Patient safety incident response policy

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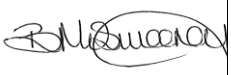
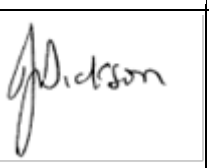
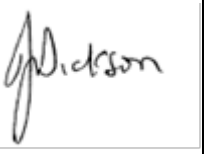
Author	**Briony McSweeney**	**Clinical Quality Partner**		**20/10/23**
Reviewer	**Clinical Practice & Policy Group / Clinical Governance Committee**	**Committee Members**		**15/11/23**
Authoriser (Executive Lead)	**Jo Dickson**	**Chief Clinical & Quality Officer**		**15/11/23**
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Ramsay Health Care

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Our plan sets out how RHCUK 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. 13

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Purpose

‘The introduction of the Patient Safety Incident Response Framework represents a significant shift in the way health care organisations responds to patient safety incidents, increasing focus on understanding how incidents happen - including the factors which contribute to them’ Aiden Fowler, National Director of Patient Safety, NHS England.

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Ramsay Health Care UK’s (RHCUK) 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 which also align to our organisation values:

- 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.

Where previously, we have had set timescales and external organisations to approve what we do, PSIRF gives us a set of principles to work to and to allow us to take accountability for the management of our learning responses to patient safety incidents. The aim of this is for learning and improvement. Previously the emphasis has been on producing a report and an action plan rather than showing how we have made meaningful changes to what we do.

Patients, families and carers need to be at the centre of any patient safety investigations and PSIRF sets out how to engage with our patients so that their voice is heard and responded to.

Ramsay fosters a just culture, where staff are able to ‘speak up’ and feel psychologically safe to highlight patient safety incidents using the Cognitive Institutes Speaking up for Safety programme. We will continue to support those affected and to listen to our teams.

As this is a new framework and a new way of managing patient safety learning, we will continuously monitor the effectiveness of the PSIRF implementation and adapt as necessary.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Ramsay Health Care UK

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.

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,
- information governance concerns
- medical examiner reviews
- 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.

This policy should be read in conjunction with other Ramsay Health Care Policies

- Being Open - RM-010
- Incident Reporting - RM-006
- Management of Patient Complaints - RM-011
- Speaking up for Safety - RM-012
- Disclosure of Information in the Public Interest (Whistle Blower) - LG-008
- Patients who Require Additional Support to Access Information and Services - CN-018
- CM-005 - Raising concerns about patient safety

Our patient safety culture

As an organisation, Ramsay Health Care have worked hard to establish a restorative and just culture within the organisation.

As an organisation we are now focusing on the key priorities to enable effective cultural change through compassionate and inclusive leadership to foster a culture of psychological safety. This is essential to continue to develop high quality, safe patient care with a just, fair and learning culture. Staff affected by patient safety incidents should be supported with a compassionate and just approach ensuring there is no focus on blame or punitive measures for individuals involved in events. Working collaboratively across services and teams to ensure a supportive, fair and just approach in the management of incidents and reviews, that is consistent across all areas and teams.

Ramsay Health Care UK (RHCUK) recognises that promoting a culture of safety and reliability is a fundamental part of our risk management framework and quality initiatives. RHCUK has partnered with the cognitive institute to introduce a professional accountability framework based on the Vanderbilt University Medical Centre and Cognitive Institute, Patient and Professional Advocacy model. This is part of RHCUK's safety framework and culture.

RHCUK is committed to promoting a culture where feedback and speaking up for safety is encouraged, supported and welcomed. RHCUK appropriately addresses behaviour that undermines patient, consumer and employee safety, quality, reliability of care and accountability. This is done through the Cognitive Institute 'Speaking up for Safety' (SUFS) programme, online reporting tool and response system as part of our commitment to a culture of safety, reliability and accountability.

Ramsay Policy CM-005 raising a concern about patient safety also highlights the steps to take to escalate concerns about patient safety.

