Patient Safety Incident Response Policy

Document control

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Related policies and documents:

04(d)(i)	Learning Events Policy
04(d)(iii)	Patient Safety Incident Response Plan
12(a)	Duty of Candour Policy
08(a)(i)	Complaints Policy
10 (k)(i)	NHS Freedom to Speak-up Policy
10(k)(ii)	Staff Whistleblowing and Speaking-up Procedure
05	Safeguarding Handbook
TeamNet resource:	PSIRF: Patient Safety Incident Review Framework – national guidance
TeamNet resource:	A Just Culture Guide/decision tree

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Southport and Formby Health'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.

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

As an independent provider organisation delivering NHS services, we are fully compliant with the PSIRF. This policy sets out Southport and Formby Health's (SAFH) approach to building on our systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

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

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

Scope

This policy is specific to patient safety responses conducted solely for the purpose of learning and improvement within Southport and Formby Health.

Responses under this policy follow a systems-based approach, recognising that patient safety is an emergent element of the healthcare system: that is, safety is provided by interactions between different components and not just from one single component. Responses do not take a 'person-focused' approach whereby the actions or inactions of people, or 'human error', are stated as the cause of a patient safety 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 are in place for the purpose of investigating the following:

- claims handling
- complaints management
- human resources investigations into employment concerns
- professional standards investigations, coronial inquests and criminal investigations, exist for that purpose.

The principle aims of each of the above responses differ from those of a patient safety response and are therefore 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.

This policy should be read in conjunction with SAFH policies for incident management and learning events, as follows:

- Patient Safety Incident Response Plan (associated with this policy)
- Learning Events Policy
- Complaints Policy
- Duty of Candour Policy
- A Just Culture Guide/decision tree
- Safeguarding Handbook
- Freedom to Speak-up Policy
- Staff Whistleblowing and Speaking-up Procedure

This policy replaces the SAFH Serious Incident Policy

Definitions

Patient Safety Incident Response Framework:

The Patient Safety Incident Response Framework (PSIRF) outlines the NHS's strategy for establishing and sustaining robust systems and processes to address patient safety incidents, with the aim of fostering learning and enhancing patient safety.

Patient Safety Incident:

A Patient Safety incident (PSI) can be any unplanned or unforeseen event that might have, or did result in harm to one or more patient receiving healthcare. Reporting these incidents enables SAFH to identify errors, learn from them, and implement measures to protect patients and ensure their safety.

Patient Safety Incident Investigation:

A Patient Safety Incident Investigation (PSII) aims to determine what happened and to prevent recurrence through learning and improvement. Incidents usually derive from multiple factors. The investigation focuses on establishing facts and identifying areas for system change, not assigning blame. It begins promptly after the incident and is typically completed within three to six months, with extensions possible if agreed between those involved, including patients, families, carers, and staff. A trained and experienced Learning Response Lead, uninvolved in the incident, leads the investigation to ensure objectivity.

System-based Approach:

This approach involves stepping back from a problem or incident to analyse a wide range of factors, including people, organisations, equipment, and structures that may have contributed to the outcome.

Psychological Safety:

Psychological Safety refers to the confidence that individuals can voice their ideas, questions, concerns, or mistakes without fear of punishment or embarrassment. It is closely tied to the culture within an organisation.

Learning from Patient Safety Events:

Learning from Patient Safety Events (LFPSE) is a newly introduced national reporting system for documenting patient safety events within healthcare and NHS services. It serves as a replacement for the former National Reporting and Learning System (NRLS).

Duty of Candour:

This legal requirement mandates that all healthcare professionals must be transparent and truthful with patients when an issue arises during their treatment or care that results in, or could result in, harm or distress. Refer to SAFH's Duty of Candour Policy for further details.

Swarm Huddle:

A swarm is a method used to quickly gather all individuals who may have valuable insights into an incident shortly after a patient safety incident occurs. These swarm-based huddles focus on identifying lessons from the incident, as well as determining immediate actions and future steps.

After Action Review:

After Action Review (AAR) is a structured evaluation method employed to analyse the outcomes of an activity or event, whether notably successful or unsuccessful. Its purpose is to extract valuable lessons to prevent failures and encourage future successes.

