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Patient Safety Incident Response Policy	
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Revision Summary

- 07/2024 New.

Revision History

- N/A

Policy Statement

What is this policy intended to achieve?

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

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

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

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

To whom does this policy apply?

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Patient & Family Services Directorate at St Helena.

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.

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

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

Who should read this policy?

PFS clinical managers selected by the Risk & Incident Group.

Our Patient Safety Culture

St Helena promotes an open, 'just culture' to improve patient safety. A culture of openness and truthfulness is vital for improving the safety of everyone who uses St Helena services, visitors, and our staff. Openness is also necessary if we are to effectively monitor and improve the safety of the care we provide. Being open and truthful requires that we apologise when things go wrong and explain what happened and why to those who suffer harm or distress as a result. All staff should feel they can be honest when mistakes are made and not worry that an apology is an admission of personal liability.

Just Culture

St Helena promotes the NHS Just Culture via our Duty of Candour Policy and Patient Engagement Policy [012] and treat staff involved in a patient safety incident or subject to complaints in a consistent, constructive, and fair way.

We strongly encourage staff to report any untoward event as an incident, even if on investigation it is later found not to have been a significant event. We also intentionally 'over report;' so, for example, we record all pressure ulcers and patient falls as incidents, even though they are an expected part of End-of-Life care. We also encourage the logging of concerns and complaints and will occasionally elevate a concern to a complaint even when the complainant has not asked us to do so.

All incidents and complaints are managed by our Risk & Incident Group, which reports to our Clinical Governance and Compliance Group and, through that, to our Board of Trustees. We report a summary of incidents and complaints quarterly to our Integrated Care Board (ICB) and to the Care Quality Commission (CQC). We also publish an anonymised summary annually in our Quality Account. Learning from incidents and complaints is also circulated to our clinical teams via our clinical governance structure and at team meetings.

We also promote openness and transparency with our Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy [331], according to which staff can raise a concern about any risk, malpractice, or wrongdoing they think is harming the service we deliver. We have a team of Freedom to Speak Up Guardians, including a Trustee, who can ensure concerns are routed to the most appropriate part of our management structure, anonymously if necessary. Two of these Guardians have responsibility for Patient & Family Services.

We proactively gather patient experience of our services – good and bad – using an electronic system provided by AlwaysOnMobile. Using this, patients and families are invited to complete an online survey. Results are shared with our teams and summarised in our reporting to the ICB and CQC.

A Safety Culture

St Helena operates a culture of patient safety. The pillars of this culture are:

Strong clinical governance and accountability culture

Our Patient and Family Services Directorate employs a structure of groups taking responsibility for the key elements of patient safety and quality. The current structure is shown in Figure 1, below.

