LUNCH and LEARN session
CQC and PSIRF

12 October 2023

hospiceUK

Network Recording Declaration

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Who is Hospice UK?

Hospice UK is the national charity for hospice and end of life care.

We work to ensure everyone affected by death, dying and grief gets the care and support they need, when they need it.

What do we do?

- **We work with 200+ hospice members** around the UK to provide outstanding hospice care for 300,000 adults and children yearly.
- **We work with governments and local communities** to make sure all hospices have the right support to look after people at the end of life.
- **We support the mental and emotional wellbeing** of hospice staff through training and peer support groups.
- **We run national knowledge sharing networks and events** to help hospice clinical staff trouble-shoot problems, learn from each other, and share the latest innovations.
- **Our online Innovation Hub** provides information and guidance for professionals in palliative and end of life care.
- **Our Dying Matters campaign and Compassionate Employers programme** help people have conversations about death, dying and grief.

CLAIRE LAND

Policy Manager

Care Quality Commission

PSIRF – Regulation & Assessment

- How PSIRF aligns to CQC's strategic ambitions
- Implications for the Hospice sector
- How PSIRF fits in to the single assessment framework and the new regulatory approach
- The Patient Safety Incident Response Standards and CQC's oversight role
- Q&A - What are your concerns about PSIRF?

Claire Land
Regulatory Policy Manager (Acute)

October 2023

Our strategy

Our overall aim and focus is on tackling inequalities and driving improvement

Safety through learning

The importance of culture	Building expertise	Involving everybody	Regulating safety	Consistent oversight and support

“We’ll be looking for cultures that have learning and improvement at their core. In a good safety culture, it accepted that all incidents provider opportunities to learn and improve”

“We’ll expect all services to have stronger safety and learning cultures and that learning and improvement should be the primary response when anyone speaks ups”

“We’ll look at how services and systems assure themselves that they have the right knowledge and expertise, and how they are investing in improving safety”

“Learning and improvement must be the primary response to all safety concerns in all types of services and local systems”

“Services that are not open to learning can’t be safe. We’ll use our powers and act quickly where improvement takes too long…where services are unable to identify systemic issues…or fail to learn lessons from widely publicised failures happening across health and care”

Considerations for Hospices

CROSS CUTTING CONSIDERATIONS

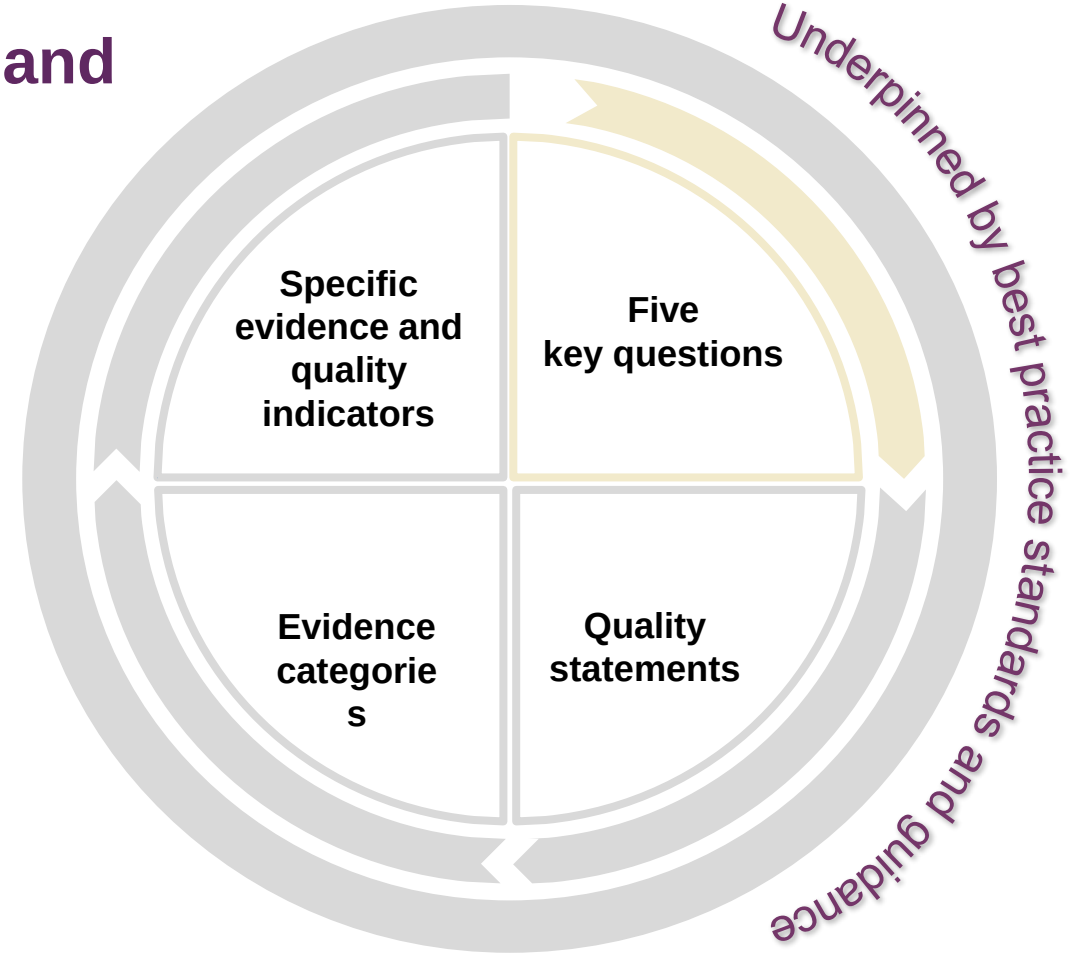
- PSIRF is a significant change for **all** providers – it is a journey not a framework
- PSIRF is a significant change for CQC operational colleagues – they won't have all the answers
- CQC is going through significant change itself
- There are other concurrent changes – such as the move to Learn from Patient Safety Events – that add further complexities

