PATIENT SAFETY INCIDENT RESPONSE POLICY

Introduction

The NHS PSIRF was launched in 2022, to be fully implemented by autumn 2023. It is a contractual requirement for the hospice and replaces the Serious Incident Framework 2015.

The hospice engaged with Suffolk and North East Essex ICB regarding its requirements for PSIRF Implementation. In view of the numbers of incidents reported annually, it was agreed a shorter concise incident response plan will be created alongside this policy.

Contents

Purpose

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

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

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

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

NHS England's Patient Safety Incident Response Framework (PSIRF).

Scope

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

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL-1.pdf

Included policies are:

- Duty of Candour
- Drug Incident policy
- Complaints and feedback
- Statutory Notifications to the CQC
- Adverse Medical and Drug alerts
- Incident reporting
- Whistleblowing
- Freedom to Speak Up
- Governance Framework

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Governance Framework signed off 11 Jan 2024.docx.pdf

Our patient safety culture

The hospice is open and honest, when things go wrong with care. In this regard, the hospice will follow the requirements for Duty of Candour which applies to notifiable patient safety incidents. A notifiable patient safety incident is an incident which is unintended or unexpected and in the reasonable opinion of a healthcare

professional, already has, or might result in death, or severe or moderate harm to the person receiving care. The requirements for Duty of Candour include a verbal and written apology, providing an update on enquiries. For the other incidents the hospice will ensure it is open with patients and families about what has happened, irrespective of the seriousness of the incident.

There is a strong culture to report all concerns and incidents, including near misses. We benchmark incidents with other hospices and report concerns as needed to the Trustees, Accountable Officer for controlled drugs, the CQC, and commissioners for transparency and learning.

The Quality, Improvement and Assurance group meet monthly. There is an audit/survey diary. This includes:-

- Inpatient Unit
- Drugs
- Community patient relatives
- Staff surveys
- Community patients
- Pressure ulcers
- Falls
- Acquired infections
- Patient Incidents
- User feedback
- Complaints and compliments
- Discharges
- Education/training
- Onecall advice line
- Bereavement
- Infection control
- Care, diet and nutrition
- Safeguarding
- Acupuncture
- Young adults service- Zest
  Medical audits, eg Corticosteroid use, Methadone prescribing, Antimicrobial stewardship etc

Patient surveys, complaints and incidents are reported through the Governance process which is Trustee led. We are active members of the LIN (Local intelligence Network), ECCH (East Coast Community Healthcare) joint governance meetings and IES Alliance Quality group.

There is a Whistleblowing policy and Speak up Guardian. The hospice uses an external organisation for staff surveys and are about to switch to Vantage software, to strengthen the reporting and management of incidents within the hospice.

The hospice collaborates on service improvements at all levels in the ICB (Integrated Care Board), chairing the Palliative and end of life group and will consider using this group for collaborative feedback on patient safety related incidents as needed.

The hospice will use the NHS Just Culture guide to treat staff involved in a patient safety incident in a consistent constructive and fair way. We support a culture of fairness, openness and learning by making staff feel confident to speak up when things go wrong rather than fearing blame.

Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

> "Families would benefit from understanding how the Just culture guide works. Often families call for accountability and think they are asking 'who' is responsible, but my experience is they really want to know 'what happened and why'. This would help them on their journey after the avoidable death of a loved one."
>
> **Joanne Hughes, NHS Improvement patient and public representative and founder of mothers instinct**
> https://www.england.nhs.uk/patient-safety/a-just-culture-guide/

Patient safety partners

The NHS Patient Safety Strategy (July 2019) recognises the importance of involving patients, their families and carers and other lay people in improving the safety of NHS care, as well as the role that patients and carers can have as partners in their own safety.

To work with hospice engagement group re: co-production

To ensure that patient safety is maintained and improved, the hospice will continue to review and discuss patient safety incidents at:

- Quality Assurance & Improvement Group
- Quality Assurance of Drugs
- Care & Clinical Governance Committee
- Staff meetings
- Multi disciplinary meetings
- By looking into thematic incidents / reviews

Together, with the wider hospice multidisciplinary team, we will undertake thematic reviews of incidents ie falls, near misses and pressure ulcers in order to try to identify patterns in data to help answer questions. This will include involving patients and their families in the process for their feedback.

An MDT approach will support teams to learn from patient safety incidents that have occurred.

Addressing health inequalities

Hospice People and Culture team looking into an Equality Impact Assessment tool to ensure the governance process minimises impact and addresses the need to improve access. Looks at practice and policy.

St Elizabeth Hospice recognises that we have a role to play in helping to reduce inequalities in health in palliative care by improving access to services around the need of our local population in an inclusive way. Under the Equality Act (2010) we will assess for any disproportionate patient safety risks across the range of protected characteristics to ensure nobody is disadvantaged.

Reasonable adjustments tool to be used for individuals for example, if a person with learning disabilities can't read or see safety signs, this will outline what we will put in place to ensure this person is aware and remains safe.

We will have representation at LeDeR panel meetings (Learning Disabilities Mortality Reviews)

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.

The hospice engage across the organisation as much as possible with the Hospice Engagement group, who represents the interest of service users and diversity.

St Elizabeth Hospice Co-production Framework

Definition
"A meeting of minds coming together to find a shared solution. The approach is built on the principle that those who use a service are best placed to help design it. It means aspiring to being equal partners and co-creators."

(Adapted with people in Suffolk in 2019, inspired by the National Coproduction Advisory Group, Think Local Act Personal.)

