St Peter's Hospice

Patient Safety Incident Response Policy

Author	Helen Ireland Head of Clinical Governance & Quality
Owner:	Chris Benson Director of Patient Care
Version	1.0
Date Issued:	01 October 2024
Estimated Review Date:	April 2026

Glossary

Term	Definition
PSIRF- Patient Safety Incident Reporting Framework	Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
PSIRP- Patient Safety Incident Reporting Plan	In response to the framework. It describes what is being done to prepare for "go live" with PSIRF and what comes next.
PSP- Patient Safety Partner	Relates to the role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.
PSII- Patient Safety Incident Investigation	A system-based response to a patient safety incident for learning and improvement. Typically, a PSII includes four phases: planning, information gathering, synthesis, and interpreting and improving.
AAR- After Action Review	An After-Action Review (AAR) is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.
Just Culture	Just Culture is about creating a culture of fairness, openness and learning in the NHS. This is to make colleagues feel confident to speak up when things go wrong, rather than fearing blame.
Duty of Candour	Every health and care professional must be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.
Systems Based Approach	A system-based approach recognises that patient safety is an emergent property of the healthcare system: that is, safety arises from interactions and not from a single component, such as actions of people. A system-based approach therefore recognises that it is insufficient to look only at one component, such as only the people involved.

Clinical Governance	A system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
SWARM Huddles	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. Swarms enable insights and reflections to be quickly sought and generate prompt learning.
MDT Review	Involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations
PSI- Patient Safety Incident	A patient safety incident can be defined as any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded healthcare.
SIs- Serious Incidents	Serious Incidents (SIs) are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

Contents

Purpose 5

Scope 6

Our Patient Safety Culture 6

Patient Safety Partners 7

Addressing Health Inequalities 9

Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident 10

Patient Safety Incident Response Planning 13

- Our Patient Safety Incident Response Plan 14
- Reviewing our Patient Safety Incident Response Policy and Plan 15
- Responding to Patient Safety Incidents 16
- Patient Safety Incident Reporting Arrangements 16
- Patient Safety Incident Response Decision-Making 17
- Responding to Cross-System Incidents / Issues 20
- Timeframes for Learning Responses 20
- Safety Action Development and Monitoring Improvement 20
- Safety Improvement Plans 21

Complaints and Appeals 23

Purpose

This policy aligns with the requirements of the Patient Safety Incident Response Framework (PSIRF) and outlines St Peter's Hospice's (SPH) approach to developing and maintaining effective systems and processes for responding to patient safety incidents. The goal is to learn from these incidents and improve patient safety.

The PSIRF promotes a coordinated, data-driven approach to addressing patient safety incidents. It integrates patient safety response into a broader system of ongoing improvement, encouraging 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 does not set additional national rules or thresholds to determine the method of response. Instead, organisations can balance their efforts between learning through responding to incidents or exploring issues and improvement work.

This policy outlines the aims and objectives of patient safety incident management at SPH and the framework within which this is achieved.

This policy should be used in conjunction with the following SPH key policies:

- Clinical Governance Policy
- Safeguarding Policy
- Health and Safety Policy
- Clinical Feedback Policy
- Medicines Management Policy and associated SOPs
- Disciplinary Policy
- Incident Management Policy
- Duty of Candour Policy

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across both Community and Inpatient services at SPH.

Responses under this policy follow a systems-based approach. Patient safety incidents result from multiple interactions between different components, rather than a single component. Therefore, responses do not focus on individuals or attribute incidents to 'human error'.

The purpose of these responses is not to assign blame or determine liability, preventability, or cause of death but for the purpose of learning and improvement.

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

To be effective in their intended purpose *other* responses can categorised as follows:

- Human Resources (HR) - including those that involve referral to professional regulators and case investigation
- Legal
- Medical Examiners – including Coroner, Medical Examiner
- Police
- Complaints and Concerns management

The Patient Safety Incident Reporting Plan (PSIRP) is a live document detailing the response types, approach, responsibilities, education, and training. This plan is based on a formal assessment of SPH's risk profile, which should be carried out every 18 months or sooner if significant changes are identified through the governance process.

