Royal Hospital for Neuro-disability
A national medical charity

Patient safety incident response policy

Effective date: 12 July 2023

Estimated refresh date: 12 January 2024 subject to continuous review and amendment for at least the first 6 months.

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Introduction

The National Health Service (NHS) and independent care service providers provide effective health care to millions of people every year. Although the majority of people are treated safely and effectively there is a risk associated with each treatment/procedure and evidence shows that things will and do go wrong, leading to some people being harmed. It is recognised good practice for care providers to identify and report incidents which occur in services within a nationally agreed reporting framework to ensure that learning and improvement takes place.

A patient safety incident is any unplanned or unintended event or circumstance that could have resulted or did result in harm to a patient. A staff related incident is referred to as a work-related event(s) in which an injury or ill health (regardless of severity) or fatality occurred, or could have occurred. Similar non-work related incidents can occur involving visitors to the hospital. A near-miss is an incident where no injury or illness occurs. Therefore, an incident can be either an accident or a near-miss.

The Royal Hospital for Neuro-disability (the RHN) provides specialist neuro-rehabilitation and continueing care services for people with complex disabilities from all over the UK. As an independent provider of predominantly NHS commissioned services the RHN has a duty to report, investigate and manage incidents through procedures aligned with national requirements.

The aim of this policy is to support staff to navigate the system of incident reporting, incident investigation and associated learning takes place across the RHN.

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the Royal Hospital for Neuro-disability's (RHN) 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.

Scope

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

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.

- claims handling,
- Workforce related investigations into employment concerns (such as competence and performance issues),
- professional standards investigations,
- information governance concerns
- financial investigations and audits
- safeguarding concerns
- coronial inquests and criminal investigations

For clarity, the RHN considers these processes as separate from any patient safety investigation / response. 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.

Our patient safety culture

The RHN is committed to improve patient safety through the adoption of the PSIRF, supporting a systematic, compassionate and proficient response to patient safety incidents; embedded in the principles of Just Culture (openness, honesty and fair accountability), shared learning and continuous improvement.

A fair and 'just culture' approach to incident reporting and responding is encouraged at RHN. This ensures an approach to errors that will contribute to a learning environment. 'A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution …… Generally, in a just culture inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture, investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However, a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts' (Gov.uk, 2018).

In line with Duty of Candour/Being Open patients, residents and/or their families must be informed of the incident and guided through the RHN complaints/concerns process in the event that they want to raise any concerns.

Our overall purpose is to improve the health, wellbeing and independence of all patients and residents. It is a priority of the RHN to deliver care in a safe environment to protect patients, residents, visitors, staff and the organisation from harm.

In line with the NHS Patient Safety Strategy (2019), patient safety is about maximising the things that go right and minimising the things that go wrong. While patient safety incidents are rare, the RHN prioritises compassionate engagement with patients, family and staff affected by them. This provides vital insight into how to improve care, ultimately making services safer for our patients and residents.

The RHN senior leadership have strongly embraced this work and with support from staff side colleagues have been instrumental in establishing the organisational transition to a restorative just culture. In the wake of an incident, restorative practices ask who are impacted, what their needs are and whose obligation it is to meet those needs. Restorative practices aim to involve participants from the entire community in the resolution and repair of harms to create a sustainable just, restorative culture. We ensure that our conduct and our dealings with colleagues is honest, kind and emphasise that we are willing to learn. We have developed a culture where we support patients / residents, family members, advocates and staff involved in an incident and

encourage openness and honesty. The main goals of restoration when an incident has occurred have been outlined as follows:

- Moral engagement
- Emotional healing
- Reintegration of the practitioner
- Organisational learning
- Prevention

PSIRF will enhance the links we have embedded between patient safety incidents and continuous learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients / residents, families, and advocates to arrive at such learning and improvement within the just culture. This will continue to ensure transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well as well as where 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, liability or define avoid-ability or cause of death.

