PATIENT SAFETY INCIDENT RESPONSE POLICY

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Document History

Version No	Date	Description of Change	Amendments by name and job title

Document Status

This is a controlled document. Any printed copies of this document are not controlled.

Contents

1. INTRODUCTION

The Patient Safety Incident Response Framework (PSIRF) is a vital policy established by OSDH to ensure effective and comprehensive responses to patient safety incidents. This policy sets the foundation for a systematic and learning-focused approach that aims to maximise patient safety, promote continuous improvement, and foster a culture of transparency and accountability.

Recognising the complex nature of patient safety incidents and the need to balance timeliness and thoroughness, OSDH is committed to implementing the PSIRF to guide the organisation in responding to incidents in a consistent and structured manner. This framework aligns with best practices, regulatory requirements, and the overarching goal of enhancing patient safety outcomes.

The PSIRF is built upon several key principles that form the cornerstone of our patient safety incident response:

Learning and Improvement: The primary objective of the PSIRF is to promote a culture of learning and improvement. It encourages a proactive approach to identify root causes, contributory factors, and potential areas for improvement to prevent future incidents and enhance patient safety.

Inclusivity and Stakeholder Engagement: OSDH recognises the invaluable perspectives of patients, families, staff, and other stakeholders in the incident response process. The PSIRF emphasises their active involvement, promoting compassionate engagement, and creating channels for effective communication and feedback.

Flexibility and Adaptability: The PSIRF acknowledges that patient safety incidents vary in their complexity and impact. It encourages a flexible approach that tailors responses to the unique circumstances of each incident, while ensuring a balance between timeliness and thoroughness.

Continuous Review and Evaluation: To maintain effectiveness, the PSIRF undergoes regular reviews and evaluations to align with emerging best practices, regulatory requirements, and organisational priorities. This ensures the framework remains responsive to evolving challenges and fosters ongoing improvement in patient safety outcomes.

OSDH is committed to implementing the PSIRF across all patient-facing services and departments. This policy will be supported by clear guidelines, training programs, and resources to equip staff with the necessary knowledge and skills to effectively respond to patient safety incidents.

Furthermore, the organisation will foster a culture that encourages incident reporting, learning from near misses, and sharing of best practices. The Governance Team, in collaboration with relevant stakeholders, will oversee the implementation and continuous improvement of the PSIRF.

By adhering to the principles outlined in this policy, OSDH strives to create a safe and supportive environment that prioritises patient safety, continuous learning, and proactive improvement.

2. PURPOSE

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out OSD Healthcare's (OSDH) 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 the 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.

The PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Instead, organisations are now able to balance effort between learning through responding to incidents or exploring issues and improvement work.

3. SCOPE

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

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, therefore, do not solely focus on the actions of individuals, or 'human error', even when these are reported to be 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, 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.

4. EXCLUSIONS

None.

5. DEFINITIONS

Term/Acronym	Definition
CQC	Care Quality Commission - independent regulator of health and social care in *England*
Definitions of Harm	Unanticipated, unforeseen accidents (eg, patient injuries, care complications, or death) which are a direct result of the care dispensed rather than the patient's underlying disease
Duty of Candour	Being open and honest with patients and families when treatment or care goes wrong.
Governance Structure	System that provides a framework for managing organisations
HSE	Health and Safety Executive
HSIB	Health and Safety Investigation Branch
Human Error	A human error is an action or decision which was not intended that has negative consequences or fails to achieve the desired outcome

Inequalities data	Facts and statistics collected relating to health inequalities which are unfair and avoidable differences in health across the population, and between different groups within society.
Integrated Care Board (ICB)	Statutory organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS.
Just Culture Approach	The treating of staff involved in a patient safety incident in a consistent, constructive and fair way.
MHRA	Medicines and Healthcare products Regulatory Agency
Never Events	A nationally recognised category of incidents that could cause harm to people that should never happen and can be prevented.
NHSE	National Health Service England
Paradigm Shift	An important change that happens when the usual way of thinking about or doing something is replaced by a new and different way
Principles of Proportionality	The least intrusive response appropriate to the risk presented
PSII	Patient Safety Incident Investigation.
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrence Regulations
Stakeholder	People or groups who have an interest in what an organisation does, and who are affected by its decisions an actions.
Swarm Huddle	Swarm-based 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.
Triangulation	Triangulation involves cross-referencing and validating data from multiple sources, such as incident reports, patient feedback, and staff observations.