Our Patient Safety Culture

SPH promotes a *just culture* approach (in line with the NHS Just Culture Guide) to any work planned or underway to improve safety culture. Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

SPH encourages and supports incident reporting whenever any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients or staff. Please refer to the Incident Management Policy for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame.

Patient Safety Partners

The Patient Safety Partner (PSP) is a new and evolving role developed to help improve patient safety.

PSP's can be patients, carers, family members or other lay people (including staff from another organisation). This role offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

At SPH, this exciting new role will evolve over time. The recruitment of Patient Safety Partners forms part of our Patient/Service User Experience and Engagement Strategy. The main purpose of the role is to be a voice for the patients and community who use our services and ensure that patient safety is at the forefront of all that we do.

PSP's will provide rational and objective feedback focused on ensuring that the patient voice is heard and included in our safety and governance processes. This may include attending governance meetings, reviewing patient safety, risk, and quality, and contributing to documentation including policies, investigations, and reports. This information may be complex, and the PSPs will provide feedback to ensure that the patient perspective is fully considered and included in our efforts to improve patient safety.

They will be supported in their role by the Head of Clinical Governance and PSQ Team Manager, who will provide expectations and guidance for the role. This will also include regular one-to-one sessions. Training needs will be agreed upon together based on the experience and knowledge of each PSP. The PSP placements are on an honorary basis and will be reviewed after one year to ensure we keep the role aligned to the patient safety agenda as this develops.

Internal Stakeholders & System Partners

SPH has a robust clinical governance process which provides the assurance for the organisation, executive and trustee boards and with the Integrated Care Board (ICB). SPH works closely with the BNSSG ICB through ongoing relationships with the Patient Safety and Quality Teams, Learning Panel and the ICB System Quality Group.

SPH also collaborates with the CQC and other local system partners for the purpose of learning, sharing, and driving change.

The following internal and external meetings, forums and committees are pivotal to the local and system oversight and shared learning:

- SPH Clinical Governance Committee
- SPH Infection, Prevention and Control Committee
- SPH Health and Safety Meeting

- SPH Safeguarding Committee
- SPH Executive Meeting
- SPH Clinical Services Meeting (Trustees)
- SPH Patient Safety and Quality Team Meeting
- SPH Senior Quality and Safety Assurance Meetings
- SPH Director of Patient Care – Senior Team Meetings
- SPH Patient Safety Incident Review and Learning Group
- BNSSG ICB – System Quality Group
- BNSSG ICS – Learning Panel
- Hospice UK Regional Quality Group
- CQC Engagement/Oversight Meetings
- Regional Hospice Collaborative
- BNSSG and Somerset CD Local Intelligence Network (CDLIN)
- SPH Team and Service Meetings and Comms

The design and development of incident response processes including engagement and involvement are detailed in the PSIRP. Prioritising and fostering stakeholder engagement is central to the success of any PSIRF approach.

Timeframes for learning responses must balance the need for timeliness and capturing information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify key contributory factors and associated learning for improvement. The PSIRP provides more detail on the types of learning responses most appropriate to the circumstances of the incident. The following framework provides guidance on the expected response times. If a response is going to exceed a time scale, it should be communicated to all appropriate stakeholders in a timely fashion.

- **Initial incident investigation** – as soon as possible, within 5 working days of reporting
- **Further learning response** (e.g.: Patient Safety Incident Investigation's (PSII's), After Action Review (ARR), Swarm huddle – within 20 working days of reporting
- **Comprehensive Investigation** – 60 - 120 working days depending on complexity.

PSIRF moves away from the identification of 'recommendations' which may lead to determining a resolution at an early stage of the safety action development process.