TeamNet

TeamNet is the cloud-based intranet used by SAFH for holding policies, for reporting learning events, patient safety incidents, complaints, accidents, audits and for providing and recording staff learning.

Duties and Responsibilities

Board

The Board of Directors has overall accountability for patient safety and the implementation of this Patient Safety Incident Response Framework (PSIRF). Their responsibilities include:

- Providing strategic oversight of patient safety ensuring that the company's quality, safety, and risk management strategies are aligned to the PSIRF policy and plan.
- Assessing corporate risks, ensuring that structures and processes are in place to monitor compliance, provide assurances and to mitigate risk.
- Promoting a Just Culture of transparency, of learning, and system improvement across the organisation.
- Signing-off PSI improvement reports and for allocating resources to promote safe working practices.

Governance Committee

The Board delegates day-to-day oversight of governance and risk to the Governance Committee. The committee includes the Medical Director, The Director of Audit and Quality, the Governance Director, and all service managers. Their key responsibilities include:

- Clinical review and analysis of patient safety incident data, trends, and learning outcomes.
- Facilitating system-based investigations and ensuring learning is embedded across the organisation.
- Engaging with patients, families, and staff to ensure compassionate and meaningful involvement in PSI and learning event responses.

- Ensuring appropriate action plans are developed and implemented based on patient safety learning.
- Monitoring risk management and governance processes to support continuous improvement.
- Identifying themes and provision of data on PSIs, patient safety trends and outcomes for review and onward submission to Board for approval and sign-off.

Director of Quality and Audit

The Director of Quality and Audit is the named patient safety lead, who provides leadership and direction to the Governance Committee for the effective implementation of our PSIRF policy and plan.

Trained in levels 1 and 2 of the NHS Patient Safety Syllabus, Essentials of Patient Safety, and in the HSSIB training course focussed on SEIPS, the lead director:

- Identifies the need for a Patient Safety Incident Investigation (PSII):
    - assuming the role of Learning Response Lead
    - providing engagement with the patient, their relatives or carers.
    - coordinating the PSII system-based investigation response
    - identifying actions and areas for improvement
    - producing the investigation report for evaluation by the governance committee and onward sign-off by Board.

The Lead director also provides:

- Oversight on quality, patient safety governance and audit systems, to identify trends and make recommendations to the governance committee for change.
- Liaison and follow up of matters arising from the Governance Committee with individual managers.
- Agreement of service-specific improvement plans with service managers.

Service Managers – individually, and through Service Manager Meetings

Service managers are trained to level 2 in the NHS Patient Safety Syllabus and play a key role in implementing PSIRF in their respective areas. Their responsibilities include:

- Reviewing and sharing patient safety incidents and trends at monthly Service Manager Meetings.
- Ensuring that staff are engaged in reporting, learning, and improving patient safety.
- Facilitating local learning and improvement initiatives in response to incidents through service improvement plans.
- Supporting a Just Culture where staff feel safe to report and discuss incidents without fear of blame.

Our patient safety culture

Patient safety is core to the culture of SAFH. This is provided through a robust governance structure that drives learning and improvement. We provide thorough and in-depth responses to incidents, and we share lessons learnt across the organisation.

A positive patient safety culture is built upon fairness, openness, and a commitment to learning, enhancing psychological safety across all areas of SAFH. Colleagues are encouraged and empowered to raise issues when they arise, as these provide opportunities for growth and meaningful change. We actively promote our Freedom to Speak Up policy, along with the Freedom to Speak Up Guardian roles supporting the policy. Concerns raised through this process are reviewed both at governance meetings and board to ensure appropriate actions and lessons are taken and are monitored.

When concerns are raised, SAFH adheres to NHS England's "A Just Culture Guide". to prioritise systems-based learning over individual blame. The principles of Just Culture are central to collaborating with colleagues to foster openness. SAFH ensures that investigations consider whether individuals require specific support or whether system-based solutions are necessary to maintain safe practice.

Similarly, the patient, their families and carers are central to this approach to ensure that their needs are met. PSIRF advocates an inclusive approach, and we have a duty of candour to be open and honest with those affected by patient safety incidents.

Risk management and continuous quality improvement are embedded into our clinical and business operations to ensure that lessons lead to actionable safety improvements. Our TeamNet management platform supports reporting processes and provides data analysis and action planning. It prompts the need to report to external agencies relevant to the incident, including Learning from Patient Safety Events (LFPSE) reporting. It provides assurance at all levels, reinforcing SAFH's commitment to safe and responsive practice.

Effective communication promotes awareness of a patient safety culture. We involve and engage colleagues in new processes and practices, by piloting new initiatives with staff feedback and evaluation to ensure they are robust.

We monitor the impact of patient safety initiatives through the governance committee, which provides clinical leadership, promotes lessons learnt, and identifies the need to engage with third parties. The TeamNet platform has the functionality to provide announcements, which require acknowledgement once they are read and understood. This technology is shared between us and all GP practices in Southport and Formby.

Patient safety incident investigations (PSIIs) undergo thorough review and approval at the governance committee with oversight at board level. Findings and lessons learnt are

shared openly to maximise their impact and promote learning for all services. The outcome of the annual audit of learning events is presented to all staff at our protected learning time events to raise awareness and promote discussion and learning.

Safety culture for patients and staff is a key element in the provision of effective and caring services. We have processes in place to foster a positive safety culture via TeamNet, which is central to our activities.

Patient safety partners

Organisations of our size are not mandated to have patient safety partners. However, patients are central to everything we do. We actively gather feedback across the organisation through various channels, including our website, email, and patient experience questionnaires. This feedback is closely monitored and used to engage with patients, ensuring that data is effectively captured, thoroughly analysed, and acted upon to drive meaningful improvements. Our services were successful in winning a national award for measuring, reporting, and acting as part of the Patient Experience Awards. These changes were informed by our data and evaluation systems.

Stakeholders

Our services are commissioned both by Cheshire and Merseyside ICB and Southport and by Formby Primary Care Network (PCN) whom we regard as safety partners. We have consulted the ICB and the PCN about the development of our PSIRF policy and our plan.

Our primary care appointments are provided as an extension to all GP practice services in Southport and Formby, and we work closely with practices to ensure that our services interface seamlessly. Our TeamNet operations management platform extends to all GP practices to provide good communications. Where required, individual patient safety incidents are shared with the registered GP practice and where appropriate, with all practices where there are shared learning outcomes.

Our cardiology service provides consultant-led cardiology consultations in a community setting, along with echocardiograms, and open-access diagnostics referred from GP practice. We provide information flows back to GP practice and onward to secondary and tertiary care where required. We prioritise safe and seamless transfer of patients from our services. Where appropriate, we will share patient safety incidents with other providers

Addressing health inequalities

Southport & Formby Health has a significant role to play in reducing health inequalities and improving access to our services. As a key member of the Primary Care Network (PCN), we work in partnership with the PCN to assess needs and to introduce developments. We are proactive in tailoring our services around the needs of individuals and to address health needs.

As part of our Navajo–in-Trust: Merseyside accreditation work, we actively promote training and initiatives to include equality and diversity. Our policies reflect statutory obligations under the Equality Act (2010). We can use data to detect trends and disproportionate patient safety risks to patients across the range of protected characteristics.

We work hard to ensure that no patient is disadvantaged when accessing our services. We have provision in place for language and sign-language translators for patients attending our services, along with hearing loops to remove barriers to health care. Our services also provide telephone consultations, where appropriate.

Our website has language translation to meet the Accessible Information Standards, and we have produced easy-read leaflets for people who have a learning disability and for children and young people. For those with disabilities or mental health problems who are worried about booking a routine appointment at a site different to their own GP practice, we offer welcome tours, so they can familiarise themselves with the environment in advance at a quiet time of day.

Our student-nurse programmes support learning disability health checks sessions in GP practices to promote good-practice for this cohort.

Our digital teams provide demographic and health related data to the PCN and we work in conjunction with the PCN to provide services to improve targeted screening programmes, along with cancer support, and appointments and interventions to support GP practices in targeting long-term conditions to improve health outcomes.

We talk to our commissioners whenever we identify gaps in our services - making recommendations to meet unmet needs and we propose changes to reduce duplication within the system.

We work with commissioners to address incident factors linked to health inequalities, especially risks to specific groups, including protected characteristics. Inequalities are considered in our safety actions and embedded in our documentation and governance.

Engaging and involving patients, families & staff following a patient safety incident

The NHS Patient Safety Incident Response Framework highlights that meaningful learning and improvement after a patient safety incident depend on the presence of robust and supportive systems and processes based on compassionate engagement and the active involvement of those impacted by such incidents, including patients, their families, and health care staff.

Those affected by patient safety incidents may have a range of needs that include clinical, emotional and psychological needs. It is part of our duty of care to understand and meet those needs where possible through engagement.

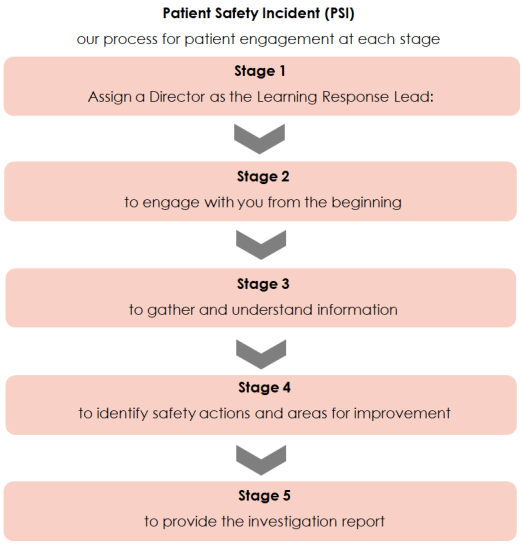
This includes setting a timeframe for the process, which typically, are usually 3 to 6 months but may be completed in 1-2 months.

Patients, families and carers

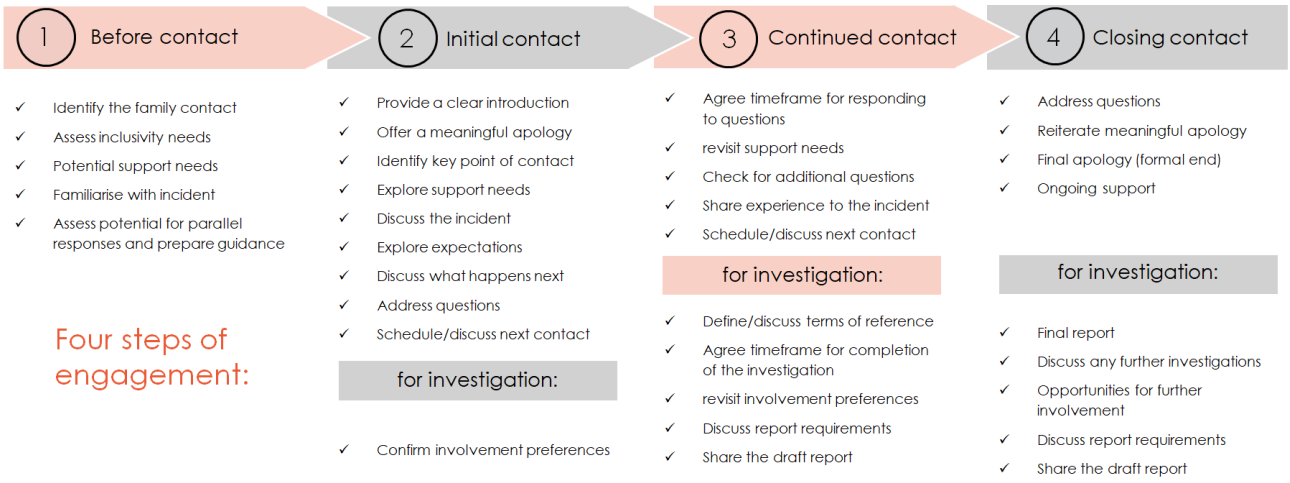
We understand the significant impact patient safety incidents can have on patients, families, and carers. We are fully committed to proportionate and compassionate engagement and the involvement of these individuals, following such incidents.

It is important that support to those affected by a patient safety incident is provided and led by the Director of Audit and Quality, as the Learning Response Lead.

Patients, families, and carers are invited to contribute to the investigation's terms of reference and to share their experiences and insights to guide learning. The following flowchart summarises our approach:



Alongside this, the organisational investigation to support the process will take place in parallel, as follows:



The Learning Response Lead will tailor their support to the nature of the incident and the needs of those affected, offering updates by phone, through written correspondence or through meetings. The duration of this support is flexible, ranging from a few days to several months, depending on individual circumstances and preferences and the length of time needed for the investigation.

Meeting people's needs helps to alleviate any harm experienced and avoids compounding further harm. While we cannot change the fact that a patient safety incident has happened, but it is always within our gift to engage compassionately with those affected, to listen and to answer their questions, and try to meet their needs. Likewise, we have a duty of candour to be open and honest and to provide a meaningful apology, for the occurrence and the impact of an incident, acknowledging accountability without necessarily assigning responsibility before an investigation is completed.

Additional support is offered or signposted based on individual needs. We will provide comprehensive information and documentation to help explain the investigation process while minimising distress or anxiety for those involved.

Where those affected by patient safety incidents have additional needs or require advocacy and advice relating to the incident, we will signpost them to the following organisations or routes to receive support:

Healthwatch Sefton: Sefton - Complaints & Advocacy service

Cheshire and Merseyside PALS: Patient Advice Liaison Service

Colleagues

We recognise the significant impact that patient safety incidents can have on colleagues, too. Providing support begins with fostering a just and supportive learning culture that prioritises systems-based learning and encourages collaborative involvement. This may include participating in a post incident response meeting, an incident learning huddle or SWARM, among other approaches. Colleagues are also given opportunities to engage fully throughout the investigation process, from beginning to end.

After a patient safety incident, colleagues should first be informed in an appropriate and transparent manner by their clinical lead or line manager. Their wellbeing will be prioritised, with regular check-ins to offer support throughout the process. Colleagues are encouraged to discuss their support needs at any time and to seek assistance from their line manager or a clinical lead as required. Psychological safety is essential for creating an environment where colleagues feel safe, valued, and cared for. We strive to normalise and develop coping strategies while fostering this culture.

Support options may include, but are not limited to:

- regular peer review sessions
- communication with the director-lead
- frequent updates on the investigation.

Colleagues also have an option access to mental health services via human resources or to talk to the Level 3 Mental Health First Aider, who is trained to provide support and to direct individuals to appropriate resources. Additional internal and external support options, both formal and informal, will be tailored to meet each colleague's specific needs.

Colleagues who feel they have been treated unfairly or have concerns during or following a patient safety incident are encouraged under our Freedom to Speak up Policy - to seek assistance from the Freedom to Speak Up Guardians, and to report concerns through the Freedom to Speak Up Pathways.

Freedom to Speak Up Guardian: FTSUG resources and contacts on TeamNet

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. The framework enables us to explore patient safety incidents relevant to our own context and the population we serve, as opposed to those that only meet nationally defined thresholds.

We have therefore designed a patient safety incident response plan to allocate our resources towards incidents, including those that fall below the Patient Safety Incident threshold, that maximise learning opportunities and enhance patient safety.

All learning events, and a wealth of additional information is recorded on our TeamNet management platform. The patient safety incident response plan considers all sources information including audits, complaints, risks, and other forms of direct feedback from staff and patients, based on:

- An analysis of relevant organisational data
- Collaborative stakeholder engagement
- A clear rationale for the response to each identified patient safety incident type.

These are updated and reviewed as required and in accordance with emerging intelligence and improvement efforts. Our plan will be published on our website.

Resources and training to support patient safety incident response

The Board of SAFH will allocate the following resources to meet PSIRF standards when responding to a patient safety incident:

Patient Safety Incident Response:	Resources required:
The learning response will first and foremost consider the patient, and their family or carers.	Reference to the four stages of engagement Development of patient literature and information.
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	Director of Quality and Audit is the Learning Response Lead Provided by the director Learning Response Lead
Learning responses are **not** undertaken by staff working in isolation.	Each patient safety incident will have a learning response team
Staff affected by patient safety incidents are given time and are supported to participate in learning responses.	Timescale for learning response agreed in advance, with appropriate time allocation and regard to A Just Culture. Additional supporting resources include: o HR support o mental health first aider freedom to speak up guardians

Patient Safety Incident Response:	Resources required:
Learning response leads have dedicated paid time to conduct learning responses,	Board to authorise dedicated Director resource response.
Subject matter experts with relevant knowledge and skills are involved, where necessary, throughout the learning response process to provide expertise.	Inclusion of: o clinical and non-clinical directors, as required o HR support o mental health first aider o freedom to speak up guardians o input from ICB experts

Once the allocation of the above resources will be agreed by Board, the Director of Audit and Quality will feed into the Governance Committee, which has both director and service manager input.