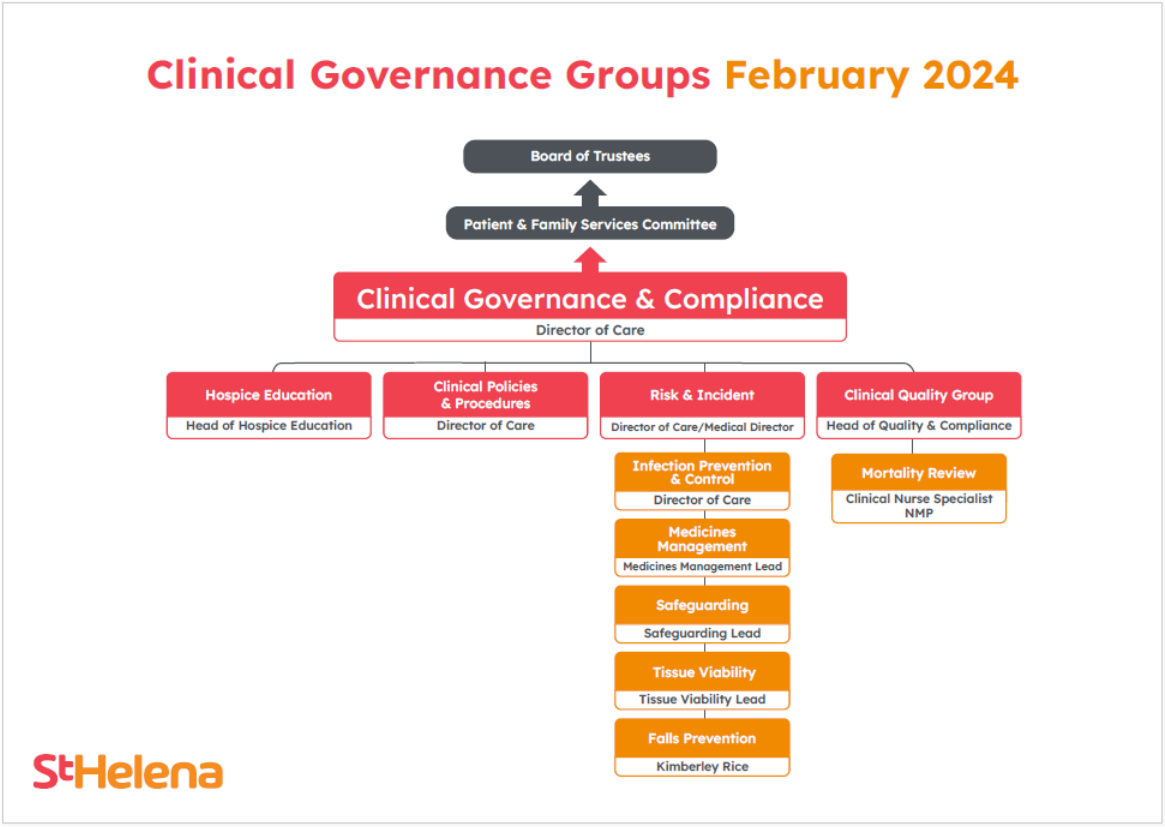

Figure 1 Clinical Governance Structure

Quarterly Quality Reporting

Each quarter, all PFS departments and functions contribute to a Quarterly Quality Report, which is collated and edited by St Helena's Quality & Compliance Department. This report is reviewed by our Clinical Governance & Compliance Group and our Trustees and sent to the Care Quality Commission.

Robust incident reporting

All incidents in PFS are logged electronically on our Sentinel system, including all pressure ulcers and patient falls. The same system is used to manage investigations and actions. All PFS incident investigations are reviewed at our weekly Risk & Incident Group (RIG). All logged incidents are reported monthly to our Senior Leadership Team and all closed incidents are reported via our Quarterly Quality Report.

Patient Engagement and Complaints Management

PFS logs and manages all complaints on a dedicated Sentinel module and complaints are managed by the RIG, with similar reporting as for incidents. As part of the PSIRF transition, we are remodelling our complaints management process, to introduce a new service, like the Patient Advice and Liaison Service (PALS) operated by acute trusts. We are also bringing our analysis of all patient feedback – patient surveys, cards and letters, and post-complaint surveys – into a single workstream and using natural language analysis to better draw out the themes within.

Strong Risk Management

Clinical risks are also managed on two dedicated Sentinel modules (one for our organisational clinical risk register and another for individual standing risk assessments) and managed weekly by the RIG. Reporting of risks echoes that for incidents and complaints.

Commitment to continuous improvement and Evidence Based Practice

Evidence based practice integrates clinical expertise, patient values, and the best research evidence into the decision-making process for patient care. St Helena has an annual programme of approximately 60 clinical audits, all of which are reported via our clinical governance structure. Actions resulting from all audits are electronically logged and monitored. We also employ validated patient outcome measures such as iPOS and the Karnofsky Performance Scale.

Staff education, training, and supervision

St Helena's Hospice Education service is a joint venture with St Elizabeth Hospice in Ipswich. It manages all clinical staff training, both online and face to face. Training compliance is reported quarterly to our Clinical Governance and Compliance Group.

All clinical staff are offered regular supervision and compliance with this is also reported quarterly.

Patient Safety Partners

Patient Safety Partners (PSPs) can be patients, carers, family members or staff from partner organisations. PSPs provide a fresh perspective on safety, often one that is unencumbered by the biases and 'we've always done it this way' preconceptions that can accumulate in any organisation.

Following the NHS Patient Safety Strategy (2019), St Helena recognises the importance of involving lay people and outside professionals for improving patient safety and quality of care. In particular, we value colleagues from other hospices who act as 'critical friends.' We consulted with St Elizabeth Hospice in the development of this policy and will do so in the future. We also involve our Trustees in clinical governance work.