Quality Improvement to support embedded learning and improvement following a patient safety investigation is key to improving patient safety outcomes. Close links have been and will continue to be developed and maintained with the Patient Safety

& Quality (PSQ) Team. PSIRF provides an opportunity to strengthen this and for the QI and Patient Safety functions to work hand in hand. Safety actions arising from a learning response should follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and thought must be given to monitoring and measures of success.

Monitoring of completion and efficacy of safety actions will be via SPH governance processes, with oversight from the PSQ Team.

Addressing Health Inequalities

SPH is committed to preventing and tackling discrimination, promoting human rights, equality, diversity, and inclusion. We achieve this by promoting equal opportunities and fair treatment in all areas of employment practice and service delivery for our workforce, and in the delivery of our services to employees, patients, service users, and carers.

It is the responsibility of everyone within SPH to complete mandatory EDI training and to behave and conduct themselves in a manner that ensures work colleagues, patients, and families are treated with dignity and respect. This includes valuing individuals' unique cultural preferences and self-defined identity. This is particularly important when responding to and reviewing patient safety incidents and supporting those involved.

When a Patient Safety Incident Investigation (PSII) is required, patients and families involved will be offered a named contact for the investigation. Terms of reference will be developed between the named contact and the patient/family to ensure the investigation meets the emotional, psychological, and physical needs of each family.

It is recognised that each patient/family has different needs, such as communication preferences and preferred language. These must be considered when investigating incidents, agreeing on time frames, writing the report, and arranging meetings with individuals.

The fair treatment of staff supports a culture of fairness, openness and learning in SPH by making staff feel confident to speak up when things go wrong, rather than fearing blame. For any circumstances where an individual's actions or behaviours require further exploration, the NHS Just Culture Guide is recommended with the purpose of:

- Supporting a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

- Asking a series of questions that help clarify whether there truly is, something specific about an individual that needs support or management versus whether the issue is wider, in which case singling out the individual is often unfair and counterproductive.
- Helping to reduce the role of unconscious bias when making decisions and will help ensure all individuals are consistently treated equally and fairly no matter what their staff group, profession or background.

Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident

SPH recognises the importance of involving patients and families following patient safety incidents. We are committed to engaging them in the investigation process and fulfilling the duty of candour requirements. Experience and research have shown that patients and families often provide a unique or different perspective on the circumstances surrounding patient safety incidents. They may have different questions or needs compared to the organisation.

This policy reinforces existing guidance related to the duty of candour and 'being open'. It emphasises the need to involve patients and families as soon as possible in all stages of any investigation or improvement planning, unless they express a desire not to be involved. Further guidance in relation to involving patients and families following a patient safety incident is available from NHSE at:

https://www.england.nhs.uk/publication/patient

https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/safety-incident-response-framework-and-supporting-guidance/#heading-2

All learning responses will be undertaken in a psychologically safe environment. If further emotional support is required, staff, patients' families and carers will be provided advice for how to obtain this, as outlined below.

Patients, Families and Carers

We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence. We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

All staff are encouraged to be transparent and open whenever there is a concern about care not being as planned or expected, or when a mistake has been made regardless of the level of harm involved. All staff follow the SPH Duty of Candour (being open) policy. Saying sorry is always the right thing to do. It is not an admission of liability. It acknowledges that something could have gone better and is the first step to learning from what happened and prevent it happening again. Duty of candour is monitored via our weekly Patient Safety meetings and quarterly Clinical Governance Committee meetings.

Any patient safety incident that has an impact of moderate or above is monitored for verbal and written duty of candour. This is shared in the Clinical Governance quarterly paper. Written information provided to patients and families, including fulfilment of duty of candour, will be tailored to the individuals taking into consideration their questions, concerns and wishes. Patients and their families will be supported throughout the Incident Investigation process by an allocated member of the PSQ Team, who will ensure that patients are supported, and that we can learn and make sure their questions are addressed by our learning responses. They will be provided with specific training to perform this role.