To enhance our safety culture, we have a strong system of shared learning throughout the organisation. Learning is shared weekly to all staff. Learning is shared from all types of incidents regardless of severity, including learning from complaints, feedback and safeguarding investigations. At ward level, staff huddles are carried out 2-3 times each week where shared learning, ideas for improvement, quality improvement projects and celebrations/successes are discussed.

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. Although, as an independent sector organisation the RHN is not specifically required to recruit PSPs we aim to embrace all aspects of the National Patient Safety Strategy and recruit to this role. We already have a large group of patients, residents and family members involved in the drafting and implementation of our Patients and Residents Experience and Engagement Strategy, as well as

being involved in other improvement activities across the organisation. We may be able to source our PSPs from this group.

Following a review of our Patient Representative Committee members' roles we aim to recruit 2 PSPs by the end of 2023 and this is an action on our longer term PSIRF implementation plan.

This exciting new role across the NHS will evolve over time and at the RHN the main purpose of the role will be to be a voice for the patients and residents who utilise our services and ensure that patient safety is at the forefront of all that we do.

PSPs will communicate rational and objective feedback focused on ensuring that patient safety is maintained and improved. This may include attendance at 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 will also ask PSPs to participate patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support specific to the role.

The PSPs will be supported in their honorary role by the Patient Safety Specialist for the RHN who will provide expectations and guidance for the role.

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

The PSP placements are on an honorary basis and will be reviewed after one year to ensure we keep the role aligned to the patient safety agenda as this develops.

Addressing health inequalities

The RHN recognises that health services have a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the population in an inclusive way.

The RHN as an independent charitable organisation is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.

Within our patient safety response toolkit, we will directly address if there are any particular features of an incident that 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.

We will also address apparent health inequalities as part of our safety improvement work. In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future versions of our patient safety incident response plan and this policy. We consider this as an integral part of the future development process.

Engagement of patients, residents, families and staff following a patient safety incident is critical to the review of patient safety incidents and their response. We will ensure that we use available tools such as easy read, talking mats, 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 responses.

The RHN's commitment to transforming organisational culture to that of restorative justice has been outlined. Further to this, the RHN has affirmed that it endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/residents, families and advocates. With explicit role modelling led by the Board of Governors and Executive Management Team, we will use these principles to underpin patient safety training and 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.

We are 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 for our patients/residents, their families, or advocates to prevent recurrence and promote learning.

We recognise and acknowledge the significant impact patient safety incidents can have on patients/residents, their families, or advocates.

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 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/residents, their families, or advocates because it is the right thing to do. This is regardless of the level of harm caused by an incident. Thus, at the RHN it has become the norm for patients/residents, their families, or advocates to be informed when an incident affecting their care has occurred and to discuss with them the findings of investigation.

As part of our new policy framework, we will be outlining procedures that support patients, families, and carers – based on our existing Being Open and Duty of Candour Policy.

In addition, at the RHN we have a Patient Experience & Safety Officer (PESO) as part of the Patient Safety & Quality Assurance team who provides support for patients/residents, their families, or advocates in raising concerns and providing feedback in relation to care and service. Anyone with a concern, comment, complaint or compliment about care or any aspect of the RHN's services are encouraged to speak up.

We recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with patients/residents, their families, or advocates to signpost to their preferred source for this:

- **Healthwatch:** Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters. https://www.healthwatch.co.uk/
- **Parliamentary and Health Service Ombudsman (PHSO)**: The PHSO makes the final decisions on complaints patients/residents, their families, or advocates deem not to have been resolved fairly by the NHS in England, government departments and other public organisations. For patients and residents who's care is NHS funded stage 3 complaints are handled by the PHSO. In the first instance mediation is preferred, but if resolution via mediation is not reached they will consider completing a full investigation. https://www.ombudsman.org.uk/
- **Citizens Advice Bureau (CAB):** The CAB provides UK citizens with information about healthcare rights, including how to make a complaint about care received. https://www.citizensadvice.org.uk/

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.

The RHN 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 responses and our existing safety improvement work streams. 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 how this has been achieved as well as how the RHN will meet both national and local focus for patient safety incident responses.

Resources and training to support patient safety incident response

The RHN 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.