Each site should have a focus on staff wellbeing, with mental health first aiders and leaders recognising and supporting those involved in incidents and near misses.

PSIRF promotes learning and improvement and the learning from events will be shared across the organisation and incorporated into learning pathways such as safety briefs and team huddles. Learning from these events will be embedded into the organisation to support the prevention of recurrence.

There should be an improvement in near miss reporting and in reporting incidents and the correct impact rating to further support learning and prevention through staff feeling safe to report without the fear of reprise or blame.

The impact of our behaviours and actions on others and ultimately patient care will be addressed through speaking up for safety and promoting professional accountability as well as 'civility saves lives'. A culture of inclusivity, belonging and kindness positively impacts on our patient and workforce experience and ultimately on how we provide safe, high quality care.

PSIRF connects the links between patient safety incidents with learning and improvement, working with those affected by a patient safety incident including staff, patients, families and carers. This should increase transparency and openness amongst the staff in the reporting of incidents and engagement in the learning and improvement that then follows.

As an organisation we are clear that patient safety incident responses are conducted solely with the purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define cause of death.

RHCUK has always fostered a strong patient safety culture with the reporting of patient safety incidents continuing to improve with the implementation of the new incident reporting system. This system aligns our own internal reporting to the 'Learn From Patient Safety Events' system (LFPSE) and therefore enabling a wider system learning across healthcare.

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 Health Care Organisations.

Ramsay Health Care is working to recruit Patient Safety Partners who will offer support alongside our staff, patients, families / carers to influence and improve safety across our range of services.

Patient Safety Partners, can be patients, carers, family members or other lay people and this offers greater opportunity to share interests, experiences and skills to develop the PSP role which will be ever evolving.

The Patient Safety Partners will provide rational and objective feedback focused on ensuring that patient safety is maintained and improved, including attendance at governance meetings, reviewing patient safety, risk and quality and being involved with contributing to documentation including policies, investigations and reports. As the role evolves, PSP's may take on additional responsibilities and assist in the implementation of patient safety improvement initiatives underpinned by training and support specific to this new role.

As Ramsay recruits Patient Safety Partners further information will be added to the policy regarding the oversight and support for PSP's.

Addressing health inequalities

Ramsay Health Care UK is committed to delivering on it's 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.

We can do this by reviewing how people access our services by ensuring equality of opportunity where we know there is a disproportionate risk to patients with specific characteristics and continue to review datasets and intelligence to proactively reduce the likelihood of poor health inequalities occurring.

As part of the PSIRF, the organisation will utilise the available protected characteristics datasets held on the incident management system to allow for incidents and intelligence to be analysed by protected characteristics, providing insight into any apparent inequalities. These can then feed into an improvement plan if this opportunity is identified.

We need to recognise different communication styles and ensure that our communication and engagement methods are available in different formats, including easy read, different languages and large print. In addition the organisation uses interpreters and translation services to ensure that where English is not the individuals first language, they do not suffer any detrimental impact as part of the patient safety incident review process. By proactively acting in an accessible manner we aim to maximise the potential of patients, families and our staff to be involved in the patient safety incident response framework. Refer to policy CN-018 - Patients who require additional support to access information and services.

RHCUK does not tolerate under any circumstances, any form of racial abuse or discrimination by our patients, visitors or staff. This includes all protected characteristics and our focus is to provide the best care to patients irrespective of their skin colour, culture, ethnicity or faith, gender or sexuality, age or if they have a disability. Staff are encouraged to report incidents using the incident management system.

Engaging and involving patients, families and staff following a patient safety incident

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.

RHCUK will work with the principles contained within the guidance document 'Engaging and involving patients, families and staff following a patient safety incident' and ensure that these are at the heart of our approach.

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

As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families and carers because it is morally the right thing to do, regardless of the level of harm caused by an incident. Ramsay Policy RM-010 Being Open has been reviewed and updated to include the PSIRF principles of engaging and involving those affected by patient safety incidents and how we can share those findings.