Patients and families can contact the PSQ Team, who are committed to improving the service we give to our patients.

They can speak confidentially to:

- Advise and support patients, their families, and their carers
- Listen to patients' concerns, queries, and suggestions
- Help sort out problems quickly on your behalf
- Inform patients, their families, and their carers about the Hospice Complaints Procedure

If the team is unable to answer the questions raised, they will provide advice in terms of organisations which can be approached to assist. We recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with patients, families, and carers to signpost to their preferred source for this.

Involving Staff and Colleagues

Involving staff and colleagues (including partner agencies) is of paramount importance when responding to a patient safety incident to ensure a holistic and inclusive approach from the outset. This approach must not be restricted to only those incidents that meet a threshold of harm or predefined categories. We will continue to promote, support, and encourage our colleagues and partners to report any incident or near-misses, with a focus on incidents or groups of incidents that provide the greatest opportunities for learning and improvement.

This new approach represents a culture shift for the organisation, which needs to provide support and guidance using the principles of good change management, so staff feel 'part of' rather than 'done to'. We will ensure regular communication and involvement through our communication framework and our wider organisational governance structures.

Staff and colleagues need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame. We will closely monitor incident reporting levels and continue to promote an open and just culture to support this.

Staff involved in a patient safety incident can be significantly impacted. The emotions and stress involved can affect their health and ability to continue working. Staff can gain support from the PSQ Team, their line managers, and senior clinical managers. SPH also offers a confidential Employment Assistance Programme, which includes access to counselling and other one-to-one support services. Details can be found on the Human Resources Communicate site.

Engagement Principles

Staff should be trained to practice compassionate engagement under the following principles:

1. Apologies are meaningful.
2. Approach is individual.
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.

These principles create the right foundations to embed PSIRF and meaningful learning for improvement. The foundations for effective and compassionate engagement are:

	Foundation	SPH Action
1	Leadership	PSIRF implementation led by the Head of Clinical Governance through PSQ and senior leadership team with compassionate engagement at the heart of all care including incident management
2	Training and competencies	PSIRF response training is developed and delivered as per the PSIRF plan
3	Support systems	Patient and family support leaflet will detail all avenues of support when an incident occurs (In development). Response leads responsible for ensuring patients and their families/significant others are fully supported and always informed.
4	Ensuring inclusivity	SPH is committed to preventing and tackling discrimination, promoting human rights, equality, diversity, and inclusion. We do this by promoting equal opportunities and fair treatment in all areas of employment practice and service delivery for our workforce and in the delivery of our services to our employees, patients, service users and carers.
5	Information resources	PSIRF leaflet for both staff and patients
6	Processes for seeking and acting on feedback	All patient feedback is managed through the patient experience and clinical governance processes. Patient feedback that is gleaned through incident or complaint management is recorded and shared through the governance systems throughout the clinical organisation.
7	Process for managing dissatisfaction	Staff, leaders and managers must be skilled to manage situations when we are unable to meet the expectations of those affected. Patients, families and staff must be given meaningful, truthful and clear explanations as to why this is not possible.

Patient Safety Incident Response Planning

PSIRF supports SPH in responding 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, SPH has explored its patient safety incidents, the context of the work done, and the population they serve, rather than only those that meet a certain defined threshold. Our PSIRP can be viewed via our webpage and intranet. This plan is set for the next 18 months and will be reviewed continually.

Clinical Education and Training

To deliver the plan there should be robust education planned and delivered to build and maintain SPH competence in patient safety and learning. The PSQ and Clinical Education team leads develops and delivers this training for the organisation. The current detail of gap analysis resides in the PSIRP.

The Director of Patient Care is accountable for the delivery of this training, the learning culture and assurance to the organisation and the senior leaders and line managers responsible and accountable for staff engagement in this process and the learning culture.

The timeline for education delivery is detailed in the PSIRP, reviewed, and amended over its lifespan.

