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Policy

Patient Safety Incident Response

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the approach Rethink Mental Illness will take to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

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

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

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

Scope

The PSIRF is a NHS approach and regulatory requirement and as such uses terminology and language familiar within the NHS. References to patient within this policy and refer to service users, the term more generally used within Rethink Mental Illness

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Rethink Mental Illness.

Response types that are outside the scope of the patient safety incident response plan are: complaints, human resources investigations, coronial inquests, criminal investigations, claims management, financial investigations and audits, safeguarding concerns, information governance concerns and estates and facilities issues. For the above, the relevant Rethink Mental Illness policies, procedures and processes will be referred to.

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, 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.

1.0 Patient safety culture

Rethink Mental Illness supports open and transparent reporting by having the following mechanisms in place:

Day to day operations: support planning and risk assessments; supervision and support; structured learning and development; incident reporting; complaints; feedback and comment (Friends and Family); service user satisfaction surveys; line management review.

Management oversight: Operations risk register; policies, procedures and processes (including complaints, whistleblowing and Duty of Candour); management performance meetings; the Quality and Safety Board which is a cross-departmental group tasked to review service user and staff related risk and risk management assurance systems.

Governance: Audit and Assurance Committee, a constituted committee of the Board of Trustees is responsible for overseeing all aspects of the charity's external and internal audit arrangements, internal control procedures and risk management and also has responsibility for monitoring health and safety and for ensuring that the charity delivers high quality services, operating in compliance with regulatory frameworks.

Independent / external assurance: Commissioner / stakeholder reviews; Care Quality Commission inspections; Quality Standards and Accreditation; Health and Safety Executive and Charity Commission.

Rethink Mental Illness promotes a climate that fosters a just culture through our internal investigation process which is implemented following a patient safety incident.

The current structure for responding to and oversight of patient safety incidents is detailed in the plan.

2.0 Patient safety partners

The Rethink Mental Illness response to the patient safety incident response framework is overseen through the Quality and Safety Board which reports on its progress to the Audit and Assurance Committee quarterly.

The Quality and Safety Board is responsible for developing and maintaining the charity's incident response policy and plan.

The Quality and Safety Board is made up of:

- Executive Director of Operations (Executive Lead for PSIRF)
- Director of Quality and Business Intelligence
- Director of Services
- Director of People and OD
- Director of Campaigns and Communications
- Head of Integrated Governance
- Human Resources Business Partner

The following patient safety partners:

- Service users
- Families and carers
- Local service management and support staff

The Head of Involvement and local Operations management will be involved where required to enable the views of our identified patient safety partners to be engaged in the incident response process.

Rethink Mental Illness have identified the following external partners:

- Care Quality Commission
- Local Authority Safeguarding Teams
- NHS Trusts (ICBs)

Where required, Rethink Mental Illness have engaged in local conversations with ICBs to ensure roles, responsibilities and oversight processes have been established.

3.0 Addressing health inequalities

Rethink Mental Illness' mission is to lead the way to a better quality of life for all people with lived experience, their carers, families and friends. We want to influence the quality of care that people receive at a national and local level and work in partnership with others to deliver support and services needed. The place-based approach the charity takes means we will make sure that regardless of an individual's situation they are always treated as a whole person and their rights respected.

The Rethink Mental Illness Communities that Care strategy identifies five principles:

1. Co-production and involvement
2. Equity and inclusion
3. Collaboration and partnership
4. Generous leadership
5. Impact

The strategy aims to deliver the following outcomes:

- **Access to health and social care:** people living with mental illness and their carers get the right treatment, care and support at the right time, in the right place.
- **Housing:** people living with mental illness have a safe and secure place to call home.
- **Employment, education, training and volunteering:** people living with mental illness have the opportunity to take on meaningful employment, education, training and volunteering which enhances self-worth.
- **Physical health:** people living with mental illness enjoy good physical health. Living with mental illness should not affect life expectancy.
- **Social connectedness:** people living with mental illness, and carers, can sustain and develop the social connections that mean the most to them.
- **Money:** people do not end up in debt because of their mental illness or become more unwell because of money problems.

For further information, refer to the Communities that Care Strategy.

There is a clear link between the physical health outcome detailed within our Communities that Care strategy and our patient safety incident response processes which support health equality and reduce inequality.

Equality considerations are an integral part of the current Rethink Mental Illness patient safety incident response processes and those identified through our work to improve the safety culture (see section 1) will help to identify any disproportionate risk to service users with specific characteristics. Any disproportionate risks will be included within the Patient Safety Incident Response Plan and learning will be shared to inform future service delivery.

Rethink Mental Illnesses patient safety incident response processes enable us to involve service users, families and staff following a patient safety incident which will take into consideration their different needs.