Each site will have an engagement lead who will support and involve patients, families and carers following a patient safety incident.

Each site has at least one mental health first aider who is able to give additional support to those staff who have been affected by a patient safety incident alongside the leadership teams. There will be ongoing work in relation to ensuring a 'Just Culture' within the organisation, ensuring a culture of fairness, openness and learning to ensure that staff feel confident to speak up when things go wrong rather than fearing blame. Ramsay supports staff o open up about mistakes to allow learning to prevent future incidents being repeated. An insight into the culture of the organisation can be seen through the staff survey results.

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.

As an organisation, RHCUK will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. The approach is based upon the principles in the document 'guide to responding proportionately to patient safety incidents' and our organisation patient safety incident response plan (PSIRP). The PSIRP is based upon the organisational patient safety profile and the information has been gained through both qualitative and quantitative data sources.

The PSIRP is an ever evolving document and will be appropriately amended and updated as we use it to respond to patient safety incidents. The plan will be reviewed every 12-18 months to ensure the focus remains up to date. With the ongoing improvement work the patient safety incident profile is likely to change. This will be done through continual analysis of our improvement plans, Patient Safety Incident Investigations (PSII), complaints, claims, inequalities data and in collaboration with our lead Integrated Care Board (ICB), Suffolk, North East Essex (SNEE).

RHCUK's patient safety incident response plan details how as an organisation we will meet both the national and local priorities for patient safety responses.

Resources and Planning to support the learning response

RHCUK is committed to ensuring that PSIRF is fully embedded within the organisation and that the requirements are met. We have used the NHS England Patient Safety Response Standard (2022) to frame the resources and training required to allow this to happen.

As an organisation we have governance arrangements in place (Appendix 1) to ensure that learning responses are not led by staff who were involved in the patient safety incident itself. Each site will have a number of learning response leads with appropriate seniority. These will be the Heads of Clinical Service, Deputy Heads of Clinical Service, Quality Improvement Leads or equivalent and Heads of Department.

Oversight of these learning responses will be through the Clinical Quality Partners and through respective governance committees. Heads of Clinical Service (HOCS) will be able to respond to patient safety incidents proportionately with oversight as detailed in the governance arrangements. The Heads of Clinical Service (HOCS) will be expected to share learning across their wider systems and the achievement of this can be discussed locally with the relevant ICB's.

Staff affected by patient safety incidents will be given the appropriate support and time to participate in learning responses. All Senior Leaders within Ramsay Health Care UK will work within the just culture principles. Each site will have processes in place to ensure that staff work within this framework to ensure psychological safety for staff.

Where appropriate and if required, external subject matter experts with relevant knowledge and skills will be used throughout the learning response to provide expertise and advice.

Training

RHCUK 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 Syllabus

Level 1 - Essentials for patient Safety

This is from the Health Education England Patient Safety Syllabus Module and can be accessed via the E-Learning for Healthcare (ELfH) platform.

- All staff employed by Ramsay Health Care UK must undertake this module

Level 1 - Essentials of Patient Safety for Boards and Senior Leadership Teams

This is from the Health Education England Patient Safety Syllabus Module and can be accessed via the E-Learning for Healthcare (ELfH) platform.

- The executive board and site senior leadership teams

Level 2 - Access to practice of the patient safety syllabus

This is from the Health Education England Patient Safety Syllabus Module and can be accessed via the E-Learning for Healthcare (ELfH) platform

- All clinical staff employed by Ramsay Health Care UK must undertake this module

Systems Approach to learning from patient safety incidents - 2 day course

All learning responses will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents. Records of training will be maintained by the individual as part of their professional practice requirements. Learning response leads must also complete level 1 & 2 of the national patient safety syllabus above.

- All identified learning response leads
  - o HOCS
  - o Deputy HOCS
  - o Quality Improvement Leads or Equivalent
  - o Heads of Department

Learning response leads will be able 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.
- manage conflicting information from different internal and external sources.
- communicate highly complex matters in difficult situations.