The Head of Clinical Governance and Quality, PSQ team and Clinical Education are responsible for education delivery, and they will also liaise with the Education team for support with delivery planning. The cohort groups and a timeline are presented below:

Cohort Groups

Cohort	Training included	Staff groups
(red)	PSIRF + PSR, RIR, TR and whole tool kit	DoPC, MD, B8 senior managers, ACP PSQ Team, B7, medics and Service Leads
(yellow)	PSIRF + RIR and associated tools	Band 6-line managers, B5 and equivalent AHP roles
(blue)	PSIRF + Incident immediate actions and associated tools	HCAs, facilities and admin staff
PSII	2-day PSII training (external)	Head of Clinical Governance, PSQ Manager. Practice Improvement Leads.

Our Patient Safety Incident Response Plan

Our plan outlines how SPH intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules and can be adjusted as needed. 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 Head of Clinical Governance is responsible for the ongoing review of the PSIRP and for the formal reviews at 1 year and 18 months following publishing. The Director of Patient Care has devolved responsibility and accountability for patient safety and learning through this and the clinical governance process.

The PSIRP has been written in consultation with our stakeholders both internally and externally.

The patient safety incident risks for SPH have been profiled using organisational data between 2020 and 2023 from the following data sources:

- Patient safety incident reports
- Review of mortality templates and themes arising
- Staff surveys
- Complaints and concerns
- Clinical governance data, oversight reviews and context including workstreams.

Incident types, recurrence, and severity were explored, along with careful consideration of patient safety and quality improvement opportunities and current plans already in place.

A range of clinical staff and managers were consulted, and a prioritised list of incident themes was agreed upon.

The criteria for incident response are detailed in the PSIRP.

Stakeholder Engagement

The SPH Executive team and Trustees have been kept informed about the development and implementation of the PSIRF and this plan. The BNSSG Integrated Care System (ICS) Quality Lead has also reviewed the data and risk assessment for SPH and has supported its content. Following the completion of this plan and supporting policy, both will be sent to the Clinical Services Trustees, Executive Team, and ICS/ICB for final sign-off.

Reviewing our Patient Safety Incident Response Policy and Plan

Our Patient Safety Incident Response Plan is a 'living document' that will be appropriately amended and updated as we use it, to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date. With ongoing improvement work 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.

A planning exercise will be undertaken every 18 months and more frequently if appropriate (as agreed with the Integrated Care Board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

The development of patient safety standards should be considered gold standard and introduced on maturity of the plans in order to provide the assurance required for the Executive team, trustees and other stakeholder. These should be audited and accommodated within the existing clinical governance audit schedule.

Responding to Patient Safety Incidents

Patient Safety Incident Reporting Arrangements

There are several mechanisms in place to allow staff, patients, and the public to record patient safety incidents. These include:

Internal Process:

- All SPH employees have access to incident reporting forms. Work is currently in progress to implement the In Phase incident management system. Until this point a paper-based incident reporting system is used.
- The reporting team's manager will be notified about the incident and will inform the PSQ team. Depending on the type of incident, they will notify the relevant SPH teams/leads
- The reporting team's manager will feedback to staff who have reported the incident. All incidents reported are discussed at the weekly Patient Safety Incident Review & Learning Group and via the quarterly clinical governance paper and committee meetings.
- All the internal processes are described in the Incident Reporting Policy. This will be reviewed and updated following the implementation of In Phase.

External Process:

- Via the NHSE website NHS England » Report a patient safety incident
- External agencies contact SPH through a dedicated and secure nhs.net email address. This is monitored by daily by the PSQ Team *(development in progress)*
- The public can raise an incident/concern through patientfeedback@stpetershospice.org
- Patients can raise a complaint which may then be triangulated with the PSQ team and an incident form generated
- The public can report via LFPSE

Patient safety incidents that require reporting to external care providers, such as the Ambulance Service, Care Homes or GP practices, are discussed at the weekly Patient Safety Huddle. For those incidents which are identified as presenting potential or significant learning and improvement for an external care provider, the PSQ Team will liaise directly with their relevant contact. Such incidents would then be closed internally.

