Practice Plus Group

Patient Safety Incident Response Framework (PSIRF) Policy

Related policies

This policy supersedes PPG/HC/IG/CG/06 Incident Reporting and Investigation.

This policy should be read in conjunction with the following related Practice Plus Group documents:

- PPG/HC/IG/RM/04 Health Care Risk Management Strategy, Policy and Procedure;
- HC/CA/ENDO/20 Guidance on Post-Colonoscopy Colorectal Cancers;
- HC/IG/CG11 Supporting staff members involved in a claim complaint or incident;
- PPG/HC/HR/10a Human Resources Equality, Diversity and Inclusion Policy;
- HG/IC/CG/13 Duty of Candour and Being Open Policy;
- HC/RQIF/02 Feedback Policy.

Directorate specific documents

- Datix Dif1 and Dif2 User Guides;
- Practice Plus Group Secondary Care Patient Safety Incident Response Plan;
- Practice Plus Group Health in Justice services Patient Safety Incident Response Plan;
- Practice Plus Group Integrated Urgent Care services Patient Safety Incident Response Plan.

Contents

Purpose

This policy supports the Patient Safety Incident Response Framework (PSIRF), and sets out Practice Plus Group's approach to developing and maintaining effective systems for responding to patient safety incidents/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 system that integrates the four key aims of the PSIRF:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents and safety issues.
4. Supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Practice Plus Group, encompassing all three directorates:

- Secondary Care Services
- Integrated Urgent Care Services
- Health in Justice Services

It should be read in conjunction with the current Patient Safety Incident Response Plan relevant to each of the component directorates.

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 exist for the purpose of:

- claims handling;
- complaints (unless relating to a significant patient safety concern);
- human resources investigations into employment concerns;
- professional standards investigations;
- coronial inquests;
- criminal investigations;
- safeguarding concerns;
- information governance concerns;
- estates and facilities issues.

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

PSIRF Strategic Aims	Improve the safety of the care we provide to our patients, and improve the overall experience of our patients, their families and carers.	Improve the experience for patients, their families and carers whenever a patient safety incident or the need for a PSII is identified.	Improve the use of valuable healthcare resources.	Improve the working environment for staff, in relation to their experience of patient safety incidents and investigations
Practice Plus Group Values	We treat patients and eachother as we would like to be treated.	We act with integrity.	We embrace diversity.	We strive to do things better.

At Practice Plus Group we are passionate about what we do and believe that anyone should be able to access excellent care. Our guiding principles flow through everything we do; our decision-making, hiring, interactions with one-another, and how we engage with all of our colleagues.

Our patient safety culture

Patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk (not accountability, liability, avoidability and cause of death). They must never undermine just culture by requiring inappropriate, automatic suspension of staff involved in patient safety incidents or their removal from business-as-usual activities.

Practice Plus Group supports a just culture, and uses the Just Culture Guide[1], as appropriate, to ensure consistent, constructive and fair treatment of staff who have been involved in patient safety incidents.

The PSIRF will promote stronger links between patient safety incidents, learning, and improvement. We will work in collaboration with those affected by patient safety incidents to learn and improve systems of care, within a culture of openness and engagement.

The safety culture of an organisation is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour. These determine the commitment, style, and proficiency of an organisation's health and safety management.

Organisations with a positive safety culture are characterised by:

- Communications founded on mutual trust,
- Shared perceptions of the importance of safety,
- Confidence in the efficacy of preventive measures.[2]

Assessing the status of the existing safety climate in a healthcare organisation is promoted as the first step for developing a strong and solid safety culture.[3]

The health and safety executive, recommends that organisations operating in high-risk industries should regularly assess their safety culture.[4]

Practice Plus Group promotes a culture of openness as a prerequisite to improving patient safety and the quality of healthcare systems. It involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers

Baseline patient safety culture surveys were undertaken across Practice Plus Group services. Themes were identified, and action plans developed, to address areas for improvement using the range of tools - including those provided by NHSE Learning response toolkit. The survey will be repeated at two-yearly intervals, or when deemed necessary by emerging themes and changes in service provision, to monitor the effectiveness of

interventions made to improve the safety culture.