Engaging with patients, families and staff following a patient safety incident - 1 day Course

Engagement and Involvement with those affected by a patient safety incident will be undertaken by those staff who have undergone a minimum of 6 hours training. Records of the training will be maintained by the individual as part of the professional practice requirements.

Engagement leads must have completed level 1 & 2 of the national patient safety syllabus as above.

- All identified Engagement and Involvement Leads
  - o HOCS
  - o Deputy HOCS
  - o Quality Improvement Leads

Engagement leads will need to:

Communicate and engage with patients, families, staff and external agencies in a positive and compassionate way

- Listen and respond in a measured and supportive way.
- Maintain clear records of information gathered and contact those affected by patient safety incidents.
- 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.

Oversight Roles

All patient safety response oversight will be led by those who have had a minimum of two days formal training in the systems approach to learning from patient safety incidents and a one day training course in oversight of learning from patient safety incidents. Records of training must be maintained as part of the individuals professional development.

The executive oversight role will be undertaken by the Chief Clinical and Quality Officer who will also have completed the appropriate modules from the national patient safety syllabus. Level 1 - Essentials of patient safety and essentials of patient safety for boards and senior leadership teams

Other staff required to undertake the oversight role

- Group Chief Medical Director
- Group Chief Pharmacist
- Group Infection Prevention Control Lead
- Clinical Quality Partners including Pharmacy,
- Identified Radiology Leaders - Governance & Peripatetic

Staff with oversight roles will be able to:

- Be inquisitive with sensitivity - know how and when to ask the right questions
- Apply human factors and systems thinking principles
- 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 RHCUK 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 the current plan can be found on the sharepoint site.

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 lead integrated care board (ICB), Suffolk, North East Essex) 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

Safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incidents onto the organisations incident reporting system (RADAR) and will record the level of harm experienced and impact rating.

While all incidents are reported via the incident reporting system, there are other mechanisms for escalating concerns, refer to policy CM-005, Raising concerns about patient safety. This includes:

- Immediate concerns are raised via 'Speaking up for Safety'
- Line Managers or Senior Leadership Team
- Speaking up for Safety online reporting tool
- Clinical Quality Partner or Corporate Clinical Team
- National Freedom to Speak Up Guardian
- Via the Ramsay Whistleblowing hot line

Each site must have mechanisms in place to review all patient safety incidents to ensure that they can be responded to proportionately and in a timely manner. This includes consideration where duty of candour applies (refer to RM-010) and notification under regulatory requirements.

Most incidents will require a site level review, however where it is felt that the opportunity for learning and improvement is significant then these should be escalated via the patient safety incident review group and other relevant clinical governance sub committees.

Patient safety incident response decision-making

RHCUK has arrangements in place to review all patient safety incidents under PSIRF. Some incidents will require a mandatory PSII while others will require an alternative learning response or referral to another body depending on the event. These national and local priorities have been set out in the RHCUK patient safety incident response plan (PSIRP).

RHCUK has used the PSIRF guidance document to develop its own learning response mechanisms and to balance the effort between learning through responding to incidents or exploring issues and improvement work. In creating our patient safety incident response plan we have considered our organisational patient safety profile, using intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety incidents.

Heads of Clinical Service should escalate incidents which meet the criteria of a PSII or other patient safety response, have the potential for learning and improvement or an unexpected level of risk to the Clinical Quality Partner and Patient Safety Incident Review Group.

The patient safety review group will have oversight of all incidents and the Chief Clinical and Quality Officer will assure the executive board that PSIRF is being implemented within the organisation and that we are meeting patient safety incident response standards.

All incidents - Hospital Directors must have arrangements in place to ensure that incidents are reported and responded to within their sites. Incident responses must include immediate actions taken to ensure safety of patients, public and staff as well as the indication of any measures needed to mitigate a problem. 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 RM-010. Significant incidents must also be reported via Learning from Patient Safety Events (LFPSE) as per RM-010

The relevant clinical governance sub committees may commission thematic or cluster reviews of such incidents to consider and understand potential emerging risks.