Supporting Open and Transparent Reporting

Incidents are reported to both external and internal stakeholders. This enables identification of risks to patient safety and potential opportunities for learning improvement at both local and national levels.

External stakeholders include:

- Integrated Care Board (ICB)
- Learning from patient safety events (LfPSE) (replacing the national Reporting Learning System (NRLS) and Strategic Executive information System (StEIS),
- Care Quality Commissioners (CQC),
- National Health Service England/Improvement (NHSE/I).
- Legal Team
- Hospice UK
- Health and Safety Executive (HSE) for patients involved in Reporting of Injuries, Diseases, Dangerous occurrence Regulations (RIDDOR) incidents,
- NHS digital via the information Governance (IG)
- Medicines and Healthcare Products Regulatory Agency (MHRA)

Internal stakeholders include:

- Board of Trustees
- Executive Team
- Med's Management Committee
- Infection prevention control Lead
- Information Governance Lead
- Safeguarding Lead
- Health and Safety Committee
- PSQ Team

Refer to *Appendix 1: PSIRF Incident Management Flowchart* for SPH incident reporting/ investigation / methods.

Patient Safety Incident Response Decision-Making

Local Level Incidents:

Managers of all service areas must have arrangements in place to ensure that incidents can be reported and responded to within their area. Incident responses must include immediate actions taken to ensure safety of patients, public and staff, as well as indication of any measures needed to mitigate a problem until further review is possible. This may include for example, withdrawing equipment or monitoring a procedure.

Any response to an incident must be fed back to those involved or affected and appropriate support offered. Where Duty of Candour applies, this must be carried out according to SPH Policy.

Band 8/ Band 7 Managers will have escalation arrangements in place for the monitoring of patient safety incidents. This includes daily escalation of incidents that may require a rapid review. This will include incidents that may reach the

requirements for a PSII or a patient safety response due to identified learning or identifying unexpected risk.

Weekly Patient Safety Incident Review and Learning Group:

This group will review all incidents that have been reported during the preceding 7-day period in line with this policy.

They may commission thematic reviews of such incidents to consider and understand potential emerging risks. Any highlighted incident will follow the incident management process as outlined in Appendix 1 (PSIRF Incident Management Flow Chart).

If a PSII is required (for example, for a Never Event) the PSQ Manager must inform the Head of Clinical Governance or Director of Patient Care as soon as possible to ensure the incident can be shared with the Executive Team.

A rapid review must be undertaken by the PSQ Team to inform decision-making and onward escalation. The table below outlines the SPH decision making process for the type of incident that has occurred.

National Priority		Incident Type	Team	Response Type	Anticipated Improvement Route & Shared Learning
1	Never events	All	All	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication
2	Learning from deaths	Where patient death is more likely than not due to problems in care	All	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication
3	Safeguarding incidents	Safeguarding provider enquiry reports. Statutory reviews	All	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication
4	Deaths of persons with learning disabilities	Work with LeDeR through information for each death for learning	All	Participate in LeDeR review. PSII as with learning from death	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication

Local Priorities & Decision Making:

	Incident Type	Detail	Planned Response	Anticipated Improvement Route
1	Documentation	Incidents where documentation issues negatively impact patient safety. Thematic analysis shows high frequency.	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication ICB and CQC
2	Communication	Complaints and concerns regarding staff/organisation communication. Incidents where communication impacted patient negatively	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication ICB and CQC
3	Falls	Incidents of Inpatient falls with potential for significant learning.	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication ICB and CQC
4	Medication	Medication incidents that have significantly impacted on patient outcomes.	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication ICB and CQC
5	Pressure Injuries	Hospice acquired Category 3 pressure ulcers and above, with potential for significant learning	PSII	Clinical Governance Committee (CGC) Tissue Viability Group PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication

Responding to Cross-System Incidents / Issues

Where cross-system incidents have been identified, SPH will collaborate closely with external care providers and the relevant ICB to support the free flow of information and timely review of any incident. A nominated member of the patient safety team will act as the liaison for cross system work.

