the Board has a formative and continuous understanding of organisational safety.

The Clinical Governance Group will provide assurance to the Quality and Clinical Governance Committee that PSIRF and related work streams have been implemented to the highest standards. Clinical Governance Group will be expected to report on 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.

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 three years to comply with hospice guidance on policy development, alongside a review of all safety actions.

17. COMPLAINTS AND APPEALS

SMH Complaints policy should be referred to if complaint is received in regard to our response to a patient safety incident.

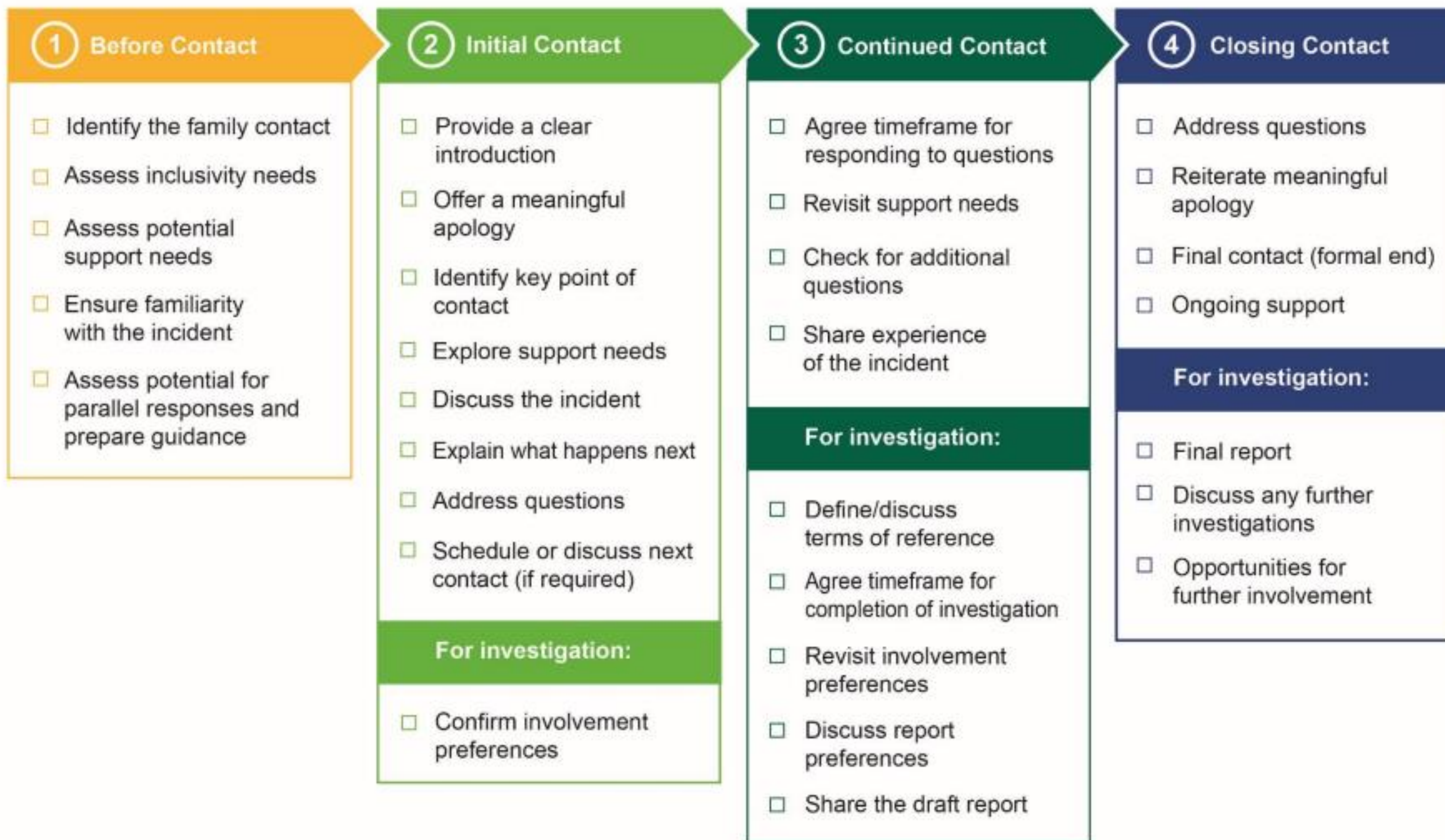
Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints 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.

Complaints can be sent to :

FAO Head of Clinical Care & Education
St Mary's Hospice,
Ulverston,
Cumbria,
LA12 7JP

APPENDIX 1 – Four Steps of Engagement



APPENDIX 2 - SMH Incident and Learning Response model

Incident reported on Vantage

Assigned Investigator

Investigator begins fact finding

Planned response by Investigator

Reviewed in Clinical Governance/Incidents Group
Determine if external reporting required eg. LFPSE/ICB/CQC

If no further action, close.
Any local learning to be cascaded to teams and reviewed if appropriate for improvement.

Potential learning improvements Nationally/PSII etc.

Review at Quality & Clinical Governance Committee

Report/Escalate, with National priorities / Risk / LFPSE

Review by HoCC&E, CEO, QIP and ICB for oversight of actions

APPENDIX 3: EQUALITY IMPACT ASSESSMENT

Identify the aims of the Policy, Standard or Service

What is the main purpose and scope of the policy / function / service being introduced or significantly changes. Who is intended to benefit and how?
To provide information on SMH's PSIRF processes and framework for all staff and general public.
What could possibly prevent the successful outcome to this Policy, Standard or Service?
Not being agreed by ICB and non compliance with framework.

Assessment of Impact

What consultation with stakeholders (protected characteristic group), including patient groups, have been carried out?
None
If none, specify the arrangements that need to be made to collect the relevant information
Review with Patient Safety Partners

Taking into account this information, indicate below whether the Policy, Standard or Service may have an intended or unintended impact – be that positive or negative – on any of the Hospice's stakeholders / protected groups.

Where the Policy, Standard or Service is not relevant to a particular group or has no potential impact. Indicate as neutral. Give reason for each outcome:

	Negative Impact	Positive Impact	Neutral Impact	Reason / Comments
Age			*	
Disability – Including physical, sensory or mental			*	
Gender – including trans* and issues relating to pregnancy and maternity			*	
Race / Ethnicity			*	
Religion or Belief			*	
Sexual Orientation – including issues relating to marriage and civil partnerships			*	

Are there any concerns about other minority populations (e.g. travellers, single parents, those on low income/homeless etc.) who may be disadvantaged by the Policy or service operation, or who may receive unequal treatment?
None identified.
If negative impact has been identified, can it be justified on the grounds of promoting equality of opportunity for one protected characteristic group? Or for any other reason?
No negative impacts identified.

Does the Policy, Standard or Service directly/indirectly discriminate against any section of the community?

YES		NO	X	Comment	

What future actions need to be taken to meet the needs and overcome barriers of the groups identified; or to create confidence that the Policy or Service and its' implementation is not discriminatory against any group?			
What?	**By Whom?**	**By When?**	**Resources required**

Date EIA Completed	26.8.24

VERSION CONTROL

Version Number	Author	Date	Changes