St Helena is committed to patient safety; however, as a relatively small charity, we do not believe having paid patient safety partners is proportionate. Nevertheless, we plan to work with colleagues at St Elizabeth and St Nicholas Hospice on mutual support and peer review of patient safety and quality matters. We will also work with Suffolk and North East Essex Integrated Care Board (SNEE ICB).

Addressing Health Inequalities

In 2022, St Helena ratified a position statement affirming our commitment to equality and fairness for all in our service delivery and employment practices, and pledging not to discriminate on grounds of gender, marital status (including civil partnerships), race, ethnic origin, colour, nationality, national origin, disability, sexual orientation, religion, or age. St Helena opposes all forms of unlawful and unfair discrimination. We recognise, respect and value diversity and will strive in all we do to serve the interests of, and engage with, our patients, carers, employees, volunteers, and the community in general.

We are committed to addressing inequalities in the provision of End-of-Life care for patients and their families in North East Essex (NEE). We take note of the five-year UK wide hospice sector strategy to 'Open Up' hospice care and its first pillar to 'tackle inequality and widen access to hospice care.' There is no single dedicated resource

assigned to the development of equality and diversity at St Helena. Instead, we have instead established an Equality, Diversity, and Inclusion (EDI) Working Group to enable all staff to contribute to this goal.

The Equality Diversity and Inclusion (EDI) Group

The EDI Group reports findings, outcomes, and proposals to St Helena's Senior Leadership Team (SLT) directly and has the following objectives:

- To widen access and improve the experiences of individuals, and their families, in accessing care with an end-of-life diagnosis,
- To understand, evidence, and articulate gaps in healthcare provision.
- To build cases to address gaps in service, including, where appropriate, accessing funding to support delivery.
- To record priorities and outcomes identified in the NHS Equality & Diversity Framework (EQIA) Impact Assessment Policy.

St Helena recognises the importance of reducing healthcare inequalities; however, as a small provider with a relatively low throughput of patients, we do not currently have sufficient data to recognise any disproportionate risks to patients with specific characteristics. Our recording of ethnicity and gender identity is inadequate for thorough analysis. It is also true to say that, in terms of ethnicity, our local population is currently over 90% white. Nevertheless, we acknowledge that our recording of ethnicity, sexuality, gender identity, and other special characteristics must improve. We will also build consideration of issues such as ethnicity into our incident reporting to highlight any potential patterns of unequal care. Formal patient safety and quality improvement plans will also incorporate consideration of healthcare inequalities.

As a small organisation, we pride ourselves on providing an individually tailored communication to all patients and families when incidents occur, or they make a complaint. We also, where possible make reasonable adjustments for people with specific additional needs.

St Helena already looks at systemic causes for incidents but will refresh this approach with renewed training for staff. We are in the process of obtaining the NHS mandated

systems-based investigation training for a small group of staff who will then pass this training on.

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

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

The term 'engagement' describes everything an organisation does to communicate with and involve people affected by a patient safety incident in a learning response. This may include the Duty of Candour notification (see below) or discussion, and actively engaging patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened.

The Duty of Candour

A culture of openness and transparency is vital for improving the safety of everyone who uses St Helena services, visitors, and our staff. Without openness and transparency there can be no true consent. Openness and transparency are also necessary if we are to effectively monitor and improve the quality of the care we provide. Being open and transparent requires that we apologise when things go wrong and explain what happened and why to those who suffer harm or distress as a result.

All staff should feel they can be honest when mistakes are made and not feel inhibited about apologising. This is the essence of what has come to be known as a 'just culture.' Specifically, it is a culture in which inadvertent human error, freely admitted, is not normally subject to punitive sanctions and, instead, where incidents and problems are traced back to systemic causes. A just culture therefore supports the Duty of Candour by encouraging honesty.

Clinicians already have an ethical duty of candour under their professional registration to tell patients about errors and mistakes. This is known as the professional Duty of Candour. The statutory Duty of Candour builds on individual professional duty by obliging St Helena as an organisation to be open with patients when harm has been caused. All St Helena staff have a responsibility to assist St Helena in meeting this legal obligation and Duty of Candour is a mandatory section of our electronic incident reporting.