In cases where a cross-system incident is too complex to be led by a single provider, SPH will approach the relevant ICB to help coordinate a multi-organisation review. This will guide the level of response required and the development, monitoring and sharing of any safety actions generated.

If SPH is asked by an ICB or an external care provider to contribute to one of their PSII investigations, an initial meeting will be held with representatives from both organisations. This meeting will determine the level of input required, who will have oversight, how actions will be agreed upon, and how/where learning will be shared. Any report will need to be signed off internally before external submission, including any improvement recommendations and safety actions.

Timeframes for Learning Responses

Where a PSII is required (as defined in the plan for both local and national priorities), the investigation will start as soon as possible after the incident has occurred. PSIIs will ordinarily be completed within three months of their start date.

In exceptional circumstances, a longer timeframe may be needed to complete a PSII. In such cases, the extended timeframe will be agreed upon by the Head of Clinical Governance, PSQ Manager, the allocated learning response lead, and the patient/family. Ideally, PSIIs will be completed within six months.

It is recognised that the right time to engage can vary for some patients/families, and the timescales will reflect and respect this. A balance will be struck between conducting a thorough PSII, the impact of extended timescales on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. If external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.

Safety Action Development and Monitoring Improvement

Through the investigation process, areas for improvement will be identified. Safety actions will be developed to address each of these areas. A quality improvement methodology will be used to ensure the actions are clearly defined, describe responsibilities and timescales, align with reportable outcome measures, and include a detailed assurance/monitoring process.

Safety actions arising from a learning response will be developed with the clinical and operational teams responsible for implementing these actions to ensure ownership of the actions and outcomes.

Monitoring of completion and efficacy of safety actions will be via SPH governance processes, with oversight from the PSQ Team. The Head of Clinical Governance alongside the PSQ Manager will maintain an overview across the organisation to identify themes, trends and triangulation with other sources of information that may reflect improvements and risk reduction. This will be reported quarterly via the Clinical Governance Committee. This is shared with both the ICB and CQC and Clinical Trustees.

Safety Improvement Plans

The Patient Safety Incident Response Plan (PSIRP) clarifies the current improvement priorities for SPH. The PSIRP details how we will ensure patient safety incidents are investigated in a holistic and inclusive way to identify learning and safety actions that will reduce risk and improve safety and quality. The themes detailed in the PSIRP are based on an extensive analysis of historical data. Each theme will have its own improvement plan, utilising QI methodology where appropriate, to determine the key drivers of patient safety risks, how improvements can be made, and how these can be monitored for completion and effectiveness. These will be monitored quarterly and reported via our Clinical Governance Committee.

Whilst the PSIRP identifies broad organisational priorities, it is recognised there may be more specific priorities and improvements identified via our Clinical Governance Committee. Although will not form part of the overarching plan, will still be managed using the more holistic and inclusive PSIRF approach.

Process for Monitoring Compliance and Effectiveness:

Process for reviewing compliance and effectiveness, i.e. audit, review, survey, incident reporting	Responsible	Frequency of Monitoring	Assurance Group
Monitor timeliness of response to patient safety incidents	Head of Clinical Governance	Weekly	Patient Safety Incident Review & Learning Group
Monitor training compliance regarding patient safety incidents.	Head of Clinical Education	Monthly	Patient Safety Incident Review & Learning Group
Monitor Frequency of meetings, Patient Safety Incident Review & Learning Group	Head of Clinical Governance	Quarterly	Clinical Governance Committee

Oversight Roles and Responsibilities

Roles and responsibilities specific to PSIRF are as follows:

Board of Trustees

- Receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms from the Director of Patient Care and Medical Director.
- Reporting will comprise of an overview of activity and any risks identified to ensure the Trust Board has a formative and continuous understanding of organisational patient safety.

Director of Patient Care/ Medical Director

- Report to the Board of Trustees all matters pertaining to PSIRF.
- Responsible for advising the board in all matters relating to the safety of patients.
- All PSIIs will be reviewed and approved as complete by the Director of Patient Care/ Medical Director/ Head of Clinical Governance.

- **Head Of Clinical Governance**
- Oversee the development, review and approval of the Patient Safety Incident Response Plan and Patient Safety Incident Response Policy.
- Responsible for reporting patient safety events, trends, and responses via the quarterly Clinical Governance Committee and report.
- Monitoring the completion of learning plans arising from patient safety incidents.
- Ensuring that all incidents are managed correctly.
- Lead quarterly Clinical Governance Meetings.
- Share Quarterly Clinical Governance data and learning responses with ICB and CQC.
- Reviews all PSIIs alongside Director of Patient Care and Medical director.

PSQ Team

- Providing assurance to the Head of Clinical Governance that PSIRF and related workstreams have been implemented to the highest standards.
- Report on ongoing monitoring and review of the PSIRP and delivery of safety actions and improvement.
- Lead Weekly Patient Safety Incident and Learning Group.
- Provide training in the reporting and management of incidents
- Support and developing incident response processes
- Ensure that all staff are made aware of SPH's arrangements for responding to patient safety incidents.
- Ensure that all learning identified from PSII's is implemented in a timely manner.

Clinical Managers Band 6-8

- Ensure that patient safety events are recorded via the risk management reporting system.
- Ensure staff can access support following a patient safety event, if required.
- Support the release of staff to provide statements or attend interviews or participate in learning response activities.
- Undertake learning responses as required.
- Ensure the prompt delivery of all action identified from learning responses.

Head of Clinical Education

- Liaise with the Head of Clinical Governance and PSQ Manager to support and facilitate the delivery of all relevant training as identified by them and within this policy.
- This includes any training required to effectively deliver the PSIRF as well as training relating to the reporting and management of incidents.
- Providing advice and support with regards to the planning, promotion, and management of identified training requirements as required.
- Facilitate the recording of any specialised training sessions and staff attendance as identified within this document on the Knowledge Centre and liaising with the Head of Clinical Governance to support with compliance reports and other training data as required.

All Staff

- Report all incidents and near misses, via the SPH incident reporting system
- Cooperate with any learning responses and provide any requested information and participate in any learning responses that are relevant to their roles.
- Completing levels 1 and 2 of the patient safety training modules.

Complaints and Appeals

SPH is focused on quality improvement and supporting those affected by patient safety incidents Therefore it is expected that all actions to support a proportionate and thorough investigation following a patient safety event will be delivered. This process should be fully inclusive of the considerations for those affected by the incident.

The Clinical Feedback Policy and the Complaints, Concerns, Compliments, & Comment Policy should be followed where patients and or families / friends do not feel the response to the patient safety incident has been appropriate or that they have not been supported appropriately.

Anyone affected by a patient safety incident who wishes to raise a concern or complaint can do so via patientfeedback@stpetershospice.org

References

NHS patient Safety strategy – Safer cultures, safer systems, safer patients. NHSE/I. 2019

NHS patient Safety strategy update – Safer cultures, safer systems, safer patients. NHSE/I. 2021.

Patient safety incident response standards. NHSE. 2022

PSIRF preparation guide. NHSE. 2022

PSIRF guide to responding proportionately to patient safety incidents. NHSE. 2022

PSIRF Engaging and involving patients, families and staff following a patient safety incident. NHSE. 2022

Patient Safety Incident Response Framework (PSIRF). NHSE. 2022

Improving patient safety culture: A practical guide. NHSE in association with the AHSN Network. 2022.

Appendix 1: PSIRF Incident Management Flowchart