Significant Incidents requiring PSII or potential for PSII according to the PSIRP

All staff, either directly or through their line manager must ensure notification of incidents that may require a higher level response as soon as practicable after the event via the incident reporting system and escalation to the senior leadership team at sites. Duty of Candour disclosure should be carried out according to RM-010.

Where it is unclear if a PSII is required, this should be escalated to the corporate nursing team and Patient Safety Incident Review Group so that the incident can be shared with the executive team if necessary. The site should undertake an initial safety review to inform decision making at the patient safety review group and onward escalation following this.

Where it is unclear if there is a potential for a PSII, these incidents must be escalated to the patient safety review group and an initial patient safety review will be undertaken to inform this decision making. Some significant incidents may require consideration for an ad-hoc PSII due to an unexpected level of risk and/or potential for learning. This includes significant near misses.

The patient safety review group will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning and any mitigation. It will also review whether the duty of candour requirements have been met. This group can also determine if a PSII is appropriate to be undertaken or if a subject matter expert input is required for any investigation. It will also determine how immediate learning is to be shared.

If a PSII is not required then an alternative learning response tool can be used as per the patient safety incident response plan.

The organisation Mortality & Morbidity Group will oversee the decision making of the patient safety review group and will support the final sign off process for all PSII's. This will assure the board that the expected oversight standards are being met and understand the patient safety and improvement profile within the organisation.

Where a PSII is required then the Heads of Clinical Service must report these incidents on the LFPSE system via the incident reporting system (RADAR). They will also be required to advise their lead ICB / Commissioner to log this on the Steis system until the learning from patient safety incidents system (LFPSE) is fully functional.

Responding to cross-system incidents/issues

The Heads of Clinical Service (HOCS) at each site will escalate any incidents identified as presenting potential for significant learning and improvement to the patient safety incident review group.

Each site Head of Clinical Service will work with their relevant ICB's to establish processes for the flow of information and collaboration in regard to joint working on cross-system incidents.

Timeframes for learning responses

Timescales for patient safety PSII

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

The timescale for completion of a PSII should be agreed with those affected by the incident as part of the setting of terms of reference if they are willing to be involved in that decision. Consideration needs to be given between the impact of extended timescales on those involved in an incident and ensuring that a thorough PSII is completed. In exceptional circumstances an extension if required should be agreed between the hospital 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 be completed within one to three months of their start date. No learning response should take longer than six months to complete.

Timescales for responses should be agreed with patients and family and regular updates provided in order to ensure transparency and inclusion.

Safety action development and monitoring improvement

RHCUK acknowledges that any form of patient safety learning response will allow the circumstances of an incident or set of incidents to be understood.

The organisation 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.

Areas for improvement identified through the learning responses should have defined safety actions generated. The term 'area for improvement' is used instead of 'recommendations' to reduce the likelihood of attempting to find a solution at an early stage of the safety action development process. Areas for improvement set out where improvement is needed without defining how that improvement is to be achieved. Safety actions in response to a defined area for improvement depend on factors and constraints outside the scope of a learning response. (NHS England Safety Action Development Guide 2022).

The Safety Action Development Guide (2022) outlines the process for the development of safety actions:

1. Agree areas for improvement - specify where improvement is needed, without defining solutions

2. Define the Context - this will allow agreement on the approach to be taken to safety action development

3. Define safety actions to address areas of improvement - focussed on the system and in collaboration with the 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 with a designated owner.

These safety actions and outcomes will be monitored by local clinical governance committees and safety actions with wider significance will require oversight by the Group Clinical Governance Committee.

Safety improvement plans

Safety improvement plans bring together the findings from various learning responses to patient safety incidents and issues. There are a number of safety improvement plans already in place at RHCUK.

The RHCUK patient safety incident response plan (PSIRP) has outlined our local priorities for focus of investigation under PSIRF. These have been developed using the outcomes of existing patient safety reviews and due to the opportunity they offer for learning and improvement across the organisation.