Patient Safety Partners

The role Patient Safety Partner (PSP) is a new and evolving role developed by NHS England / NHS Improvement to help improve patient safety. Partners are actively involved in the safer healthcare design at all levels in the organisation. This includes roles in safety governance – e.g., contributing to relevant committees to support compliance monitoring, involvement in how safety issues should be addressed as well as providing appropriate challenges to ensure learning and change. Our PSPs support a patient-centred approach to safer healthcare.

Practice Plus Group is recruiting a number of part-time PSPs as part of its commitment to involving patients and the public in patient safety. Our partners will engage with services and patients to review safety data, our responses to incidents and complaints, and be at the heart of how our organisation investigates, learns and shares improvements to organisational safety. We will train our partners to undertake their role and provide them with access to our services and decision-makers - enabling them to promote a different perspective on patient safety and reinforce the patient voice in the organisation.

PSPs will be supported in their role variously by the governance managers, patient experience leads, and patient safety managers within the respective services who will provide expectations and guidance. The role will be reviewed annually to ensure it aligns with the patient safety agenda as it continues to develop and expand - to ensure we represent the diverse communities we serve, including population groups who may sometimes experience challenges in accessing our services.

Addressing health inequalities

The NHS has a duty to reduce inequalities in health by improving access to services and tailoring those around the needs of the local population in an inclusive way. Practice Plus Group is committed to delivering on its statutory obligations under the Equality Act (2010), and will use data intelligently to assess any disproportionate safety risk to patients across the protected characteristics.

Through our learning responses we will seek to support health equality, reduce inequalities, and will apply a more flexible approach to how we use data to help us better identify disproportionate risks to patients with specific characteristics.

Through our patient safety response approaches we will;

- Strengthen capabilities for analysis of patient safety event reports according to important patient characteristics and the translation of these data into tangible actions,
- We will seek to learn from “all incidents” as part of the move away from the Serious Incident Framework;
- Consider inequalities as part of the Systems Engineering Initiative for Patient Safety (SEIPS) approach to patient safety responses;
- Ensure staff have the relevant training and skills to support a systems-based approach;
- Ensure our engagement and involvement with patients, families

and carers recognises, reflects and appreciates the diversity of the populations we serve.

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.

We will seek to continuously improve a system that supports compassionate engagement and involvement of those affected as reflected in the engagement and involvement guidance[5] and best practice standards[6].

As part of our engagement approach, we will:

- Ensure engagement is made explicit within our learning responses, defining "who, when and how" to reflect the individual needs;
- Provide staff involved in learning responses the training and competencies required for engaging and involving those affected by patient safety incidents
- Involve our Patient Safety Partners wherever possible in co-producing our learning responses;
- Alongside our professional and statutory requirements for duty of candour, we commit to being open and transparent regardless of the level of harm caused by an incident.

Duty of candour

A statutory requirement to implement duty of candour was introduced in November 2014 for the NHS and from 1st April 2015 for NHS Providers; this is part of our CQC registration requirements. Our duty of candour and being open policy describe the infrastructure required to support openness between healthcare professionals and patients, their families and carers, following a patient safety incident.

Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident. It encompasses communication between healthcare organisation, healthcare teams and patients and/or their carers.

Supporting our staff

We recognise it can be beneficial for our staff to seek support following a patient safety incident and Practice Plus Group advocates the equal importance of both mental and physical health. Practice Plus Group recognises that wellbeing and performance are linked. Improving an employees' ability to handle pressure to balance work and home life will ultimately lead to improvements in individuals and organisational performance.

Through our wellbeing policy we aim to;

- raise awareness,
- provide guidance for issues relating to health and wellbeing,
- encourage the adoption of a proactive approach to prevent and minimise the risks associated with poor health and wellbeing within the workforce,
- help promote a culture of health within Practice Plus Group, create a supportive environment that enables employees to be proactive in supporting their own health and wellbeing,
- support improvement in the engagement score for health and wellbeing in our Over to You (OTY) survey.