6. OUR PATIENT SAFETY CULTURE

OSDH is committed to adopting a just culture approach, in accordance with the NHS Just Culture Guide, to enhance safety culture through ongoing and planned initiatives. Extensive research on organisational safety consistently highlights the significance of fostering an open and transparent culture where colleagues can freely report incidents and express concerns without apprehension of negative consequences. This culture is crucial for continuous improvement in safety.

OSDH actively encourages and supports incident reporting from all staff members whenever they witness or anticipate an event that has caused or could potentially cause harm to patients or staff.

To support and enhance the safety culture at OSDH implementation has commenced in August 2023 of the new Risk Management and Oversight system. In addition to being a vehicle to support active and timely reporting it will support triangulation of risk management data.

The importance of triangulation of risk management data in healthcare cannot be overstated, as it plays a pivotal role in supporting incident reporting and fostering a transparent culture.

By utilising this comprehensive approach, OSDH can gain a more accurate and holistic understanding of potential risks and safety issues. Triangulation not only ensures the reliability of data but also helps identify patterns and trends that may have otherwise been overlooked, allowing for more targeted interventions and risk mitigation strategies. In turn, this robust and evidence-based approach instils confidence in incident reporting, as OSDH employees feel their concerns are being taken seriously and addressed with diligence.

The ultimate aims are that a more transparent culture will emerge at OSDH from this process, openly acknowledging and learning from incidents, promoting open communication, and collaboratively engaging stakeholders in continuous improvement initiatives. Consequently, the adoption of triangulation in risk management not only enhances patient safety outcomes but also promotes a culture of trust, accountability, and proactive commitment to delivering high-quality healthcare services at OSDH.

7. PATIENT SAFETY PARTNERS

OSDH is dedicated to implementing patient safety partners in accordance with the NHSE guidance Framework for involving patients in patient safety. Patient Safety Partners (PSPs) will play a crucial role in supporting our Patient Safety Incident Reporting Framework (PSIRF) by providing invaluable patient perspectives to drive continuous improvement.

A Patient Safety Partner (PSP) actively participates in the design of safer healthcare practices across all levels of the organisation. This entails maximising positive experiences and minimising adverse incidents for patients throughout their treatment, care, and service journey with us. Leveraging their personal experiences as patients, caregivers, family members, or members of the local community, PSPs will offer support and advice on activities, policies, and procedures aimed at enhancing patient safety and delivering high-quality care.

PSPs will collaborate with staff, volunteers, and patients, attending both face-to-face and online meetings. They will actively engage in projects to co-design patient safety initiatives, contributing to and participating in key discussions and meetings within OSDH that focus on patient safety. With a strong commitment to improving outcomes, PSPs will ensure that the patient, caregiver, and family perspective is represented, and that committee and meeting members adopt a patient-centric approach.

OSDH will undertake an internal exercise in Autumn 2023 to explore ways to recruit patient safety partners from its private patient membership database and will also explore opportunities for recruiting Patient Safety Partners with local healthcare providers.

8. ADDRESSING HEALTH INEQUALITIES

As an independent Private Acute Hospital, OSDH recognises its supportive role in addressing health inequalities in collaboration with local partner agencies and services. Through the implementation of the Patient Safety Incident Reporting Framework (PSIRF), OSDH will leverage data and insights gained from investigations to identify and address actual and potential health inequalities. Recommendations based on these findings will be made to the OSDH Board and partner agencies to promote actions that tackle health inequalities effectively.

OSDH currently holds a number of NHS sub-contracts for commissioned services, this ensure that patients have access to a range of services. Sharing resources, expertise, and data can lead to more comprehensive and integrated care for patients.

Under PSIRF, which emphasises a holistic and integrated approach to patient safety, OSDH is committed to fostering collaboration with the patient experience and inclusivity agenda. Investigations and the subsequent learning process will encompass these crucial aspects of the broader health and societal landscape. In engaging with patients, families, and carers following a patient safety investigation, due consideration will be given to diverse needs, ensuring inclusivity for all.