The RHN will have governance arrangements in place to ensure that learning responses are not led by staff who were involved in the patient safety incident itself.

Responsibility for designating leadership of any learning response sits within the Patient Safety & Quality Assurance Team in liaising with senior leaders across the hospital. A learning response lead will be nominated and the individual should have an appropriate level of experience and training to respond to an incident. This may also depend on the nature and complexity of the incident and response required, but learning responses are led by staff at Band 6 and above. Although national guidance states that learning response leads should be Band 8a or above the RHN is a small organisation with limited resources, and so it is accepted practice that Band 6 and 7 will be trained to complete local incident responses.

The RHN will have governance arrangements in place to ensure that where possible learning responses for more complex cases are not undertaken by staff working in isolation. The Patient Safety & Quality Assurance team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given opportunity to participate in learning responses. All RHN managers will work within our just and restorative culture principles and utilise other services such as Health and Wellbeing to ensure that there is a dedicated staff resource to support them. The RHN will have processes in place to ensure that managers work within this framework to ensure psychological safety.

The RHN will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process.

Training

The RHN 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 the NHS England Health Education England Patient Safety Training Syllabus as follows:

- Induction training by the Patient Safety & Quality Assurance Team: This comprises local training at induction for all new staff, setting out the RHN's expectations of staff for reporting and responding to incidents, including an outline of staff responsibility for Duty of Candour and PSIRF.
- Level 1 Essentials for Patient Safety: This is an e-learning module that all staff are required to complete every 3 years.
- Level 1 Essentials of Patient Safety for Trustees and the Executive Management Team: This is provided face to face by the RHN Patient Safety Specialist.
- Level 2 Access to Practice: This is an e-learning module that managers and staff at Band 6 or above, with potential to support or lead patient safety incident management. They are required to complete training every 3 years (except Trustees and non-clinical members of the Executive Management Team).
- Lot 4a Learning Response Leads PSIRF training. Staff with the potential to lead patient safety incident responses and investigations are required to complete training over 2 days. Training is currently sourced externally. Learning response leads will need to contribute to a minimum of two learning responses per year. They will be trained to:
    - 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.
    - Review conflicting information from different internal and external sources.
- Duty of Candour: This is an e-learning module and all staff are expected to complete it every 2 years.
- Lot 4b Engaging With and Involving Those Affected By a Patient Safety Incident. Staff with a role to support those affected by patient safety incidents attend a 3 hour training course, currently externally sourced. Engagement leads are expected to:
    - 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 contact with those affected by patient safety incidents.
- Lot 4c Oversight training: All those with an oversight role in relation to PSIRF will complete this training of 6 hours duration. staff with oversight roles will be able to:
    - Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
    - Apply human factors and systems thinking principles.

- Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
- Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
- 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).
- Summarise and present complex information in a clear and logical manner and in report form.

Our patient safety incident response plan

Our plan sets out how the RHN 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.

A copy of our current plan can be found on the RHN Intranet: https://data.rhn.org.uk/userselfservice/policy

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 may change over time. 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, deep dive thematic reviews, quality improvement projects, formal complaints and incident 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 the RHN incident reporting system (Datix) and will record the level of harm they assess has been experienced by the person affected (see Appendix A).

Local managers ensure that patient safety incidents are responded to proportionately and in a timely fashion. This should include consideration where Duty of Candour may apply (following the RHN Being Open & Duty of Candour Policy & Procedure). 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 appropriately (see Patient safety incident response decision-making below).

The Patient Safety & Quality Assurance team will escalate any incident which appears to meet the requirement for reporting externally. This may be to allow the RHN to work in a transparent and collaborative way with our ICB and/or regional NHS teams, CQC and the Charity Commission if an incident meets the national criteria for PSII or if supportive co-ordination of a cross-system learning response is required.

The Patient Safety & Quality Assurance team will act as liaison with external bodies and system partner providers to ensure effective communication via a single point of contact for the RHN.

Patient safety incident response decision-making

The RHN 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 PSIRP.

PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. The RHN has adapted its governance structure under the Serious Incident Framework to support PSIRF.