The intent of the regulation is that healthcare providers are 'open and transparent with people who use services and other "Relevant Persons" (people acting lawfully on their behalf) in general in relation to care and treatment.' This should be an integral part of our culture and extend from our dealings with patients and relatives through all layers of management and up to our board of Trustees. It should be reflected in all policy and practice.

The duty is established by Regulation 20 of the Health and Social Care Act (2008) (Regulated Activities) Regulations (2014). It applies to all incidents whereby moderate harm, severe harm or death has occurred. It does not apply to near misses, no harm, or low harm incidents. This notwithstanding, and in line with PSIRF principles, it is the policy of St Helena that low harm incidents should be communicated to the Relevant Person unless, in the judgment of the relevant clinician, to do so would cause them unnecessary distress.

To improve compliance in this area, we will shortly review our DoC arrangements and begin a regular audit of compliance. We will also, during 2024-25, provide to key staff the training mandated by the PSIRF framework. [1]

St Helena supports the involvement of patients and families when things go wrong; however, it must be remembered that hospice patients may be near end of life and families already under considerable stress. Engagement must therefore be tempered

[1] NHS England (2022) 'Patient safety incident response standards' Version 1 Standard 8.

by pragmatic compassion. For most of our common incidents – pressure ulcers, falls, and medicines errors -- patient and family involvement will be neither necessary nor desired beyond discharge of our Duty of Candour.

For more serious incidents – or those where the patient or family request to be involved – we will follow the principles of engagement outline in PSIRF.[2] We will continue to ensure that all staff know that apologies must be meaningful. We will continue to apply the general hospice ethos of individualised, respectful, and compassionate care, ensuring that support is tailored to patients and families involved in incidents. We will consult with those affected on the timing of investigations, as we do with complaints, to ensure that we balance the need for timely response with sensitivity.

We will also ensure that, as per our complaints process, any patients or families engaged in the investigation of an incident are provided with a single point of contact who will navigate internal processes on their behalf and provide them with clear information and explanation of the process. For incidents requiring a PSII, we will also provide an information pack like the one we provided to complainants. As meaningful communication must be two way, we will also ensure that the point of contact documents the views and concerns of all people affected by the incident, incorporating them into the terms of reference for the investigation, and establishing with them any actions or restitution they seek. We will always assume the credibility of patients and families' perceptions when coming to a clear understanding of what happened. The point of contact will keep patients and families informed of all findings and actions proposed. In doing all this, we will ensure that we are collaborative and open. Where a patient of family is dissatisfied with the process or outcome, we will provide the same appeals process as for complaints, culminating in our support to refer the matter to the Parliamentary Health Service Ombudsman. Where appropriate, we will also use user satisfaction surveys as we will for complaints.

Our engagement process will follow the four steps laid out under PSIRF.

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[2] NHS England (2022) 'Engaging and involving patients, families and staff following a patient safety incident' v2.