Throughout the investigation process, OSDH will actively identify and address any potential inclusivity or diversity issues. Engagement with patients and families, particularly during the duty of candour and open disclosure processes, will serve as a platform to identify and address these concerns effectively.

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

The Patient Safety Incident Reporting Framework (PSIRF) acknowledges that genuine learning and improvement following a patient safety incident can only occur when supportive systems and processes are established. Therefore, it promotes the establishment of an effective patient safety incident response system that places compassionate engagement and involvement of those affected at the forefront.

The PSIRF prioritises the engagement of patients, families, and staff who have been affected by patient safety incidents. This entails working closely with them to comprehensively understand their concerns and inquiries related to the incident. Furthermore, it involves providing appropriate guidance and support, directing them to relevant resources or assistance whenever necessary.

By emphasising compassionate engagement and involvement, the PSIRF aims to ensure that those affected by patient safety incidents are heard, respected, and supported throughout the response process. This inclusive approach enables the development of a learning environment that fosters continuous improvement in patient safety.

To support delivery of an approach that is both supportive and engaging with families, patients and staff, a cohort of front-line staff who will be involved in investigating patient safety incidents will undergo formal training with an external provider.

OSDH will also consult with its network of staff members who are enthusiastic and trained in a variety of roles such as Mental Health First Aiders, Freedom to Speak Up Guardians and Dementia Leads to support in ensuring that our approach is supportive and engaging.

9.1 Involving Patients & Families

OSDH acknowledges the significance of involving patients and families following patient safety incidents and is fully committed to engaging them in the investigation process while fulfilling the requirements of the Duty of Candour.

Through experience and research, it has been recognised that patients and families often offer unique perspectives on the circumstances surrounding patient safety incidents. They may also have distinct questions or needs that differ from those of the organisation. Therefore, this policy reinforces the existing guidance pertaining to the Duty of Candour and the principle of 'being open.' It emphasises the necessity of involving patients and families in all stages of patient safety incident investigations and improvement planning, unless they express a desire not to be involved.

To ensure comprehensive guidance on involving patients and families following a patient safety incident, the policy directs stakeholders to consult the relevant resources provided by the National Health Service England (NHSE). Detailed information can be found at the following link: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/#heading-2

See also the OSDH **Duty of Candor Policy CORP-06**.

9.2 Involving Staff, Colleagues and Partners

Similarly, OSDH acknowledges the utmost importance of involving staff and colleagues, including partner agencies, in the response to patient safety incidents. This approach ensures a comprehensive and inclusive response right from the beginning. The policy aligns with existing guidance, such as the incident reporting and management policy, while recognising that it should not be limited to incidents meeting harm thresholds or predefined categories.

OSDH will continue to promote, support, and encourage staff and partners to report all incidents or near-misses, shifting the focus towards incidents or groups of incidents that offer the greatest potential for learning and improvement. This approach prioritises a proactive learning culture.

Implementing this new approach signifies a culture shift within the organisation. To facilitate this change, OSDH will provide the necessary support and guidance utilising principles of effective change management. It is vital that staff feel engaged and included throughout the process rather than feeling that changes are imposed upon them. Regular communication and involvement will be ensured through the organisation's established communication framework and wider governance structures.

Furthermore, OSDH recognises the importance of fostering an environment where staff and colleagues feel supported and empowered to speak out and report incidents and concerns openly, without fear of recrimination or blame. Incident reporting levels will be closely monitored, and an open and just culture will be actively promoted to sustain this supportive atmosphere.

10. PATIENT SAFETY INCIDENT RESPONSE PLANNING

The Patient Safety Incident Reporting Framework (PSIRF) facilitates organisations in responding to incidents and safety issues in a manner that prioritises learning and improvement, rather than relying solely on arbitrary or subjective harm definitions. In addition to meeting national requirements, organisations are encouraged to explore patient safety incidents within their specific context and the populations they serve, rather than being limited to incidents that meet a predefined threshold.

OSDH fully embraces this approach, aiming to allocate resources effectively by focusing on incidents or groups of incidents that offer the greatest potential for learning and improving safety. This proactive stance enables the organisation to address specific challenges and enhance safety measures based on its unique circumstances and patient demographic.