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

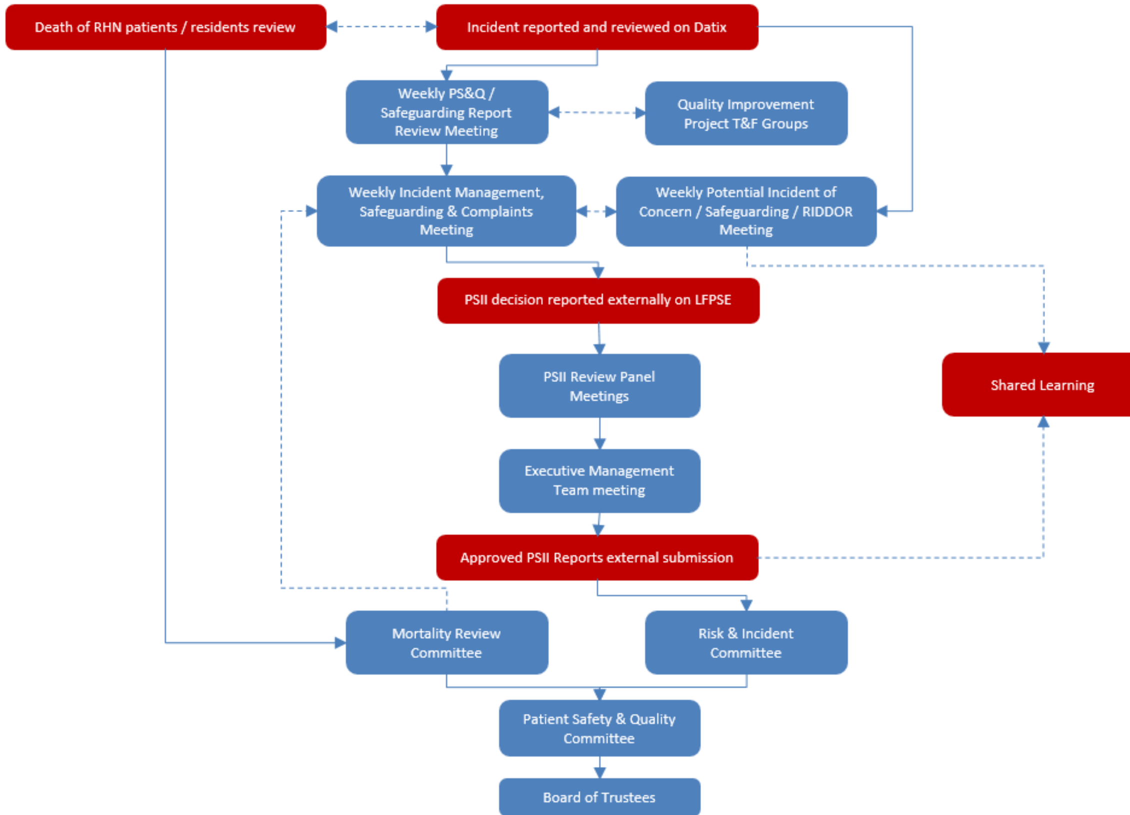

Chart 1: RHN PSIRF Governance Structure

MEETING / PROCESS	MEETING PURPOSE / PROCESS DESCRIPTION
Incident reported and reviewed on Datix	• Incidents are reported on Datix by staff online. • PS&QA, Safeguarding, senior nursing, EMT and some senior managers receive email notifications of all incidents reported. • Other managers receive email notifications of incidents that occur in their area of responsibility. • All incidents are reviewed and escalated as appropriate by the PS&QA team. Investigators are assigned to each incident. • Potential incidents of concern, that may require a more in-depth investigation, are requested for 24-hour reports to be completed for discussion at the next available weekly Incident Management, Safeguarding & Complaint Meeting. • Potential Safeguarding referrals are escalated by/to the Safeguarding team.
Death of RHN patients / residents review	• The Head of PS&QA, other managers and EMT are notified by email of all deaths of RHN patients, whether they have died at the RHN or in Acute Care. • The Head of PS&QA notifies the CQC of all deaths. • As part of the notification process the Head of PS&QA reviews the patient's EPR to determine whether there are any potential issues that need further review/escalation. • The Head of PS&QA also receives a mortality matrix completed by a doctor or GP within 24-hours of the death. This may also identify potential concerns for review. • Incidents leading up to a death may also be reported on Datix for further review. • Any potential concerns are firstly discussed with the patient's clinical team for clarification. Potential incidents of concern will be reviewed via the 24-hour report and weekly Incident Management, Safeguarding & Complaint Meeting process.