In addition, our Employee Assistance Programme (EAP) provides independent, professional assistance for staff who may need additional support.

Health in Justice services

Practice Plus Group has a duty of care under the Management of Health and Safety at Work Regulations (1999) to protect the physical and mental wellbeing of all staff as far as practicable. Due to the particular needs of practitioners within this service, our Health in Justice (HiJ) services have implemented Trauma Risk Incident Management (TRiM) as an organisational response when post incident care is required.

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 may explore patient safety incidents relevant to their context and the populations they serve, rather than only those that meet a certain defined threshold.

Practice Plus Group will take a proportionate approach to its response to patient safety incident ensuring the focus in on maximising improvement; our Patient Safety Incident Response Plans (PSIRPs) detail how this will be achieved alongside how we respond to meet both national requirements and our local priorities.

Our PSIRPs aim to understand what the top themes are and what learning can be taken from them. It does not mean that some incidents will not be investigated, but that the opportunity to learn and improve is a priority. Our services undertake a review of incidents, complaints, claims and information from risk registers to identify emergent themes. This approach will ensure we focus on understanding how incidents happen, rather than apportioning blame on individuals; allowing for more effective learning and improvement, and ultimately making care safer for patients.

Resources and training to support patient safety incident response

PSIRF training is being provided to those staff who require the skills and competencies to undertake learning responses. This approved training programme, additional to the national patient safety syllabus, will equip a designated cohort of staff (appointed as investigators) with the skills and expertise to support high quality learning responses.

Those that lead learning responses and investigations will be trained to the

required level to undertake and support leadership wherever possible, and to support engagement and involvement of those affected.

Patient safety managers and clinical staff will be involved in leading and completing (or assisting in the completion) a learning response to support learning responses, Continuing Professional Development (CPD), participation in audit, and clinical governance activities form part of medical staff job plans.

Each lead Investigator will be supported by members of the service, patient safety personnel, and subject matter experts. Governance processes will ensure that learning responses will not be led by staff who were involved in the patient safety incident itself or by those who directly manage the staff involved.

Implementation of this policy across Practice Plus Group is supported by training packages comprising:

- National Patient Safety Syllabus Level 1 (Essentials for Patient Safety) – all staff, irrespective of role;
- National Patient Safety Syllabus Level 1 (Essentials of patient safety for boards and senior leadership teams) – all staff with managerial responsibilities;
- Patient Safety Syllabus Level 2 (Access to Practice) – all nominated staff who will be involved in incident responses;
- Engagement Lead training – Governance Managers, Heads of Nursing, Local Medical Director and Hospital Director;
- HSIB Level 2 training (previously Level 3 - Silver) / or externally provided two-day equivalent – nominated staff who will be involved in incident responses;
- Oversight training – Medical Directors, Chief Nurses, Head of Patient Safety, Specialty Heads (e.g., Head of Diagnostic Imaging and Endoscopy, Chief Pharmacist, VTE Lead, Head of Infection Prevention and Control).

Additionally, a four-module, e-learning package in human factors is available to all staff via our organisation Learning Management System (LMS). The package is credited with 2 CPD points by the Royal College of Physicians and accredited by the Chartered Institute of Ergonomics and Human Factors.

A suite of learning response tools and templates is being developed to support staff to implement our patient safety incident response plan. These will be generated from the Datix incident record (Datix being our central incident recording system), and pre-populated with the information already recorded.

Our patient safety incident response plan

Secondary care services

The framework for the measurement and monitoring of safety[7] is applied to the Practice Plus Group secondary care environment to identify the patient safety issues most pertinent to the organisation.

The review of organisational patient safety data[8] documents the data analysis

undertaken to define our patient safety incident profile which forms the focus of the secondary care Patient Safety Incident Response Plan (PSIRP). It also serves to facilitate consultation with both internal and external stakeholders on the proposed patient safety priorities.

The patient safety improvements and service transformation work underway across Practice Plus Group secondary care services are aligned to the patient safety analysis undertaken in the review.