As an organisation, RHCUK will use these existing patient safety reviews plus the relevant learning responses under PSIRF to create safety improvement plans to ensure we are focusing our improvement work.

Where system issues are identified by learning responses outside of the organisations local priorities within the patient safety incident response plan, a safety improvement plan will be developed. These will be identified through the governance processes and monitored through the group clinical governance committee.

Sharing of learning will be both locally and organisationally through safety flashes, local learning documents and outcomes with learning (OWL's).

Oversight roles and responsibilities

Working under PSIRF, organisations are advised to design oversight systems to allow the organisation to demonstrate improvement rather than compliance.

Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control. This means focusing on what we need to improve but also looking at what we need to stop doing. (NHS England, 2022)

There are responsibilities set out within this framework for national and regional teams and Providers of NHS funded care, Integrated Care Boards (ICB's) and the Care Quality Commission (CQC).

The framework sets out specific organisational responsibilities and to ensure we meet these responsibilities, RHCUK's Chief Clinical & Quality Officer has been designated as the executive lead for PSIRF.

The responsibilities of the PSIRF executive lead are:

1. Ensure the organisation meets national patient safety incident response standards

The Chief Clinical & Quality Officer, supported by the rest of the board will oversee the development, review and approval of the organisation's policy and plan for patient safety incident response, ensuring we meet the expectations set out in the patient safety incident response standards.

2. Ensure PSIRF is central to overarching safety governance arrangements

It is the PSIRF executive leads responsibility to ensure that patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans and progress are discussed at the executive committee.

Assurance will be given to the executive committee regarding the implementation of PSIRF through existing reporting mechanisms such as the group Clinical Governance Committee so that the executive committee have an understanding of organisational safety.

The patient safety review group and mortality & morbidity committees will provide assurance to the Clinical Governance Committee that PSIRF and related workstreams and improvement work have been implemented to the highest standards. Each hospital site will be expected to report on their patient safety incident learning responses and outcomes. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and the delivery of safety actions and improvement.

Each hospital site will have it's own arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of the policy are effective. The sharing of learning should also include cross system processes in conjunction with local ICB's.

A review of this policy will be undertaken 3 yearly or in response to changes within the guidance as necessary and the patient safety incident response plan will be reviewed every 12-18 months.

3. Quality assuring learning response outputs

The organisation's mortality & morbidity committee will have oversight to ensure that all PSII's are conducted to the highest standards to support executive sign off and ensure that learning is shared and safety improvement work adequately directed.

Complaints and appeals

RHCUK recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of care and the services provided. This includes the response to incidents.

Ther is a clear distinction between complaints and concerns and these should be managed as per RM-011 - Management of Patient Complaints Policy.

Complaints provide a valuable opportunity to promote a just and learning culture, improve service delivery and reduce future risk to patients and others. Timely collection, reporting and review of all complaints are necessary for the development and implementation of risk reduction strategies and is an opportunity to develop and improve services and people.