MEETING / PROCESS		MEETING PURPOSE / PROCESS DESCRIPTION

Weekly PS&Q / Safeguarding Report Meeting	Quality Improvement Project T&F Groups	Weekly PSQ/Safeguarding Report meeting:
		• Led by the Head of PS&QA and Head of Safeguarding.
		• Attended by the Director of Nursing, Director of Service Delivery, Director of Governance, Head of Therapy Services and Head of Service.
		• Weekly report is submitted to EMT for their update.
		• Weekly report includes:
		  • PSQA section update on open/closed/overdue incidents, PSIIs, formal complaints, requests for information from the CQC or Charity Commission, Quality Account, quality improvement projects, Patient Experience Strategy, PSIRF implementation.
		  • Safeguarding section update on potential and ongoing safeguarding referrals, training compliance, safeguarding business.
		
		Quality Improvement Task & Finish Groups:
		• Meet monthly, in general, to discuss progress on QI project and update action plan.
		• Action plans are submitted to EMT weekly for their update.

MEETING / PROCESS		MEETING PURPOSE / PROCESS DESCRIPTION

Weekly Incident Management, Safeguarding & Complaints Meeting	Weekly Potential Incidents of Concern / Safeguarding / RIDDOR Meeting	Weekly Incident Management, Safeguarding & Complaints Meeting:
		• Chaired and led by the Head of PS&QA.
		• Co-chaired by a clinical member of EMT (Director of Nursing, Medical Director and/or Director of Service Delivery)
		• All staff are welcome to attend.
		• Those not able to attend receive meeting papers to read outside of the meeting.
		• At the meeting staff receive a weekly update on:
		  • Formal complaints, informal concerns, compliments.
		  • Safeguarding activity
		  • PSIIs, open/overdue incidents awaiting investigation, actions for closing.
		  • 24-hour reports for discussion and decision as to their most appropriate method of investigation. Those that are agreed for reporting as PSIIs are externally reported on LFPSE and 24-hour/72-hour reports are submitted to SW London ICB, NHSE, funding ICB, CQC and Charity Commission (the Charity Commission is notified of only serious incidents that are also referred to the Local Authority as Safeguarding concerns).
		
		Weekly Potential Incident of Concern / Safeguarding / RIDDOR Meeting:
		• Chaired and administered by the Head of PS&QA.
		• Attended by Senior Nursing team, TVN, Head of Safeguarding, Risk Manager.
		• At the meeting there is:
		  • A review of all incidents reported the previous week to agree their most appropriate method of investigation.
		  • Methods of investigation may include PSII, trend analysis, quality improvement project, After Action Review.
		  • This includes a triage of all potential incidents of concern, safeguarding concerns, RIDDOR reportable incidents.
		  • A review of the Tissue Viability Tracker to identify any pressure damage acquired/deteriorated at the RHN and determine if further investigation is required.
		  • A review of open actions from previous meetings.
		  • A review of all incidents closed the previous week to identify incidents for shared learning.

MEETING / PROCESS	MEETING PURPOSE / PROCESS DESCRIPTION
PSII declared and reported externally on LFPSE	• After a 24-hour report has been discussed at the weekly Incident of Concern/Safeguarding & Complaint meeting, those agreed for investigating as PSIIs are externally reported on LFPSE. • The 24-hour and 72-hour reports are submitted to SW London ICB, NHSE, funding ICB, CQC and Charity Commission (the Charity Commission is notified of only PSIIs that are also referred to the Local Authority as Safeguarding concerns). • The Duty of Candour / Being Open process is followed as appropriate (DoC for moderate harm and higher; being open for low/no harm). • The investigation process takes approximately 60 working days but is negotiated with the patient or family affected depending on complexity.
PSII Review Panel Meetings	• Draft PSII investigation reports are tabled for an MDT review approximately 10-15 working days before final submission externally. • PSII panel meetings are arranged and chaired by the Head of PS&QA. • They are attended by the lead investigator, investigation team, a clinical member of EMT, any other relevant staff. • The patient and/or family may be invited to attend. • Representatives from SW London ICB, NHSE, CQC and the funding ICB are invited to attend. • The lead investigator will present the investigation report, its main findings, recommendations, learning and proposed actions. • There is a discussion in relation to the investigation to identify any areas requiring clarity, any gaps in the investigation or report, and to agree the proposed action plan. • The meeting closes with a summary of any agreed actions and/or amendments to the report. • Once finalised the investigation report is submitted to EMT for final internal approval.

MEETING / PROCESS	MEETING PURPOSE / PROCESS DESCRIPTION
Shared Learning	Shared learning is circulated hospital wide on Workplace for: • PSIIs and other investigations under PSIRF. • Safeguarding investigations. • Low/no harm incidents identified for shared learning. • Complaint outcomes. • Patient led shared learning on their experiences. • Importance of following process. • Shared learning from other providers in SW London. • HSIB investigations. • National Patient Safety Updates.
Executive Management Team meeting (weekly)	EMT have oversight of the following: • Weekly PSQA/Safeguarding Report. • Quality Improvement Project action plans • PSII reports for final approval.
Approved PSII Reports external submission	• Once approved by EMT final PSII reports are submitted externally to SW London ICB, NHSE, CQC and the funding ICB for their records. • PSII actions are input to a central actions tracker and reported through the PS&Q Committee.

MEETING / PROCESS		MEETING PURPOSE / PROCESS DESCRIPTION
Mortality Review Committee	Risk & Incident Committee	Mortality Review Committee: • All deaths of RHN patients are discussed via Structured Judgement Review. • Any PSII reports in relation to patient deaths are tabled and discussed at the meeting. • Any concerns as a result of the SJR that require further investigation will be referred to the weekly Incident Management/Safeguarding/Complaints meeting and 24-hour report process. Risk & Incident Committee: • New, ongoing and closed PSIIs • Shared learning circulated since the last meeting. • Trends analysis on patient related incidents including tracheostomy, enteral care, medication, tissue viability, falls, patient behaviour. • Safeguarding cases update • Patient experience.

MEETING / PROCESS	MEETING PURPOSE / PROCESS DESCRIPTION
Patient Safety & Quality Committee	The committee received the following updates: • New, ongoing and closed PSIIs • PSII actions closed since the last meeting and those remaining open / overdue. • Safeguarding cases update. • Trends analysis on patient related incidents including medication, tissue viability, falls. • Patient outcomes (rehabilitation and mortality) • Patient experience. • Shared learning circulated since the last meeting. • A presentation on the outcome of a Quality Improvement project. • PSIRF update.
Board of Trustees	The committee receives the following updates: • New, ongoing and closed PSIIs. This includes PSIIs that are also referred to the Local Authority as Safeguarding cases.

Responding to cross-system incidents/issues

The Patient Safety & Quality Assurance team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent.

The RHN will work with system partner providers and SW London 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 RHN Patient Safety Specialist will act as the liaison point for such working.

Learning from cross system incidents and issues will be cascaded via the following methods:

- SW London Patient Safety Steering Group
- SW London ICB Chief Nurses Forum
- National Patient Safety Specialist Forum

Timeframes for learning responses

Timescales for PSII

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. There must be a balance 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, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the RHN 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. Quality improvement projects may have longer term timescales applied, depending on their complexity and resources available.

Safety action development and monitoring improvement

The **RHN** 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 reduce risk, safety actions are needed.