The patient safety improvement programme is supported by the head of clinical effectiveness and improvement, and monitored via the quarterly Clinical Audit and Effectiveness Group (CAG). The chair of the CAG is the head of clinical effectiveness and the head of patient safety is a member. The quality improvement strategy is aligned to the patient safety profile, and the various workstreams are designed to reduce the risks associated with our current patient safety priorities.

External stakeholders included the Integrated Care Boards (ICBs), with which the organisation has contractual arrangements to deliver NHS services, and our Patient Safety Partner (PSP).

A learning response algorithm details the six initial patient safety priorities identified through this process, and the proportionate responses to be undertaken in each case. It also describes how the outputs from the responses will inform subsequent PSIRP reviews.

Integrated Urgent Care (IUC) services

Our urgent care services consist of the NHS 111 service, Urgent Care (previously known as the Out of Hours Service) and our Clinical Assessment Service (CAS). The PSIRP for Integrated Urgent Care services is developed following scrutiny of historic recorded complaints, incidents, risks and claims. In common with all Practice Plus Group directorates, key themes are identified from this data and make up the safety incident priorities. These activities will also direct our safety priorities with consideration given to quality improvement priorities.

Health in Justice Services

Our plan sets out how we intend to respond to patient safety incidents over a period of 12 to 18 months. The plan is produced as in all Practice Plus Group services, by a review of patient safety incidents through incident reporting, complaints and concerns, identification of risks and claims. 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 special circumstances within which our HiJ services operate means that our themes are derived not only from patients in our care, but also from some outcomes for patients post-release. Irrespective, our plan is developed through a collaborative effort with operational, clinical and commissioner involvement.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plans are ‘living documents’ that will be reviewed and updated as we use them to respond to patient safety incidents to ensure our focus remains up to date; with ongoing improvement work our

patient safety incident profile is likely to change. Our plans will be presented to the Practice Plus Group by our executive leads.

In line with other Practice Plus Group policies, our PSIRF Policy will be reviewed every three years, with the proviso that interim reviews may need to be undertaken where statutory guidance is updated. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

Internal arrangements

All Practice Plus Group employees have access to the organisation risk management system (Datix) which facilitates incident reporting and generates alerts to incident response leads so that a response may be provided. With the implementation of the Learn from Patient Safety Events (LFPSE) service, these reports will be uploaded to the NHSE system to support national learning.

Potential patient safety incidents are reviewed and triaged daily by dedicated resource within each of our services after which appropriate cases are escalated. The current approach will remain but will be matured to capture a learning response format and where required will identify the requirements for any further learning response. All the internal processes and associated policies will be updated in line with our PSIRF Plans and Policy. Emergent issues are reviewed and discussed at service Quality Assurance (QA) meetings and any themes by incident, complaint or risk that are identified are added to the existing directorate PSIRPs.

Reporting of incidents will continue in line with the existing Practice Plus Group policy on incident investigation. Practice Plus Group has assurance systems in place to ensure oversight of incidents at both a divisional and organisational level. Quality governance and patient safety teams work with clinical and operational managers 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 and trends (incidents, complaints, risks);
- Identification of any incidents requiring external reporting (e.g. – Never Events, Neonatal deaths, RIDDOR);
- Identification of any other incidents of concern that do not fall within the current PSIRPs;
- Themes and trends that provide the greatest opportunity for learning improvement themes identified in the PSIRPs.

Practice Plus Group adopts a system-based approach recognising patient safety is an emergent property of the healthcare system. The organisational approach promotes scrutiny of any number of components that make up the incident; people involved, environmental and cultural factors etc. This approach identifies where changes need to be made and then monitors them within the system to improve patient safety.

Practice Plus Group responds to incidents in a manner that maximises learning and improvement rather than basing responses on arbitrary definitions of harm. Our approach is to examine patient safety incidents relevant to their context and the populations they serve rather than exploring only those that meet a certain nationally defined threshold.