HOSPICE SPECIFIC CONSIDERATIONS

- Various commissioning arrangements and the impact this has on the *provider level* development of the PSIRP
  - Large private providers
  - Small private providers
  - NHS trusts

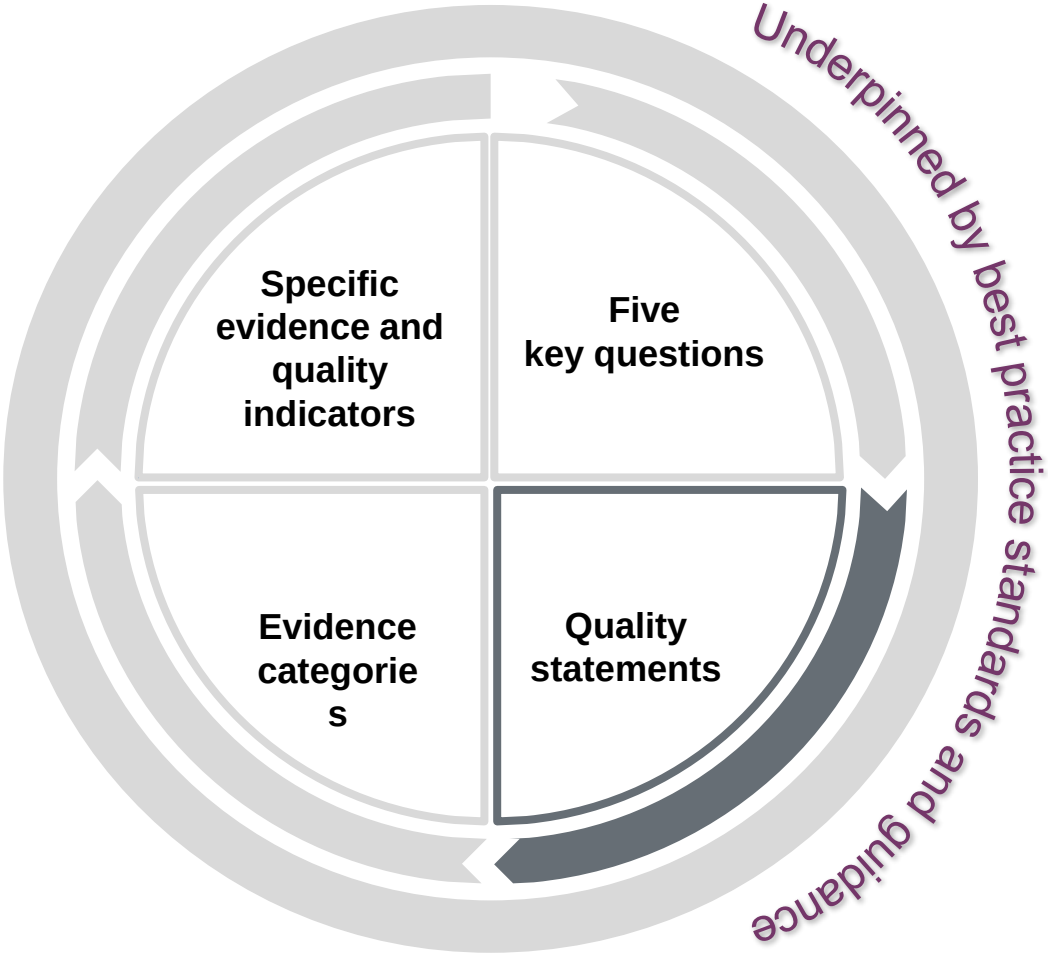
Evidence for compliance and how PSIRF fits into the Single Assessment Framework