Key principles

- Upholding the value of shared decision-making-'Nothing about me, without me'
- Co-production engages groups of people in equal partnership at the earliest stages of service design, development and evaluation.
- People with 'lived experience' are often best placed to advise on what support and services will make a positive difference. This is known as Experience- based co-design.
- All contributions are equal. It is important to have diverse representation, from those who use/have used services and those who understand the wider community
- Barriers to inclusive participation should be addressed EG accessibility, expenses, reasonable adjustments.
- All participants should be willing to explore and negotiate different ways forward. It is important to avoid pre-conceived outcomes.
- There are different levels of co-production. The level employed should be overtly recognised and identified during projects. (See ladder below).
- Effective co-production takes time. Realistic pace and project timescales are essential.
- Evidencing 'We said, we did' is essential to ensure the value, time and resources involved are justified

There are many opportunities for staff and volunteers to share views and any concerns, across the hospice, including staff surveys, 1;1 and team meetings and having availability of the senior managers and People and Culture team,

The hospice states in its complaints and service user feedback procedure that
'all feedback will be welcomed and encouraged. Those making a complaint will be supported and listened to, not disadvantaged and treated with courtesy and empathy'.

Duty of Candour – duty of candour is required for notifiable patient safety incidents: that is those that are unintended or unexpected, have occurred during the provision of an activity the CQC regulate and in the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care.

Our values are;
- One Team, one community
- Learning never ends
- Compassion takes courage
- Every moment matters

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. St Elizabeth Hospice will take a proportionate approach in its response to patient safety incidents to ensure that the focus is on maximising improvement. The details will be expanded on in our PSIRF plan.

For better understanding of issues and causal factors, we will engage with patients, families and carers using a system based approach.

Examples of patient safety incidents which will be investigated are:

- Any incident involving a patient
- Pressure ulcers
- Medication incidents
- A near miss incident which has potential to cause injury or damage
- Acts of violence or aggression which may lead to patient harm
- Incorrect clinical procedures
- Ill health ie allergy

Where necessary, some incidents may require review or referral to another body or team, for example, Learning Disability Mortality Review Programme (LeDeR), Safeguarding.

A PSII (Patient Safety Incident Investigation) is required where an incident meets a national priority.

These include incidents, such as Never Events and deaths thought more than likely than not due to problems in care (that is, those meeting the Learning from Deaths criteria for investigation). A PSII is required to be logged on the Strategic Executive Information System (StEIS), which will be replaced by the Learning From Patient Safety Events System (LFPSE). The ICB will be notified when a PSII is commissioned.

We will carry out thematic reviews of incidents, such as near miss incidents in order to be proactive and anticipate potential harmful incidents.

Resources and training to support patient safety incident response

Head of Patient Safety/Patient Safety Specialist will be the hospice contact if an incident is to be shared with the SNEE ICB.

The Director of Patient services and Governance Lead of the Hospice will advise and monitor and investigate incidents and complaints as needed.

They will have the following training;

Patient, family and staff involvement in learning from patient safety incidents	1 day
A Systems Approach to Learning from Patient Safety Incidents- Oversight Training	1 day
Systems approach to Patient Safety Incident Investigations	2 days

Further Actions;

- Review of all relevant to PSIRF policies
- Introduction and raising awareness of PSIRF across the hospice
- Further training to be identified for investigators

Our patient safety incident response plan

Our plan sets out how St Elizabeth 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. We will share draft plans with system partners as needed and the ICB.

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

A PSII is required when an incident meets the national criteria or for any local priorities where the agreed response is a PSII as set out in the incident response plan. A PSII may also be commissioned for any unexpected incidents of significant harm. The Clinical Governance Lead / Director of Patient Services will be required to inform the ICB Head of Patient Safety / Patient Safety Specialist so that the incident can be raised on St. Elizabeth Hospice.

Patient safety incident response decision-making

St Elizabeth Hospice has set out a plan that outlines how the hospice will respond to incidents (please refer to PSIRF plan). Where a significant incident is reported, for example, either a near miss which could have caused lasting harm or an incident of moderate or greater harm, this will be reviewed internally for a decision on the most proportionate response, following the Hospice Incident Response Plan. St Elizabeth Hospice Director of Patient Services or Governance Lead will discuss any significant incidents with the ICB for sharing, support and advice regarding the most proportionate investigation response.

Responding to cross-system incidents/issues

On occasions, St Elizabeth Hospice may be required to meet with other partners to discuss and learn from an incident which may not necessarily be our incident investigation to lead on. However, the hospice may have played a part in that patient's journey and so we will be willing to have a cross system approach in order to achieve the best, co-ordinated learning outcome.

Timeframes for learning responses

If a PSII is required, we will aim to complete this within 1 - 3 months (no longer than 6 months). We will liaise with family on a regular basis including any changes to the timeframes of an investigation.

Safety improvement plans

Actions from surveys, audits, complaints, incidents and other feedback are entered on to an Action plan. This is discussed and reviewed at the Quality Improvement Group and any concerns, trends and reportable incidents are escalated to the Trustees at the Care & Clinical Governance Committee and Governance & Oversight Committee. There is a particular attention to trends, improvement and rises.

The Board of Trustees, along with the Senior Management team, receives a monthly Data Dashboard which includes staffing sickness, recruitment, patient activity as well as complaints and incidents, which helps build a wider picture.

DOCUMENT HISTORY:

Revision	Effective date	Description	Author	Approved	Ratified	Review date
	Nov 23	New Policy	Sharon Cave – Clinical Governance Lead	Verity Jolly – Director of Patient Services	Board of Trustees Nov 2023	Nov 2025