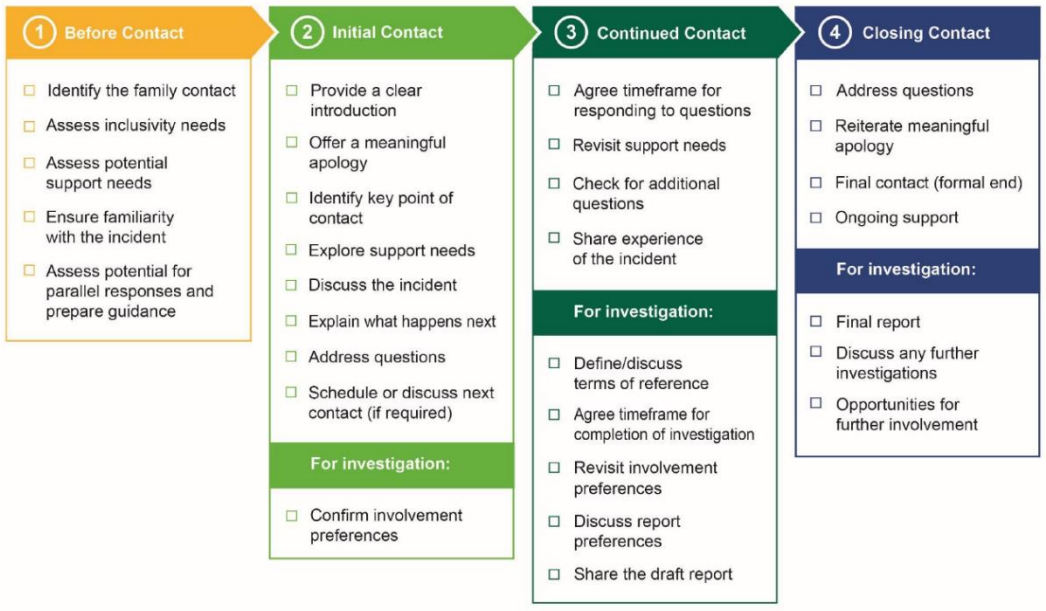

Figure 2 Four steps of engagement[3]

Learning

Learning from incidents will be combined with learning from complaints, risks, and patient experience to help provide a cohesive picture of St Helena service delivery.

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.

A proportionate response to incidents is crucial for maximising learning and minimising the time clinical staff are diverted from clinical care. It is also important to create a framework for managing incidents that is suitable for a given organisation, its activity, and the mix of patients for which it cares. St Helena, as a small hospice focused on symptom alleviation and rehabilitation for patients nearing end of life, contrasts with a

[3] NHS England (2022) 'Engaging and involving patients, families and staff following a patient safety incident' v2., p. 19.

large, acute trust with dozens of specialities and a focus on remedying conditions and mending injuries. As such, we generate fewer incidents and of more restricted variety: over 80% are pressure ulcers, falls or minor medicines errors.

Resources and training to support patient safety incident response

Patient safety incident management at St Helena is distributed among key staff in PFS. There are individual leads and trained staff responsible for investigating the bulk of our incidents (pressure ulcers, falls, and medicines errors) where the potential for learning is low and audits of records are required rather than investigations in a meaningful sense.

Where a more thorough investigation is required, for incidents that are more unusual, more serious or promise more learning, the investigation will be conducted by a Matron, Department Head or (Associate) Director. These investigations will be closely supervised by the RIG with support from the Quality & Compliance Department.

We will ensure during 2024-25 that key senior staff receive refresher training on how to investigate incidents within the context of the PSIRF principles, adapting Healthcare Safety Investigation Branch (HSIB) training. The key staff involved in incident management are:

- Associate Director for Clinical Services.
- Hospice Matron, supported by Senior Sisters.
- Hospice in the Home Matron, supported by Senior Sister.
- Medical Director.
- Tissue Viability Lead (supported by the Tissue Viability Group).
- Falls Lead (supported by the Falls Prevention Group).
- The Medicines Management Lead and the Operational Medicines Management Lead, (supported by the Medicines Management Group).
- Head of Quality & Compliance.
- Clinical Compliance Officer.
- PA to the Associate Director for Clinical Services.

Our patient safety incident response plan

Our plan sets out how St Helena 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. The current plan will be published on our external website during May 2024, as will updated versions.

Our plan was drawn up by our head of Quality & Compliance, in consultation with our Director of Care, SNEE ICB, and colleagues at other hospices. To create it, we analysed data for PFS incidents, complaints, risks, and clinical audits to establish a baseline. This indicated, as expected, that pressure ulcers, falls, and medicines errors comprised over 80% of our incidents in a two-year period. It also showed that we had approximately 120 complaints during the period, although there had been no thematic analysis of them. It was a similar case for our risks with 21 analysed for the period. We did note in our plan that our risk management underwent extensive improvement during 2023. We also considered our Freedom to Speak Up, but engagement has been low at St Helena, with so few issues raised analysis is redundant.

Reviewing our patient safety incident response plan and policy

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 as 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 three years and more frequently if appropriate (as agreed with SNEE ICB) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for

example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement. Amendments to the plan will also inform updates to this Policy.

Responding to patient safety incidents

Internal Process

Incident reporting is governed by the PFS Incident Management Policy & Procedure [013]. It applies to everyone working in Patient & Family Services (PFS) and to any incident that affects PFS. This policy will be updated in 2024 to acknowledge the roll-out of PSIRF. All incidents are reported on and managed with our electronic management system, Sentinel.