- **Five key questions** - remaining at the core - aligned with “I” statements, drawn from work by Think Local Act Personal (TLAP), National voices and the Coalition for Collaborative Care on Making it Real.
- Focused on what people expect and need from their care.
- A basis for gathering structured feedback.

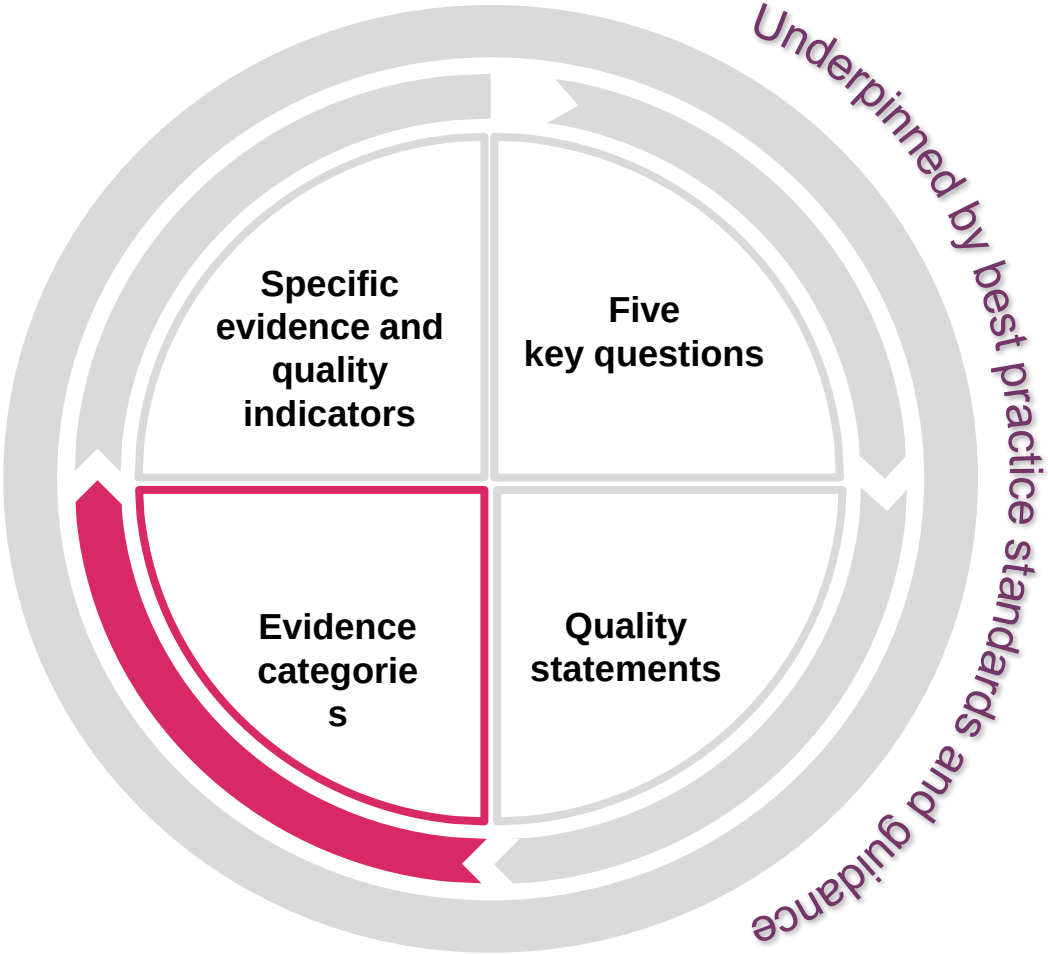


Learning culture