The **RHN** 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 **that** might result in **the** identification of **further** areas for improvement. The **RHN** will generate safety actions in relation to each of these defined areas for improvement. Following this, the **RHN** will have measures to monitor any safety action and set out review steps.

Safety action development will be completed in a collaborative way with a flexible **and multidisciplinary** approach and **with** the support of the **Patient Safety Specialist's quality** improvement expertise.

Safety Action development

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

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

Safety Action Monitoring

Safety actions will continue to be monitored within the PSIRF governance structure to ensure that they remain effective and sustainable. Reporting on the progress of safety actions will be reported to the Board via the Patient Safety & Quality Committee.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The RHN Patient Safety & Quality Assurance team has a centralised actions tracker in place and centrally manage RHN wide quality improvement projects.

The RHN PSIRP outlines the local priorities for focus of investigation under PSIRF.

Where overarching systems issues are identified by learning responses outside of the local priorities, a safety improvement plan will be developed. These will be identified through the RHN PSIRF governance structure and progress will be reported to the Board via the Patient Safety & Quality Committee. Safety action development will be completed in a collaborative way with a flexible and multidisciplinary approach and with the support of the Patient Safety Specialist's quality improvement expertise.

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 RHN has a PSIRF governance structure in place that enables effective incident management oversight and oversight of learning and safety actions completion and monitoring of their effectiveness.

Responsibilities

Alongside our NHS regional and local ICB structures and our regulators, the Care Quality Commission (CQC) and Charity Commission, we have specific organisational responsibilities with the Framework.

In order to meet these responsibilities, the Trust has designated the Director of Nursing to support PSIRF as the executive lead.

Ensuring that the organisation meets the national patient safety standards

The Director of Nursing will oversee the development, review and approval of the RHN'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 restorative just culture that the RHN has achieved.

To achieve the development of the plan and policy the RHN will be supported by internal resources within the Patient Safety & Quality Assurance team led by the Patient Safety Specialist who reports to the Director of Nursing.

To define its patient safety and safety improvement profile, the RHN will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders.

Ensuring that PSIRF is central to overarching safety governance arrangements

The RHN Board will receive assurance regarding the implementation of PSIRF and associated standards via the Patient Safety & Quality Committee, which is a committee of the Board.

The Patient Safety Specialist will provide assurance to the Patient Safety & Quality Committee that PSIRF and related work streams have been implemented to the highest standards. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.

Senior leaders will have arrangements in place via the PSIRF governance Structure 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. This will be overseen by the Patient Safety & Quality Assurance team.

The RHN will source necessary training such as the Health Education England patient safety syllabus and other patient safety training 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 will be undertaken at least every 3 years to comply with RHN Policy on Writing and Implementing Policies alongside a review of all safety actions.

Quality assuring learning response outputs

The RHN's PSIRF governance structure will ensure that PSIIs are conducted to the highest standards, support the executive approval process, ensure that learning is shared, and safety improvement work is completed and monitored effectively.

Complaints and appeals

Concerns and complaints are a valuable resource for monitoring and improving patient safety. The RHN recognises that there will be occasions when patients, residents, family members or advocates are dissatisfied with aspects of the care and services provided. All types of feedback at the RHN are managed via the Complaints, Concerns, Compliments and Comments Policy & Procedure.

Royal Hospital for Neuro-disability
A national medical charity

Appendix A: Incident Grading

All incidents will be graded in order to determine the level of investigation required. The grading of the incident is determined by two factors:

- The actual consequence, outcome or severity of the incident
- The probability or likelihood of the incident occurring/reoccurring.

Determining Consequence

Table 1: Measure of Consequence / Incident Severity:

Level	Descriptor	Description
1	No Injury	No injury or adverse outcome
2	Minor	Short term injury/damage (e.g. resolves in a month); a number of people are involved
3	Moderate	Semi-permanent injury (e.g. takes up to year to resolve)
4	Severe	Permanent injury; major defects in plant, equipment, drugs or devices; the incident or individual involved may have a high media profile
5	Catastrophic	Death

References

NHS England (2022) Patient safety incident response standards

B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)

NHS England (2022) Safety action development guide

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