We have undertaken work to develop the engagement and involvement of service users and families within our processes and ensure that staff undertaking patient safety incident investigations have the appropriate training and skills to do this in a positive and compassionate way.

4.0 Engaging and involving parents, families and staff following a patient safety incident

As a registered provider of regulated care services, Rethink Mental Illness has a general responsibility under the duty of candour to be open and transparent with people receiving care from our services.

The duty promotes a culture of openness where harm occurs in connection to the provision of care. Where harm does occur, there is a requirement to tell a service user in person what has happened and give an apology, and follow up in writing.

Rethink Mental Illness ensure that when a safety incident is identified that may invoke the duty, the Duty of Candour Panel will convene and ensure all relevant action is taken in line with the policy and Regulation.

Rethink Mental Illness will ensure that the engagement principles as identified in the patient safety incident response standards are followed:

1. Apologies are meaningful
2. Approach is individualised
3. Timing is sensitive
4. Those affected are treated with respect and compassion
5. Guidance and clarity are provided
6. Those affected are 'heard'
7. Approach is collaborative and open
8. Subjectivity is accepted
9. Strive for equity

The approach Rethink Mental Illness takes to investigations following a patient safety incident already incorporates engaging and involving staff who have been affected.

Rethink Mental Illness recognises the importance of working with those affected by patient safety incidents to understand and answer questions they have in relation to the incidents, provide appropriate support and ensure that learning and improvement is achieved.

Rethink Mental Illness aims to build on the Duty of Candour process already in place where harm or potential harm has been caused to a service user.

5.0 Patient safety incident response planning

PSIRF supports Rethink Mental Illness to respond to incidents and safety issues in a way that maximises learning and improvement. Beyond nationally set requirements, PSIRF allows Rethink Mental Illness to explore patient safety incidents relevant to our context and the service users we support, rather than only those that meet a certain defined threshold.

PSIRF will allow Rethink Mental Illness to focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improving 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 Rethink Mental Illness patient safety incident response plan will reflect these standards and will be published alongside this policy.

6.0 Resources and training to support patient safety incident response

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. It is therefore essential that we evaluate our capacity and resources to deliver our plan.

Currently the following have been identified to support and facilitate the PSIRF framework:

A PSIRF panel will be convened. Standing panel members include: Director of Quality and Business Intelligence, Safeguarding Nominated Lead; Head of Integrated Governance or Head of Quality and Service Support; relevant Regional Associate Director and/or Head of Area. The Associate Director of People and OD and/or the Clinical Lead will attend as required.

There is a pool of trained investigators who can undertake investigations, though all have substantive roles and must therefore be allocated time within working hours to complete investigations.

The Patient Safety Incident Response Plan further details the requirement for additional training in relation to engaging and involving service users and families following a patient safety incident.

All staff receive training (briefing) which covers the basic requirements of reporting, investigating and learning from incidents. It is therefore expected that operational managers will involve all relevant staff in more routine and/or low risk incident reviews.

We will seek regular feedback from colleagues with regard to investigating and learning from incidents and consider whether any additional or bespoke training is required, either more widely or targeted at specific teams or individuals.

7.0 Patient safety incident response plan

Our plan sets out how Rethink Mental Illness 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.

Our plan has been developed following engagement events and following the thematic review of data relating to Quality Audits, Quality and Safety Board investigations and Human Resources Investigations from between 2021-2023 and further reviewed with data from 2024.

The priorities identified in the plan will be regularly reviewed against Quality and Business Intelligence governance reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

8.0 Reviewing our patient safety incident response policy and plan

The 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. The plan will be reviewed 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 planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with Somerset our lead Integrated Care Board) 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.

9.0 Responding to patient safety incidents

9.1 Patient safety incident reporting arrangements

Patient safety incident reporting will remain in line with the Incident Reporting Management Policy and Toolkit. 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 an open culture.

Operational managers, the Head of Integrated Governance and the Head of Quality and Service Support will ensure incidents that may meet the patient safety incident threshold are identified and shared through existing channels, i.e. the Quality and Safety Board.

Certain incidents will require external reporting to the relevant Trust (ICB), commissioner, Care Quality Commission (CQC), local authority safeguarding team, Health and Safety Executive and RIDDOR. Mechanisms for escalating and reporting patient safety incidents to external partners are in place.

9.2 Patient safety incident response decision making

Rethink Mental Illness, where acting as Lead Accountable Body, will ensure we are responsive to incidents reported by partners that require input and will seek assurance that engagement, information sharing and learning has been achieved and taken forward.

The reporting of incidents should continue in line with the existing policy and toolkit. There are oversight and assurance systems in place to ensure the oversight of incidents at a local and organisational level. The Integrated Governance and Quality Teams will work with operational managers to ensure the following arrangements are in place:

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends or clusters of incidents within a specific service
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risk and issues, e.g. CQC concerns
- Identification of any incidents requiring external reporting or scrutiny
- Identification of any other incidents of concern such as serious near-misses or significant failures in established safety procedures

Any incidents identified that may meet the patient safety incident profile must be reported to the Head Of Area within 24 hours of being identified. Within 48 hours a meeting of the PSIRF

panel will be convened. A log of all incidents possibly meeting the patient safety incident profile will be maintained.

The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under the plan. This may mean no further investigation is required, especially where the incidents falls within one of the improvement themes identified in the plan.

It is recognised that some incidents may still require a comprehensive investigation, even though they fall outside of the PSIRF framework.

The Quality and Safety Board will have oversight of the PSIRF Panel and any investigations falling outside of the patient safety incident response plan.

9.3 Responding to cross-system incidents/issues

Where Rethink Mental Illness is working in partnership we will ensure we are responsive to incidents and will seek assurance that engagement, information sharing and learning has been achieved and taken forward. We will have information sharing agreements in place with key partners to ensure effective communication during an incident response and during any improvement work that has been identified. We recognise our role in the escalation of learning responses to beyond those partners who are immediately involved.

9.4 Timeframes for learning responses

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

Complete and accurate incident reporting when the circumstances are fresh in people's minds is key and these principles are set out in the current Incident Reporting Management Policy and Toolkit and are reinforced through the PSIRF.

The plan provides more detail on the types of learning response most appropriate to the circumstances of the incident; however, the following guidelines are in place:

- Initial incident investigation – as soon as possible and within 5 working days of reporting
- Comprehensive investigation – 30 – 60 days depending on complexity.

9.5 Safety action development and monitoring improvement

Actions identified from patient safety incidents are reviewed and signed off by the Quality and Safety Board. Actions are shared with the Director of Services, Regional Associate Director and Head of Area initially. Learning is then further disseminated to the local service team by the Head of Area; however, the Patient Safety Incident Response Plan recognises that further alignment is required to ensure a consistent approach to the dissemination of learning at a local level, and where necessary to the wider Operations Directorate and/or organisation.

An action plan is completed at a local level, with support from the Quality and Service Support Team, if necessary. Completion of actions is overseen by the Quality and Service Support Team and monitored by the Quality and Safety Board and progress against actions is reported to the Audit and Assurance Committee on a quarterly basis.

The Patient Safety Incident Response Plan identifies further work in relation to improved monitoring of the implementation of safety actions and improved evaluation of the effectiveness of actions.

9.6 Safety improvement plans

Rethink Mental Illness has developed a Patient Safety Incident Response Plan which details our improvement priorities. The plan 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 across our services.

The improvement priorities (themes) detailed within the plan are based on an analysis of data and information from a range of sources (e.g. Quality audits, safeguarding investigations, whistleblowing investigations, service user deaths, complaints and Human Resources investigations).

For each theme, the plan will determine what the key drivers are to patient safety risks, how improvements can be made and how these can be monitored for completion and effectiveness. Whilst the plan identifies the broad priorities, it is recognised there may be more specific priorities and improvements at a local service level which will not form part of the overarching plan, but can still be approached using the PSIRF approach.

The Patient Safety Incident Response Plan details our improvement priorities. The Quality and Safety Board which provides oversight, has representation from Integrated Governance, the Quality Team and Operations, ensuring that expertise is available when responding to and monitoring the effectiveness of safety improvement plans, The Quality and Service Support Team will provide support and guidance as required to services.

Rethink Mental Illness is reviewing its internal governance processes in line with PSRIF guidance so it is clear how the improvement priorities detailed within the plan will be overseen through Corporate governance structures and processes.

10.0 Oversight roles and responsibilities

Responsibility for the oversight of the PSIRF for provider organisations sits with the Board of Trustees. The Board of Trustees has designated the Audit and Assurance Committee as the committee that holds responsibility for effective monitoring and oversight of PSIRF. The sections above describe more operational principles of monitoring and oversight, principally via the Quality and Safety Board.

Rethink Mental Illness recognises and is committed to close partnership working with the relevant local ICBs and Somerset ICB, our Lead ICB, to ensure oversight and provide assurance that improvements and priorities under PSIRF are progressing and improvements in quality and safety are being delivered.

11.0 Complaints and appeals

Any complaints relating to this policy or its implementation can be raised via the Complaints process.

Related Rethink Mental Illness documents:

Best Practice Guide for Investigations
Complaints Policy
Duty of Candour Policy
Incident Reporting and Management Policy and Toolkit
Whistleblowing Policy
Audit and Assurance Committee Terms of Reference
Quality and Safety Board Terms of Reference

Equality Impact Assessment

The content of the policy does not adversely affect any group with protected characteristics as defined by the Equality Act 2010.

Authorised by:

Chief Executive Officer