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

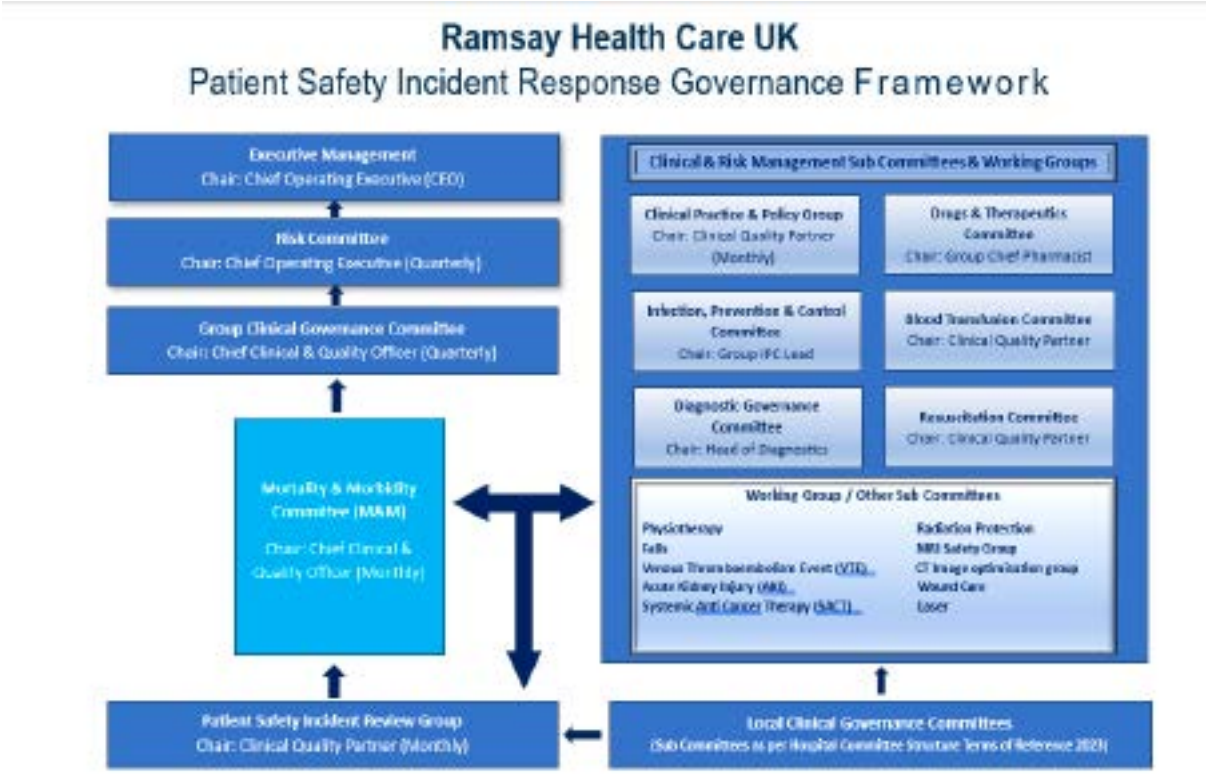
Glossary

PSII - Patient Safety Incident Investigation	PSII's are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care to our patients.
PSIRF - Patient Safety Incident Response Framework	PSIRF is designed to enable a risk based approach to responding to patient safety incidents, prioritising support for those affected, analysing incidents and reducing future risk
PSIRP - Patient Safety Incident Response Plan	The local plan for how Ramsay Health Care UK will carry out PSIRF locally. This has been developed through a collaborative and data driven approach
Patient Safety Incident	Something unexpected or unintended has happened or failed to happen, that could have or did lead to patient harm.
Never Events	Patient Safety Incidents that are considered to be preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers
LFPSE - Learning from Patient Safety Events	The LFPSE service allows for the recording and analysis of patient safety events which occur within healthcare to support and improve learning.
AAR - After Action Review	A model of emergent learning in which individuals are actively involved in self learning and self discovery and build their own understanding of how to improve performance.
Swarm Huddle	Swarm Huddles are used to identify learning from patient safety incidents. Immediately after an incident staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.
Thematic Analysis	A method of analysing qualitative data and identifying patterns in data to help answer questions, show links or identify issues
Multidisciplinary Team Review (MDT)	The MDT review supports teams to identify learning from multiple patient safety incidents and agree through open discussion the key contributory factors and system gaps in patient safety incidents.
SMART	Smart criteria are used to guide how objectives or goals are set to ensure that they achieve what they intend to achieve: **S** - Specific A goal should not be too broad but target a specific area for improvement **M** - Measurable A goal should include some indicator of how progress can be shown to have been made **A** - Achievable A goal should be able to be achieved within the available resources including any potential development needed **R** - Relevant A goal should be relevant to the nature of the issue for improvement **T** - Time Related A goal should specify when a result should be achieved or targets might slip.