Any member of staff may raise a potential patient safety incident. Once it is recorded on Datix, senior operational, clinical and quality teams of the service are notified and hold an incident call to determine whether it meets the patient safety incident threshold,

In line with the PSIRF Guide to Responding Proportionately to Patient Safety Incidents[9] Practice Plus Group adheres to nationally mandated responses to certain categories of event and sets out whether that mandated response needs to be a PSII or some other response type, including referring the event to another organisation to manage. Incidents meeting the Never Events criteria[10] and deaths thought more likely than not to have been due to problems in care, require a locally-led PSII. The resources required to support PSII following such incidents are based on previous years' incident trends and are included within Practice Plus Group's respective directorate PSIRPs.

External arrangements

Patient safety incidents identified that appear to meet requirements for external reporting and/or escalation, (mandated and/or recommended), will be identified by the local service and processed according to policy arrangements. This includes, but is not limited to, Care Quality Commission (CQC), Health Service Safety Investigation Body (HSSIB), the Prison and Probation Ombudsman (PPO). Where the requirement for cross-system working with relevant partners is identified in the review of a patient safety incident or through an emerging theme this will be escalated to the ICB to support a collaborative approach, and as part of system oversight arrangements.

Patient safety incident response decision-making

Through its PSIRF policy and plans, our services will have arrangements to meet the requirement to review patient safety incidents under PSIRF, ensuring those that require a mandated/recommended response are reported and investigated as required.

PSIRF itself sets no further national thresholds to determine what method of response should be utilised for learning and improvement. Practice Plus Group will continually develop a range of response mechanisms to balance the efforts between learning and exploring emerging issues alongside ongoing improvement work. Service monthly Quality Assurance (QA) meetings will provide decision-

making groups to review incidents and to identify those incidents that appear to meet the need for further exploration. QA meetings provide the oversight and scrutiny of incident response decision making and the application of learning response approaches, ensuring these are proportionate and reflect any required external reporting thresholds. As detailed in the Practice Plus Group Clinical Governance Policy, incidents of note (themes and learning) are shared monthly with the senior leadership and upwards to the board where the PSIRF executive leads provide assurance. In addition, medical and clinical leads meetings review emergent themes and progress with sharing learning and completion of safety improvement plans.

Responding to cross-system incidents/ issues

Cross-system investigations are considered each time an investigation is initiated. In the event that a cross system incident is identified, the lead investigator (or their deputy) is designated to work with all relevant organisations and ensure that the patient and their family receives a 'single voice' response during investigation updates and action planning.

Where multiple organisations need to be involved in a single learning response, the response is led by the organisation best placed to investigate the concerns. This may depend on capability, capacity, or remit. Commissioners may be invited to act as facilitator in more complex safety incident investigations.

As part of the organisational investigation process, Practice Plus Group will consider whether a learning response needs to examine the care provided throughout a specific care pathway as opposed to focussing solely on the part of the pathway most proximal to the incident. Practice Plus Group will actively engage partner organisations that provided care to the patient(s) involved where that care may have played a role in the incident being examined and work together and co-operate with any learning response that crosses organisational boundaries. The learning response will be led by the organisation best placed to investigate the concerns, which will reflect capability, capacity or remit.

Time-frames for learning responses

Learning responses need to balance the need for timeliness with thoroughness and a sufficient level of investigation to identify the key themes and learning for service improvement. We will seek to complete learning responses within one to three months and/or no longer than six months. Time-frames will be agreed in conjunction with those affected as part of the agreement of the terms of reference and the learning response approach/ method to be adopted.

In exceptional circumstances, (i.e., when a partner organisation requests a pause, or processes of external bodies delay access to information), the service can consider whether to progress and determine whether new information would indicate the need for further review once this is received. The decision for this would be made by the lead incident investigator in consultation with subject matter experts within the service. There may be occasions where a longer time-frame is required for completion, in this case, all extended time-frames will be agreed between the service and those affected.

Safety action development and monitoring improvement

Safety actions will be developed to address areas of improvement arising from learning responses where it is meaningful to do so; these will be developed with relevant stakeholders, including those responsible for implementation.

To ensure an integrated approach to risk reduction a central repository of safety actions will held by the respective QA teams within each directorate, with the opportunity to compare measures taken across directorates at the QA and risk committee where senior clinical, patient safety and risk leaders are in attendance.