Furthermore, OSDH recognises the importance of incorporating feedback and intelligence from various sources in its forward planning. This includes considering inputs from complaints, risk assessments, legal claims, mortality reviews, and other forms of direct feedback from both staff and patients. By embracing a holistic approach to data and information, OSDH can better identify areas for improvement and implement necessary changes to enhance patient safety.

PSIRF guidance specifies the following standards that our plans should reflect:

1. A thorough analysis of relevant organisational data
2. Collaborative stakeholder engagement
3. A clear rationale for the response to each identified patient safety incident type

They will also be:

1. Updated as required and in accordance with emerging intelligence and improvement efforts
2. Published on our external facing website

The associated OSDH patient safety incident response plan (PSIRP) will reflect these standards and will be published alongside this overarching policy framework.

11. RESOURCES AND TRAINING TO SUPPORT PATIENT SAFETY INCIDENT RESPONSE

PSIRF recognises the finite nature of resources and capacity to investigate and learn from patient safety incidents effectively. Therefore, it is crucial for OSDH as an organisation to assess its capacity and resources to ensure the successful implementation of the plan.

Currently, the Governance Team comprises the following working time equivalent posts to support and facilitate the PSIRF framework:

1 x Associate Director of Quality and Governance

1 x Compliance and Quality Administrator

1 x Governance Secretary

OSDH is actively working towards establishing a pool of trained investigators capable of conducting comprehensive investigations. However, it should be noted that the majority of investigators have substantive clinical or governance roles, which necessitates allocating time within their job plans to complete investigations. The OSDH PSIRP will provide more specific guidance on incidents that require comprehensive investigation.

As part of mandatory patient safety training, all staff are required to complete training covering the fundamental aspects of reporting, investigating, and learning from incidents. Operational managers are expected to involve relevant staff in routine/low-risk incident reviews, although the Governance Team is available to provide additional advice and guidance if needed. It is important for the organisation to seek regular feedback from colleagues regarding incident investigation and learning, and to assess whether additional or tailored training is necessary for wider implementation or specific staff groups and individuals.

12. THE PATIENT SAFETY INCIDENT RESPONSE PLAN

The Patient Safety Incident Response Plan (PSIRP) outlines OSDH's approach to responding to patient safety incidents within a 12-month period. It is important to note that the plan is not rigid or permanent, and OSDH remains adaptable to consider the unique circumstances surrounding each patient safety incident and the needs of those affected.

The PSIRP is developed based on a comprehensive analysis of themes and trends observed in incidents spanning the period from 2020 to 2022. This analysis encompasses incidents across various levels of harm, including low harm, no harm, and near misses. Additionally, inputs from risk registers, complaints, audit outcomes, and feedback from staff and patients are taken into account. These comprehensive sources of information contribute to the identification of priorities within the PSIRP.

To ensure ongoing effectiveness, the priorities outlined in the PSIRP undergo regular review. This continuous evaluation process ensures that the plan remains responsive to unforeseen or emerging risks, allowing for necessary adjustments and improvements in patient safety practices.

13. REVIEWING OUR PATIENT SAFETY INCIDENT RESPONSE POLICY AND PLAN

The OSDH PSIRP is a dynamic and ever-evolving document that will be appropriately amended and updated as it is utilised to respond to patient safety incidents. The plan will undergo a comprehensive review every 12 months to ensure its relevance and effectiveness. This review process acknowledges that our patient safety incident profile is subject to change as we continually strive for improvement.

The regular plan review also provides an opportunity to re-engage with stakeholders and seek their input on any changes made during the previous 12 months. This collaborative approach ensures transparency and alignment among all involved parties.

Updated versions of the plan will be published on our website, replacing any previous iterations. This enables easy access for staff, patients, and other stakeholders to stay informed about our current patient safety incident response approach.

Additionally, a rigorous planning exercise will be conducted every four years, or more frequently if deemed appropriate by our integrated care board (ICB). This comprehensive review will encompass multiple elements, such as assessing response capacity, mapping services, analysing organisational data (including patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data), and engaging with a wide range of stakeholders.

14. RESPONDING TO PATIENT SAFETY INCIDENTS

14.1 Patient Safety Incident Reporting Arrangements

Patient safety incident reporting will remain in line with OSDH's Incident Management Policy. It is recognised that staff must continue to feel supported and able to report any incidents, or concerns in relation to patient safety, to promote a system of continuous improvement and a just and open culture.

Operational managers and the Governance Team will ensure any incidents that require cross system or partnership engagement are identified and shared through existing channels and networks, and that partnership colleagues are fully engaged in investigations and learning as required.

Certain incidents require external reporting to national bodies such as HSIB, HSE, RIDDOR and MHRA.

15. PATIENT SAFETY INCIDENT RESPONSE DECISION-MAKING

The reporting of incidents within OSDH will adhere to the guidelines outlined in the OSDH Incident Management Policy and associated guidance documents.

As part of our ongoing improvement efforts, OSDH is transitioning from one risk management system to another. The new system will provide enhanced functionality to effectively oversee incidents, risks, complaints, central alerts, NICE Guidance, and audits.

The Governance team equips Heads of Department with access to Power BI dashboards, which present comprehensive data on incidents, complaints, patient feedback, and patient satisfaction. This enables Heads of Department to review relevant information for their respective areas.

Regular reports are generated by the Governance team using the Power BI analytics platform, and they are shared with Governance Groups and Committees. The reporting frequency varies, ranging from monthly to quarterly, allowing for the identification and tracking of emerging themes and trends that extend beyond typical variations. These reports are compared against the identified priorities in the Patient Safety Incident Response Plan (PSIRP) to determine if any adjustments in focus are necessary.

The PSIRP and supporting guidance will encompass a wider range of options for further investigation, as outlined in the Patient Safety Incident Response Framework (PSIRF). The decision-making process within OSDH's PSIRP will be guided by the principles of proportionality and a focus on incidents that provide the greatest potential for learning. Consequently, there may be instances where no further investigation is deemed necessary, particularly if the incident aligns with one of the improvement themes identified in the PSIRP.

16. RESPONDING TO CROSS-SYSTEM INCIDENTS/ISSUES

OSDH will ensure it is responsive to incidents reported by partner colleagues that require input from the OSDH, primarily by directing enquires to the relevant clinical teams or colleagues and seeking assurance that engagement, information sharing and learning has been achieved, or taken forward.

OSDH has actively built-up relationships with its NHS partners. In addition to regular monthly reporting of incidents and patient feedback, quarterly quality meetings and annual visits, there is often open dialogue to discuss patient incidents and feedback. This will come from individual departments and/or from the Governance Team. Cross organisational learning is already evident.

OSDH holds regular Radiological Events and Learning Meetings with consultants with Practicing Privileges. These Consultants often hold contracts with local NHS Providers and in keeping with the ethos of the meeting we are able to share learning from across organisations.

17. TIMEFRAMES FOR LEARNING RESPONSES

Learning responses within OSDH must strike a balance between the need for timely information capture and the thoroughness required to identify key contributory factors and associated learning for improvement. It is essential to achieve this equilibrium to ensure effective learning and improvement processes.

Timeliness in learning responses heavily relies on the prompt and accurate reporting of incidents while the details are fresh in the minds of the incident reporter and the wider team. The importance of these principles is already outlined in the current incident reporting policy, but their significance must be reinforced through the Patient Safety Incident Response Framework (PSIRF).

The PSIRP offers more comprehensive guidance on the appropriate types of learning responses based on the specific circumstances of each incident. While specific timeframes for learning responses may not be universally applicable, the following guidelines are provided:

Immediate Actions: Swift actions should be taken when immediate risks or patient safety concerns are identified.

Rapid Response: Actions should be initiated promptly, typically within 72 hours, to address incidents with significant potential for harm or systemic issues.

Expedited Response: Incidents requiring a more in-depth analysis and investigation should be addressed within a reasonable timeframe, typically within two weeks.

Standard Response: Incidents that are less severe or have limited immediate impact should be investigated and responded to within a reasonable timeframe, typically within 30 days.

These timeframes serve as guidelines to ensure a reasonable balance between timeliness and thoroughness in the learning response process.

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

One of the most important factors in ensuring timeliness of a learning response is thorough, complete and accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team. These principles are set out in the current incident reporting policy but must be reinforced through the PSIRF.

The PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident. Highly prescriptive timeframes for learning responses may not be helpful so the following are included as a guideline only:

- Initial incident investigation – as soon as possible, within 5 working days of reporting
- Further learning response (eg: PSII, AAR, Swarm huddle) – within 20 working days of reporting
- Comprehensive Investigation – 60 - 120 working days depending on complexity.

A toolkit of learning response types is available from NHSE at:
https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

18. SAFETY ACTION DEVELOPMENT AND MONITORING IMPROVEMENT

The weekly Quality Surveillance Group will play a key role in deciding how OSDH will respond to any individual PSII's. Where necessary the group will seek advice and guidance from both internal and external advisors.

Monitoring of completion and efficacy of safety actions will be through organisational governance processes with oversight at the Governance Committee and Corporate Assurance and Ethics Group. Each department with the development of the new risk management system will have an overview across their department. The Governance team will also have an overview across the organisation to identify themes, trends and triangulation with other sources of information that may reflect improvements and reduction of risk.

It is important that monitoring of completion of safety is a means to improve safety and quality outcomes and reduce risk. OSDH is committed to development of its new risk management system and Power BI platforms to provide focus on measuring and monitoring these outcomes.

19. SAFETY IMPROVEMENT PLANS

OSDH has developed a Patient Safety Incident Response Plan (PSIRP) that clarifies what the OSDH improvement priorities are. The PSIRP details how we will ensure patient safety incidents are investigated in a more holistic and inclusive way, to identify learning and safety actions which will reduce risk and improve safety and quality.

These themes, as detailed in the PSIRP, are based on an analysis of historic data and information from a range of sources.

OSDH will review its existing governance processes in line with the PSIRF guidance so it is clear how the PSIRP improvement priorities will be overseen through governance structures and processes. Corporate oversight at the Corporate Assurance and Ethics Group will provide 'ward to board' assurance.

20. OVERSIGHT ROLES AND RESPONSIBILITIES

Responsibility for oversight of the PSIRF sits with the OSDH Board. The Executive Leads are the CEO and the Medical Director who hold joint responsibility for effective monitoring and oversight of PSIRF.

OSDH recognises and is committed to close working, in partnership, with the local ICBs and other national commissioning bodies as required. Oversight and assurance arrangements will be developed through joint planning and arrangements must incorporate the key principles detailed in the guidance above, namely:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Policy, planning and governance
3. Competence and capacity
4. Proportionate responses
5. Safety actions and improvement

It is important that under PSIRF there is a paradigm shift from monitoring of process, timescales and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients.

It is recognised that ICB's through the local NHS Providers who OSDH provides NHS subcontracted services to, will wish to seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety. The metrics, measures (objective and subjective) and evidence required to do this will need to be defined within the PSIRP for each priority which will be agreed in discussion with the ICB.

21. COMPLAINTS AND APPEALS

Any complaints relating to this guidance, or its implementation can be raised informally with the Associate Director of Quality and Governance, initially, who will aim to resolve any concerns as appropriate.

Formal complaints from patients or families can be lodged through OSDH's complaints procedure.

22. ASSOCIATED DOCUMENTATION

- Policy for the Management of Incidents GOV–06
- Duty of Candour Policy CORP-06
- Complaints Management Policy CORP-05

23. EQUALITY IMPACT ASSESSMENT

	Yes/No	Comments
1. Does the policy affect any group less or more favourably than another on the basis of:	No	
Gender	No	
Race	No	
Ethnic Origins	No	
Nationality	No	
Culture	No	
Religion or Belief	No	
Sexual Orientation	No	
Age	No	
Disability - learning disabilities, sensory, impairment and mental health problems, physical disabilities	No	This policy will be available electronically so the font and background colour can be adjusted to accommodate visual impairment.
2. Is there any evidence that some groups are affected differently?	No	
3. If you have identified potential discrimination, are there exceptions valid, legal and/or justifiable?	No	
4. Is the impact of the policy likely to be negative?	No	
5. If so can the impact be avoided?	N/A	
6. What alternative is there to achieving the requirements of the policy without impact?	N/A	
7. Can the impact be reduced by taking different action?	N/A	
8. Please list any staff training on equalities issues arising from this assessment.	N/A	

Completed by: Corrie Sellers, Associate Director of Quality and Governance Date: 31 January 2024

Equality Impact Assessed As (please highlight e.g.): Low Medium High