References

- NHS England (2022) Patient Safety Incident Response Framework NHS England » Patient Safety Incident Response Framework
- NHS England (2022) Engaging and Involving patients, families and staff following a patient safety incident NHS England » Engaging and involving patients, families and staff following a patient safety incident
- NHS England (2022) Guide to responding proportionately to patient safety incidents B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf (england.nhs.uk)
- NHS England (2022) Safety Action Development Guide B1465-Safety-action-development-v1.1.pdf (england.nhs.uk)
- NHS England (2022) Oversight Roles & Responsibilities B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk)
- NHS England (2023) Policy Guidance on recording patient safety events and levels of harm NHS England » Policy guidance on recording patient safety events and levels of harm
- https://ramsayuk-my.sharepoint.com/personal/briony_mcsweeney_ramsayhealth_co_uk/Documents/Migrated Files/PSIRF/Governance Structure/Ramsay Health Care UK PSIRF Governance Framework.docx

Appendix 1


Ramsay Health Care UK
Patient Safety Incident Response Governance Framework
Executive Management
Chair: Chief Operating Executive (CEO)
Risk Committee
Chair: Chief Operating Executive (Quarterly)
Group Clinical Governance Committee
Chair: Chief Clinical & Quality Officer (Quarterly)
Mortality & Morbidity Committee (M&M)
Chair: Chief Clinical & Quality Officer (Monthly)
Patient Safety Incident Review Group
Chair: Clinical Quality Partner (Monthly)
Clinical & Risk Management Sub Committees & Working Groups
Clinical Practice & Policy Group
Chair: Clinical Quality Partner
(Monthly)
Drugs & Therapeutics Committee
Chair: Group Chief Pharmacist
Infection, Prevention & Control Committee
Chair: Group IPC Lead
Blood Translation Committee
Chair: Clinical Quality Partner
Diagnostic Governance Committee
Chair: Head of Diagnostics
Resuscitation Committee
Chair: Clinical Quality Partner
Working Group / Other Sub Committees
Physiotherapy
Falls
Venous Thromboembolism Event (VTE)
Acute Kidney Injury (AKI)
Systemic Anti Cancer Therapy (SACT)
Radiation Protection
MRI Safety Group
CT Image optimisation group
Wound Care
Laser
Local Clinical Governance Committees
(Sub Committees as per Hospital Committee Structure Terms of Reference 2023)

Appendix 2

NHS England – Policy guidance on recording patient safety events and levels of harm

(2023)

This policy guidance sets out expectations for the recording of patient safety events and their associated levels of harm when using the 'Learn from patient safety events' (LFPSE) service.

Definitions – Harm Grading

No physical harm

No physical harm

Low physical harm

Low physical harm is when all of the following apply:

- minimal harm occurred – patient(s) required extra observation or minor treatment
- did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit
- did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication
- did not or is unlikely to affect that patient's independence
- did not or is unlikely to affect the success of treatment for existing health conditions.

Moderate physical harm

Moderate harm is when at least one of the following apply:

- has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks
- additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention
- has limited or is likely to limit the patient's independence, but for less than 6 months
- has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

Severe physical harm

Severe harm is when at least one of the following apply:

- permanent harm/permanent alteration of the physiology
- needed immediate life-saving clinical intervention
- is likely to have reduced the patient's life expectancy
- needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions
- has limited or is likely to limit the patient's independence for 6 months or more.

Fatal (previously documented as 'Death' in NRLS)

You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

Psychological harm

Please note that when recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available.

No psychological harm

Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.

Low psychological harm

Low psychological harm is when at least one of the following apply:

- distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit
- distress that did not or is unlikely to affect the patient's normal activities for more than a few days
- distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

Moderate psychological harm is when at least one of the following apply:

- distress that did or is likely to need a course of treatment that extends for less than six months
- distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months

Severe psychological harm

Severe psychological harm is when at least one of the following apply:

- distress that did or is likely to need a course of treatment that continues for more than six months
- distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

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