We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Related regulations
Regulation 12: Safe care and treatment
Regulation 16: Receiving and acting on complaints
Regulation 17: Good governance
Regulation 20: Duty of candour

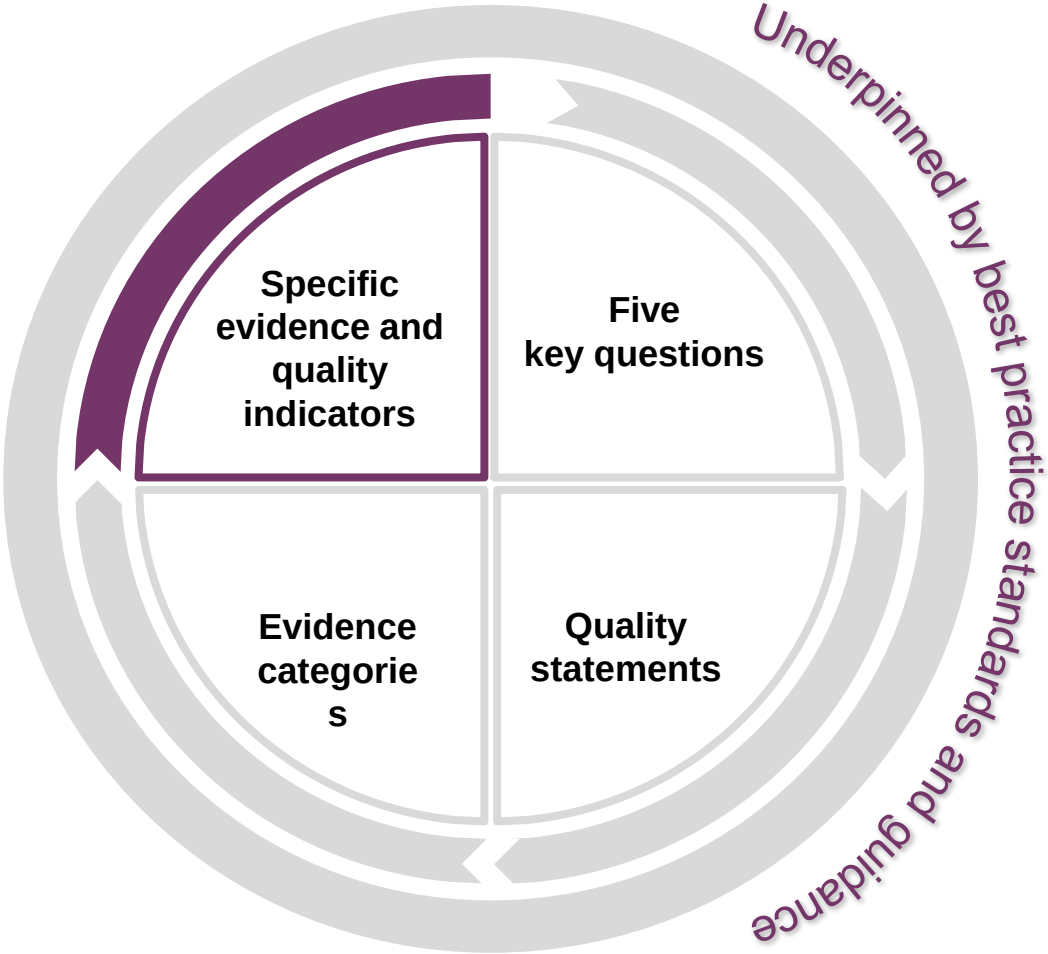


1. People's experience
2. Feedback from staff and leaders'
3. Feedback from partners
4. Observations
5. Processes
6. Outcomes