Safety improvement plans

Safety improvement plans will be developed, distinct within each directorate (health in justice services, integrated urgent care services, secondary care services), due to the particular nature of the services and the themes that emerge. Improvement plans will contain;

- data analysis of trends and themes;
- review of outputs from learning responses to single incidents, when it is felt that they may contribute to the learning of identified themes, or lead to the identification of a new, emergent theme.

Oversight roles and responsibilities

The leadership and management functions of PSIRF oversight are wider and more multifaceted compared to previous response approaches. When working under PSIRF, Practice Plus Group, ICBs and regulators will focus on oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures". To achieve this Practice Plus Group will look carefully not only at what they need to improve but also what they need to stop doing. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control.

The Practice Plus Group approach to PSIRF oversight focuses on reviewing and monitoring investigation outcomes and improvements in the safety of care. Learning is shared across the service, within sister services and with community partners and ICBs as required. Learning focuses on identifying the system factors that contribute to patient safety incidents and changing and adapting systems as a result. Collaboration is key to the Practice Plus Group approach; working with partner organisations and commissioners to evidence that learning is embedded and patient safety improvements are made. The Practice Plus Group policy Duty of Candour and Being Open guides investigation teams and staff on how they may adopt a transparent and enquiring approach to review of practice.

We will:

- collaborate and share information with relevant stakeholders, including the ICBs, CQC and others to support effective communication during both learning responses and improvement work;
- support continuous development across local systems (e.g., peer to peer collaboration) and idea generation through local networks (e.g., patient safety improvement networks).

Appointment of PSIRF executive leads

Practice Plus Group has identified two PSIRF executive leads; the medical director leads within primary and secondary care services. Our executive leads provide direct leadership, advice, and support in complex/high profile cases, and liaise with external bodies as required. Both are members of the Practice Plus Group Senior Leadership Team. The PSIRF executive leads ensure that the leadership team monitor the balance of resources going into patient safety incident responses and improvement. Leads are responsible for reviewing PSII reports at Executive level, and reporting to the Practice Plus Group board.

Complaints and appeals

The Practice Plus Group Feedback Policy sets out how we manage, respond to and learn from complaints made about our services. We are committed to providing high quality services and will strive to ensure that all compliments, concerns and complaints are addressed, resolved and shared as quickly as possible.

At the outset of each Patient Safety Incident Investigation (PSII), we identify a colleague to act as family/carer liaison to address any concerns or worries about any aspect of the investigation or report

Should using this route not address the concern, or those affected by the incident would like to raise a formal complaint in relation to a patient safety learning response/investigation they may contact dedicated staff members at the service from which they received their care, who will guide them through our complaints/ appeals process.

We recognise that staff training is important in the development and maintenance of a culture within our organisation which values and encourages the effective management of comments, compliments, concerns and complaints. Our staff are required to have the necessary skills to respond to concerns and complaints at an early stage with courtesy and sensitivity. Colleagues engaged in the complaints process attend training to keep their skills up to date with statutory guidance and best practice.

References

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Equality impact assessment

This document has been subject to an equality impact assessment.

This document complies with Practice Plus Group's equality and diversity statement which can be found in the 'Equality, Diversity and Human Rights Policy'

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of: • Race • Ethinc origin • Nationality • Gender • Culture • Religion or belief • Sexual orientation • Age • Disability - learning disabilities, physical disabilities, sensory impairment and mental health problems	No	
2.	Is there any evidence that some groups are affect differently?	No	
3.	If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	No	
4.	Is the impact of the policy/ guidance likely to be negative?	No	
5.	If so, can the impact be avoided?	N/A	
6.	What are the alternatives for achieving the policy/ guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

	Title	Date
Authors	Patient Safety Leads, Integrated Urgent Care and Health in Justice Head of Patient Safety, Secondary Care	January 2024
Reviewer	Clinical Quality and Compliance Committee Practice Plus Group Board	26 February 2024 02 April 2024
Authoriser	NHS Hampshire and Isle of Wight ICB NHS Suffolk and NE Essex ICB	06 March 2024 23 May 2024