It is PFS policy that staff actively identify and report incidents, near misses, and hazards as soon as possible. Our standard is that all incidents should be reported within no more than 24hrs of occurrence. As understanding the prevalence of incidents is an important part of safety culture, the presumption in case of doubt is to always report. We report all pressure ulcers, falls, and medicines errors, irrespective of harm.

Each incident is reported to a single, Main Recipient who becomes Incident Owner. Sentinel will often suggest this Main Recipient so, for instance, falls, pressure ulcers, and medicines errors are all routed to the appropriate lead. The system also steers the reporter to notifying appropriate Additional Recipients. The Incident Owner is responsible for quality assuring the initial report and ensuring that, where needed, the incident receives a timely investigation.

All completed investigations are submitted to the Risk & Incident Group (RIG), which meets weekly. RIG includes representatives from The Hospice, Hospice in the Home, the Medical Team, Safeguarding, and Quality & Compliance. It reviews and approves investigations, ensures affected patients and families are supported, mandates actions, communicates learning from incidents to the wider directorate, sends feedback to the reporter where requested, and closes incidents once all necessary work is complete.

Where incidents concern multiple providers, the RIG works with them to identity the lead organisation to coordinate the investigation (including with patients and families). Where required, St Helena contributes to wider system reviews.

The Quality & Compliance Department, which sits outside of PFS, is responsible for monthly reporting of all logged incidents to our Senior Leadership Team and quarterly reporting of recently closed incidents to our Clinical Governance and Compliance Group via the Quarterly Quality Report. This report then goes to our Trustees and to the Care Quality Commission.

Quarterly, we also benchmark pressure ulcers, falls, and medicines errors with Hospice UK standards and report controlled drugs errors to our Local Intelligence Network.

Other organisations, patients, families, and members of the public may report and incident by contacting any member of staff.

External process

- Incidents may be reported via the NHS England website.
- External partners may report an incident to any member of St Helena staff who will then log it on our system. They can also contact our Associate Director of Clinical Services directly using secure email.
- The public may raise an incident by contacting our Complaints Service using the details on our external website. An incident or concern, as appropriate, will then be generated internally.

Patient safety incident response decision making

The RIG has principal responsibility for decision making about all patient safety incidents, taking note of our PSIRF Plan, this Policy, and our Incident Management Policy [013]. This is then regulated quarterly by our Clinical Governance and Compliance Group.

Incident Owners take first line responsibility for deciding on the response to a patient safety incident. As noted above, St Helena does not generate many patient safety incidents each year beyond pressure ulcers, falls, and medicines errors. Consequently, our electronic incident form includes standard templates for pressure ulcers, falls, and

medicines errors. For pressure ulcers and falls, these comprise mini audits of the relevant documentation and preventative measures to determine whether anything that should have been done was not done. Simple medical errors (documentation errors) will be coded to fit a standard typology with some commentary on the circumstances of the error. These incidents will only receive a more thorough investigation if it is suspected there has been significant failure of care from which we can learn.

Patient Safety Incidents that fall outside of these three principal categories may be subject to a 'light touch' investigation at the discretion of the Incident Owner. Incidents that are more unusual or where there is an expectation of substantial learning may be subject to an After Action Review (AAR) or a Patient Safety Incident Investigation (PSII) at the discretion of our Risk & Incident Group.

Incidents meeting the 2018 Never Events criteria (or its successor) (see Appendix 1), and deaths thought likely to have been caused or hastened by problems in care (i.e. incidents meeting the learning from deaths criteria for PSII) will require a PSII. Where this is suspected, we will work closely with SNEE ICB.

Emergent issues are detected via reporting and analysis in specialist areas. For example, the Medicines Management Group may detect a run of medicines errors with the same coding, leading RIG to commission an analysis. Our Clinical Governance and Compliance Group looks at a range of safety and quality data via our Quarterly Quality Report and can require investigations and improvement work and allocate resources across the Directorate.

Responding to cross-system incidents/issues

St Helena will work with other healthcare providers when an incident spans us and another organisation. The RIG and the Associate Director for Clinical Services will coordinate this work. Where an incident spans several providers, St Helena will rely on SNEE ICB to facilitate a cohesive and effective collective response.

Timeframes for learning responses

St Helena policy requires that the investigation for most incidents will be available to the RIG within 20 working days of them being reported. This applies in particular to run-of-the-mill pressure ulcers, falls, and medicines errors. Incidents that are more complex and require a PSII will be granted more time, but the expectation will be that the investigation report will be available within two months. Compliance with timescales is monitored by the RIG. Reporting and investigation compliance for pressure ulcers, falls, and medicines errors is reported via our Quarterly Quality Report. Overall incident investigation compliance is reported monthly to our Senior Leadership Team.

Safety action development and monitoring improvement

The learning from patient safety incidents is analysed thematically by the RIG, which shares it with other governance groups, team meetings and other Directorates. The Clinical Governance and Compliance Group considers learning from incidents in the round with learning from complaints, risks, clinical audit, and patient experience.

All actions resulting from incidents are recorded on the relevant electronic incident record with automatic email notification and overdue reminders. Actions comprise the Incident Sponsor, the Incident Owner, details of the action itself (which should be SMART), evidence required to demonstrate completion, and due date. Where actions mandate certain items, such as a clinical audit or risk, these can be linked to the incident from the relevant Sentinel module, linking quality and safety work.

Action compliance is monitored weekly by the RIG and reported quarterly to the Clinical Governance & Compliance Group.

Safety improvement plans

Safety improvement plans can be generated for individual areas of activity by the responsible governance group; for instance, Infection Prevention and Control (IPC), the Clinical Quality Group, or Medicines Management. They can also be generated in

response to specific incidents or clusters of incidents by the RIG. Safety improvement plans can also be developed by the Matrons for our two MDTs.

In all these cases, the Clinical Governance and Compliance Group will monitor the plan. The CGCG can also look at inputs coming from all these subsidiary bodies, via the Quarterly Quality Report, and mandate Directorate-wide plans in response.

This is the approach best aligned with the size of our organisation and the work of a hospice, which is primarily about the alleviation of symptoms and rehabilitation.

Oversight roles and responsibilities

As per the PSIRF guidelines, St Helena will uphold the following standards:

3.1. Roles and responsibilities in relation to patient safety incident response are clearly described and understood by staff.

All roles and responsibilities are clearly defined in our PFS Incident Management Policy & Procedure [013] and are reinforced to staff through training and internal communications.

3.2. Oversight processes are underpinned by the 'oversight mindset' principles described in the Oversight roles and responsibilities specification (e.g. focus on improvement, are collaborative).

The PSIRF oversight principles will be incorporated into our quality improvement work, including the work of our RIG, and communicated via staff training. These principles are:

- Improvement is the focus. PSIRF oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality.
- Blame restricts insight. Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.
- Learning from patient safety incidents is a proactive step towards improvement. Responding to a patient safety incident for learning is an active strategy

towards continuous improvement, not a reflection of an organisation having done something wrong.

- Collaboration is key A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation – it must be done collaboratively.
- Psychological safety allows learning to occur Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.
- Curiosity is powerful. Leaders have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge.

3.3. Oversight approaches consider the recommendations in the Oversight roles and responsibilities specification (e.g. a variety of data is used, is not 'one size fits all').

These will be incorporated into our PFS Incident Management Policy & Procedure [013] and staff training as appropriate:

1. Use a variety of data
2. Reduce the information collection burden
3. Oversight is not 'one size fits all'
4. Capture meaningful insight from patients, families, and staff
5. Metrics require clarity and purpose
6. Be aware of perverse incentives

Complaints and appeals

Any complaints relating to our handling of an incident may be made verbally, by letter, by email or via our online complaints form. Details of all these can be found on our external website at https://www.sthelena.org.uk/contact-us

Everyone making a complaint will receive a complaints pack, including our Complaints Policy [011] within three working days of us receiving it. The complaint will then be

assigned an investigator, and the Complainant will be told who their point of contact and offered a face to face meeting, at a location of their choosing. At this meeting, the Complainant will be invited to outline the main points of their complaint, and action they would like taken, and whether they will receive a verbal or written response.

Following investigation of the complaints, we would hope to respond within 28 working days, at which time we will send the Complainant to report and/or arrange another face to face meeting to outline our findings and any actions taken or pending. We will offer the Complainant 20 days to indicate whether they are happy with the outcome before we close the complaint. However, we are sympathetic to reopening complaints if a longer period elapses. If the Complainant is dissatisfied with our report, we will work to resolve any outstanding concerns. If we are not able to reach an agreement, we will facilitate them having a meeting with one of our Trustees who will have the ability to make their own finding based on the investigation. Complainants are also welcome to contact our Chief Executive, whose details are available through our website.

Should the Complainant remain dissatisfied with the investigation, we will signpost them to the Parliamentary and Health Service Ombudsman who may choose to investigate.

Associated Policies and Procedures

- Access to Services Policy [904]
- Clinical Governance Policy [037]
- Duty of Candour and Patient Engagement Policy [012]
- Equality, Diversity, and Inclusion Policy Statement [916]
- Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy [331]
- Incident Management Policy and Procedure [013]
- PFS Complaints and Concerns Policy & Procedure [011]
- Privacy & Dignity Policy [004]
- Risk Management Policy [915]

Compliance with Statutory Requirements

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12: Safe care and treatment
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good governance
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20: Duty of candour

Staff Training Requirements

The PSIRF standards require the competencies required of engagement leads as the ability to:

- communicate on highly complex matters and in difficult situations
- 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[4]

Fortunately, as St Helena is a hospice, clinical staff already have training in advanced communications techniques are these are already applied to incident and complaint handling and all forms of communication.

Monitoring (Including Audit) and Frequency of Review

This policy will be reviewed every two years.

[4] NHS England (2022) 'Engaging and involving patients, families and staff following a patient safety incident' v2., p. 13.

Data Protection

Does this Policy require sign off from the Data Protection Officer?	No

Equality Impact Assessment Initial Screening Tool

Document Reviewer(s):	Clinical Compliance Officer	Date Assessment Completed:	22/08/2024

Assessment of possible adverse impact against any minority group			
Could the document have a significant negative impact on equality in relation to each area below?	Response		If yes, please state why, and the evidence used in your assessment
	Yes	No	
1. Age		X	
2. Sex		X	
3. Disability		X	
4. Race or Ethnicity?		X	
5. Religion and Belief?		X	
6. Sexual Orientation?		X	
7. Pregnancy and Maternity?		X	
8. Gender Reassignment?		X	
9. Marriage and Civil Partnership?		X	

- You need to ask yourself:
- Will the document create any problems or barriers to any community or group?
- Will any group be excluded because of this document?
- If the answer to either of these questions is yes, you must complete a full Equality Impact Assessment.

Assessment of positive impact			
Could the document have a significant positive impact by reducing inequalities that already exist?	Response		If yes, please state why, and the evidence used in your assessment
	Yes	No	
1. Promote equal opportunities		X	
2. Eliminate discrimination		X	
3. Eliminate harassment		X	

4. Promote positive attitudes towards disabled people		X	
5. Encourage participation by disabled people		X	
6. Consider more favourable treatment of disabled people		X	
7. Promote and protect human rights		X	

On the basis of the information/evidence/consideration so far, do you believe that the document will have a positive or negative adverse impact on equality?

Positive	Please rate (delete as applicable) the level of impact					Negative
			NIL			

Is a full equality impact assessment required? No

Appendix One – 2018 Never Events Criteria

For more details, see https://www.england.nhs.uk/wp-content/uploads/2020/11/2018-Never-Events-List-updated-February-2021.pdf

Surgical

- Wrong site surgery.
- Wrong implant/prosthesis.
- Retained foreign object post procedure.

Medication

- Mis-selection of a strong potassium solution.
- Administration of medication by the wrong route.
- Overdose of insulin due to abbreviations or incorrect device.
- Overdose of methotrexate for non-cancer treatment.
- Mis-selection of high strength midazolam during conscious sedation.

Mental health

- Failure to install functional collapsible shower or curtain rails.

General

- Falls from poorly restricted windows.
- Chest or neck entrapment in bed rails.
- Transfusion or transplantation of ABO-incompatible blood components or organs.
- Misplaced naso- or oro-gastric tubes.
- Scalding of patients.
- Unintentional connection of a patient requiring oxygen to an air flowmeter.
- Undetected oesophageal intubation (temporarily suspended as a never event).