- **Specific evidence and quality indicators** - Data and information specific to the area of work being considered

- The PSIRF and associated guidance will be (one of) the underpinning best practice standards and guidance for the Learning Culture QS



Patient Safety Incident Response Standards

Organisations should uphold the patient safety incident response standards to ensure they meet the minimum expectations of the PSIRF. The standards cover 4 aspects of PSIRF:

Policy, planning and oversight

1. Policy standards
2. Plan standards
3. Oversight

Competence and capacity

4. Incident response resources
5. Training provider requirements
6. Learning response training
7. Competencies for learning for response leads
8. Engagement and involvement training
9. Competencies and behaviours for engagement leads
10. Oversight training
11. Competencies for individuals in training roles

Engagement and involvement of those affected by PSI

12. Compassionate engagement with those affected
13. Meaningful involvement of those affected

Proportionate responses

14. Timeframes
15. Incident response methodology
16. Cross-system responses
17. Safety action and improvement

CQC's Oversight Role

The Care Quality Commission's (CQC's) assessment of a provider's leadership and safety considers an organisation's ability to respond effectively to patient safety incidents, including whether change and improvement follow its response to patient safety incidents.

CQC teams will apply the PSIRF and associated patient safety incident response standards as part of its assessment of the strength of an organisation's systems and processes for preparing for and responding to patient safety incidents.

Where it specifically considers PSIIs, CQC's review will consider how these meet the national patient safety incident response standards. CQC will assess, in partnership with the NHS England PSIRF team, the specific training requirements for those undertaking reviews of PSIIs.

PSIRF Oversight roles and responsibilities framework

2. Plan standards

Are processes for developing, maintaining, and revising the organisation's Patient Safety Incident Response Plan (PSIRP) robust?

- Have appropriate stakeholders (including the ICB, service users, improvement team) been identified and involved in the development of the PSIRP?
- Was a variety of quantitative and qualitative data used to develop the PSIRP? (e.g., incident reports, complaints, litigation claims, mortality reviews, clinical audits, discussions with stakeholders)
- Does the organisation's PSIRP reflect the data reviewed during the plan development?
- Is it clear how the organisation selected learning response priorities?
- Is the plan reviewed on a regular basis and amendments made when appropriate?
- Does the PSIRP incorporate different specialties across the organisation?
- Does the organisation's risk register reflect the key themes highlighted in its PSIRP?

Those who use services

- Patient Safety Partner(s)
- Local patient / family / carer representative groups
- Local Healthwatch

Staff and leaders

- Board / Executive Team
- PSIRF executive lead
- Patient safety team
- Patient Safety Specialist (PSS)
- Improvement team

Partners

- ICB PSS
- ICB PSIRF lead

Processes

- Patient Safety Incident Response Policy (should be on internet)
- Patient Safety Incident Response Plan (should be on internet)
- Minutes of relevant PSIRF meetings such as patient safety committee and response review group
- Risk register extracts
- Board papers where PSIRP is referenced

3. Competence and capacity

Are training and competency requirements met?

- Have learning response leads, engagement leads and those in the (provider) oversight roles
  - Completed the training requirement set out in the Competence and Capacity section of the patient safety incident response standards?
  - Maintained appropriate CPD, including involvement in at least two learning responses a year?
- Has training for PSIRF been delivered in line with the training provider requirements set out in section 5.1 of the patient safety incident response standards?

If training needs cannot currently be met:

- What plans are in place to work towards meeting training and competency standards?
- What mitigations are in place to ensure incident response quality remains of a high standard?

Staff and leaders

- Board / Executive Team
- PSIRF executive lead
- Patient safety team
- Patient Safety Specialist (PSS)
- Improvement team

Processes

- ESR or other training records for learning response, engagement and oversight leads
- PSIRF Policy (should be on internet)
- Organisation's overarching mandatory training matrix

Over to you….

Q&A

General discussion

What are your concerns about PSIRF – are there particular standards you are worried about?

Thank you

Please complete the quick feedback survey: