Patient Safety Incident Response Policy

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Policy approved for Spirit Healthcare and Spirit Clinical Services

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1. Purpose

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

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

This policy supports 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.

This policy should be read in conjunction with our current Patient Safety Incident Response Plan (PSIRP), which is a separate document setting out how this policy will be implemented.

Key Spirit policies that should be read alongside the PSIRF policy include:

- Continuous Improvement Policy (Including Incident Management/Serious Incidents and Near Misses)
- Complaints Policy
- Being Open and honest (Duty of Candour Policy)
- Whistleblowing (Freedom to Speak Up) Policy
- Equality Opportunities Policy
- Adult Safeguarding Policy
- Children's Safeguarding Policy

2. Scope

Spirit will undertake a systemic approach to investigate incidents. The focus of a system-based approach is examining the components of a system (e.g. person(s), tasks, tools and technology, the environment, the wider organisation) and understanding their interdependencies (i.e. how they influence each other) and how those interdependencies may contribute to patient safety.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

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

3. Our patient safety culture

At Spirit we aim to create a restorative and learning culture of openness, in which all categories of workers do not feel afraid of reporting adverse events or feel blamed when they are involved in an incident. In this way learning can take place and improvements made locally, and may be shared across other services if appropriate.
Spirit will ensure that, incident reporting is not associated with blame or disciplinary action unless where it is clear this action is required and justified. As an example, Spirit may consider using disciplinary or legal action against individuals in untoward events when there is:

- Alleged gross or repeated misconduct,
- Alleged professional mal-practice or criminal behaviour,
- An incident which results in a police investigation.

This list is non exhaustive.
At Spirit we are committed to promoting and improving the quality and safety of care and treatment all patients receive, as well as preserving the safety of its staff, visitors, and others. To achieve this, it is important to support and embed a positive reporting culture throughout the organisation to enable learning when things do not go as expected.
A safety conscious organisation is one which is receptive to adverse incidents so it can learn, develop, and change practice. We have embedded these principles into our procedures for the review of incidents. In accordance with the Equality Act 2010 and the Francis Report (2013), this policy will support Spirit to ensure that learning responses and investigations are reviewed with fairness and transparency ensuring that all staff regardless of their protected characteristics are supported and listened to when raising a concern or reporting an incident relating to the quality of care and patient safety. Spirit recognises the significant impact being involved in a patient safety incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place. There is a range of support and information available:

- Spirit's employee assistance scheme www.lap-addist.co.uk

Username – spirithealth
Password – employee

- Telephone service available 24/7 – number 0330 058 4885
- Workplace Health and Wellbeing support
- Mental Health First Aiders
- Freedom To Speak Up Guardian - A confidential service for people if they have concerns about Sprit's response to a safety incident.
- Professional bodies

All categories of workers with knowledge of the events being reviewed are encouraged to actively participate in the learning response. That may be through submitting written information, joining a review/debrief meeting as part of a learning lessons. All contact with those involved will involve the collection of their account of the events and their views and opinions on how systems can be improved. Whomever is leading the review will agree the timescales for feedback of progress and findings in accordance with the type of review method being utilised.

4. Patient safety partners

As part of our commitment to working with members of the public we have many members of the public working with us to develop and improve service. These individuals sit on within our Leadership Teams, attend patient facing sessions and provide written narrative to share with others.

5. Addressing health inequalities

Spirit is committed to ensuring our services and employment practices are fair, accessible, and appropriate for everyone we serve. We believe that everyone is entitled to fair and equal services that take account of individual needs and backgrounds. We actively advocate for equality and believe that everyone we come into contact with deserves the same standard of treatment and support.
Furthermore, it is essential for us that people using our services, their carers, and our employees, have opportunities to be involved in shaping how our services develop. All our services are working towards reducing inequalities. We want to ensure staff are consciously inclusive in their day-to-day practice and interactions with our diverse patients, service users, and teams, recognising their mix of abilities, experience, and knowledge. In doing so, this will ensure the Equality, Diversity and Inclusion agenda becomes a golden thread through the whole organisation.

6. Engaging and involving patients, service users, 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 as required.

Spirit is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned. There is a responsibility as well as a statutory requirement under CQC Regulation 20, Duty of Candour for all healthcare organisations to be open and transparent with patients and their families when things go wrong with treatment or care delivery. Registered professionals should also refer to their professional guidance with reference to Duty of Candour requirements.

Where it has been identified that an incident is suspected of causing moderate or severe harm, or death, then the Statutory Duty of Candour must be enacted by the Clinician responsible for the care of the patient. Adhering to Being Open principles however is good practice and Spirit encourages being open with patients and their families regardless of level of harm. It is the responsibility of the Division's to ensure all Duty of Candour requirements are met and that the accompanying evidence is recorded centrally within the divisions.

7. Duty of Candour and Being Open

This section should be read alongside Spirit's Being Open and Duty of Candour Policy.

Statutory Duty of Candour was brought into law in 2014 for NHS Trusts (Regulation 20) and 2015 for all other providers who are registered with Care Quality Commission (CQC).
Spirit mandates being open and honest with patients, service users, families, and carers when a patient safety incident occurs, and we want to support our staff in this process.
The definition of a 'notifiable safety incident' which will trigger the Duty of Candour, is any unintended or unexpected incident in the provision of a regulated activity which, in the reasonable opinion of a healthcare professional, could result in, or appears to have resulted in or requires treatment to prevent:

- Fatal Harm/death or
- Moderate physical harm and/or
- Moderate Psychological harm or
- Severe physical harm and/or

- Severe psychological harm

The Duty of Candour requirements involve:

- Recognising when an event occurs that impacts on a patient in terms of harm;
- Acknowledging when things go wrong;
- Conducting a thorough investigation or learning response as per escalation process.
- ***Written notification of Incident investigation or learning response***: including formal learning response or review, a further verbal and written notification ensuring the patient, family and carers are appropriately and adequately supported and kept informed following the event and during the investigative process.
- Keeping proper records of all steps in the process
- Supporting those involved to cope with the physical and psychological consequences of what happened.

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

Resources and training to support patient safety incident response–

Spirit is committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen, outlined below.

Competence and capacity}

- All learning responses must be adequately resourced (including funding, time, equipment, and training).

Learning resources recommendations}

- Learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

- Learning response leads should have an appropriate level of seniority and influence within an organisation – this may depend on the nature and complexity of the incident and response required.
- Learning responses are not undertaken by staff working in isolation.
- Staff affected by patient safety incidents are given time and are supported to participate in learning responses.
- Learning response leads have dedicated paid time to conduct learning responses. If necessary, their normal roles are backfilled.
- Subject matter experts with relevant knowledge and skills are involved, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.
- There is dedicated staff resource to support engagement and involvement of those affected.
- Learning response leads, those leading engagement and involvement and those in PSIRF oversight roles require specific knowledge and experience.

Learning response training requirements}

- Appropriate formal training will be provided to deal with patient safety incidents and experience of patient safety incident response.

9. Resources and training to support patient safety incident response

Our patient safety incident response plan

Our plan sets out how Spirit intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is fluid and will change as required and is not restricted to a review date. 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.

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. The next full formal review of the plan will take place in March 2026 to ensure efforts continue to be balanced between learning and improvement.

10. Responding to patient safety incidents

Patient safety incident reporting arrangements

All staff are required to:

- Report all incidents, patient safety events and near misses via the CIP forms on SharePoint
- Ensure the details of any incidents or patient safety events are contemporaneously and objectively reported in the patient / service user's clinical record.
- Raise any concerns about situations that led to, or could lead to, an incident, patient safety event, or a near miss, with their line manager or relevant Director.
- Actively participate in any subsequent reviews or learning responses, providing a written account, attending multidisciplinary fact-finding and feedback meetings etc as needed.
- Undertake mandatory training in the reporting of incidents / patient safety events.
- Undertake additional training, as required.

We will make available appropriate support to those staff involved in an incident or patient safety event, where this is required.

Patient safety incident response decision-making

Patient safety incidents will be responded to with due regard to our PSIRP. Responding proportionately to balance learning and improvement efforts will require a thorough understanding of the local patient safety incident profile and ongoing improvement work.

We will respond to incidents in a way that maximises learning and improvement and will explore patient safety incidents relevant to the context of our organisation and the populations we serve rather than exploring only those that meet a certain nationally defined threshold.

Responding to cross-system incidents/issues

Many patients and service users receive care from more than one provider. On occasion, an incident may be reported that involves multiple services, when this is the case we will work with all agencies concerned to resolve the incident and prevent it happening again.

Timescales for patient safety CIP Reporting

Where learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within three months of their start date.
The time frame for completion of a CIP will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough investigation, the impact that

extended timescales can have 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.

Safety improvement plans

Robust findings from investigations and reviews will provide key insights and learning opportunities. Safety improvement plans will bring together findings from learning responses to patient safety incidents and issues so that these can be translated into effective improvement plans and implementation.
Reports to the leadership teams will be shared and will include aggregated data on:

- Patient safety incident reporting.
- Audit and review findings.
- Findings from patient safety incidents
- Progress against the PSIRP.
- Results from monitoring of improvement plans from an implementation and an efficacy point of view.
- Results of surveys and/or feedback from patients and service users, families and carers, on their experiences of our response to patient safety incidents.

Results of surveys and/or feedback from staff on their experiences of our response to patient safety incidents.

Safeguarding

Safeguarding requires consideration throughout all patient safety events.

Whilst there are some specific incidents that will follow the specialty nursing pathway for review, others may require safeguarding input or referrals.

The Mental Capacity Act (MCA, 2005) also requires specific consideration throughout all patient safety events. An individual's capacity to consent or ability to make an informed decision relating to care/treatment may influence their level of involvement in learning responses.

The role of both safeguarding and MCA will be reviewed by the Trust safeguarding team who attend the Incident Response Group (IRG) and Patient Safety Incident Response Group (PSIRG meetings)

Spirit Healthcare is committed to safeguarding, our approach is described in our Safeguarding Adults Policy and Safeguarding Children Policy.

IPC

Our organisation has established a Local IPC Review Plan that is in accordance with the national PSIRF methodology.

We ensure the availability of qualified IPC professionals and the necessary tools by allocating adequate staffing and resources to facilitate effective IPC communication and governance.

Medicines Safety

Spirit is committed to the avoidance of harmful events and has an established culture of learning from patient safety incidents.

Medicines are integral to patient care and the learning from patient safety events is a core function for all organisations delivering healthcare services.

Healthcare professionals delivering the medication safety agenda in their organisation require an understanding of national policy, frameworks and legislation. Embedded in all learning response pathways will be the inclusion of subject specialists informing the review process and identifying improvement strategies. In instances where medicines safety incidents are identified, our investigation process will involve collaboration, and any insights derived from these investigations will be disseminated throughout the organisation to facilitate collective learning and improve our practices.
Spirit Healthcare is committed to avoiding harmful events and ensuring patient safety, through improving our policies and processes in response to incidents. Our approach to continuous improvement is described in our Continuous Improvement Policy.

11. Roles and responsibilities

Spirit will work with other organisations including but not limited to NHS providers, ICBs, and regulators so that systems for oversight allow for improvement, rather than compliance with prescriptive, centrally mandated measures.
Roles and responsibilities are described in relation to our response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents (*see also Continuous Improvement Policy including Serious Incidents and Near Misses, and the Patient Safety Incident Response Plan*).

Chief Executive and Leadership Team Members

CEO and The Leadership will also ensure appropriate arrangements are in place throughout Spirit to ensure there is accountability for effective governance and learning through assurance of our PSIRP and take responsibility for leading the development of a just, open and learning culture within the organisation, and for role modelling the behaviours required to achieve this.

The Chief Executive is accountable and responsible for ensuring that resources, policies and procedures are in place to ensure the effective reporting, recording, review and treatment of incidents.

The Chief Executive

Has overall responsibility for ensuring there are processes that support an appropriate response to patient safety incidents.

- Has overall responsibility for ensuring the development of a patient safety reporting, learning and improvement system.
- Ensures that systems and processes are adequately resourced: funding, management time, equipment and training.
- Ensures compliance with internal and external reporting/notification requirements.
- Acts as spokesperson in complex or high-profile cases where the media and/or public is engaged.

Medical Director

The Medical Director is our nominated lead responsible for ensuring we have appropriate arrangements in place for the management of incident/patient safety event reporting and associated reviews or learning responses.
The Medical Director is our lead in the formation and implementation of clinical strategy, taking a lead on clinical standards in relation to the quality and safety of care, and providing clinical advice to the Leadership.
The Medical Director will attend a Coroner's inquest on behalf of Spirit if called to do so.

The Leadership Teams

The Leadership Teams ensures accountability from the directorates regarding the implementation of actions and dissemination of learning following patient safety incidents, highlighting incident trends emerging issues. It also provides assurance that our policies in regard to Being Open and Duty of Candour are adhered to in terms of informing patients and service users, and/or relatives, of incidents and the subsequent sharing of reports.
Each Directorate will:

- Maintain local risk management systems and relevant incident reporting systems to support the recording and sharing of patient safety incidents and monitoring of incident response processes.
- Support the development and review of the PSIRP.
- Work with services to address identified areas for improvement in our response to patient safety incidents, including gaps in resource, such as skills and/or training.
- Support and advise staff involved in the patient safety incident response.
- Ensure links between Spirit's culture work and PSIRF.

- Ensure stakeholder feedback is incorporated into the final PSIRF policy and plan.
- Understand their responsibilities in relation to the PSIRP and act accordingly.
- Know how to access help and support in relation to the patient safety incident response process.

12. Complaints

This section should be read alongside the Complaints Policy.

Spirit is committed to dealing with any complaints that may arise as quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.
Complaints can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services.

13. Review Frequency

This policy will be reviewed every 3 years in accordance with Spirit policy.

This policy will also be reviewed in the event that there isi a relevant update to an associated document (e.g, Patient Safety Incident Response Plan)

14. VERSION HISTORY TABLE

VERSION	DATE	UPDATED BY	REASONS	SCHEDULED DATE OF NEXT REVIEW
V2.0	Februar y 2025	Andy Coxon	Guidance on Safety Improvement Plans, Safeguarding, IPC and Medicines Optimisation added to section 9 of document.	March 2028
V1.0	January 2024	Lisa Wakeford	New policy	Feb 2027