The Patient Safety Lead, service managers and staff will undergo the following training to equip them with the skills required:

Training matrix:

Course:	Content	Who
HSSIB - Health Services Safety Investigations Body	• 2-day HSSIB training course focussed on SEIPS	Patient Safety Lead
Patient safety syllabus level 2: Access to practice (NHS eLearning)	• Introduction to systems thinking and risk expertise. • Human factors • Safety culture	Patient Safety Lead Service Managers
Patient Safety syllabus level 1: Essentials for patient safety (NHS eLearning)	• Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well. • Creating a just culture that prioritise safety and is open to learn about the risk and safety.	All staff
Patient Safety Incident Response Framework Training (TeamNet)	• This module is designed for primary care staff to assist with their understanding of the patient safety incident response framework and how this information should be applied in their daily working lives in primary care.	All staff annually

Our patient safety incident response plan

The patient safety incident response plan associated with this policy describes the areas we have identified for improvement. We based our priorities for improvement on analysis of our data over the lifetime of the organisation.

Although the analysis in our associated patient safety incident response plan is based on low-level incidents, these are incidents that have potential to be serious if left unchecked. The analysis has enabled us to put in place robust processes and measures to prevent patient safety incidents and to provide a proportionate response when a learning event or a patient safety incident does occur.

Reviewing our patient safety incident response policy and plan

The plan is intended to be a 'living document' and it will be amended and updated as we use it to respond to patient safety incidents and the needs and views of those affected.

We will audit and review the plan every 12-18 months to ensure our focus remains up to date. With ongoing improvement work our patient safety incident profile is likely to change and will include engagement with all stakeholders to discuss and agree any changes made since the first plan.

Updated plans will be published on our website, replacing the previous version.

A planning exercise will be undertaken every four years and more frequently if required, as agreed with the 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, and will include a review of organisational data. For example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, reporting data, and wider stakeholder engagement.

Responding to patient safety incidents

Patient safety incident reporting arrangements

Internal reporting arrangements:

Our TeamNet reporting platform, is the repository for reporting all incoming incidents, including patient safety incidents, learning events, accidents, complaints, and safeguarding incidents. All events are recorded regardless of whether they are classed as a Patient Safety Incident or not, as all incident types have potential for learning.

Although in the main, these are reported by service managers, any member of staff can initiate an event on TeamNet, by choosing the appropriate category, and following company guidance on the reporting of events.

Colleagues are also encouraged to raise concerns with any of our trained Freedom to Speak up Guardians.

TeamNet provides a template for each type of incident. Once an event has been logged, an automatic email alert notification is sent from TeamNet to the governance officer, the HR manager and all governance committee directors to ensure that a timely and appropriate response can take place.

When an event of any type is logged, a risk rating is assigned and is scored using the following matrix:

Risk Assessment Matrix		Consequence				
		Negligible	Minor	Moderate	Major	Catastrophic
		1	**2**	**3**	**4**	**5**
Likihood						
Almost Certain	**5**	5	10	15	20	25
Likely	**4**	4	8	12	16	20
Possible	**3**	3	6	9	12	15
Unlikely	**2**	2	4	6	8	10
Rare	**1**	1	2	3	4	5

Once the risk score is recorded, we then categorise the risk score to inform the local response to the patient safety incident or the minor learning event, as follows:

Risk definition and process to be followed:

Risk Score	Definition of Risk	Process and Monitoring
1 – 3	Low	Local Service Review
4 – 6	Medium	
8 – 15	High	Enter on to Risk Register & Local Service Review
15+	Extreme	Patient Safety Incident Investigation (PSII)

When a director receives an alert email to notify reporting of an event, the email provides a link to the TeamNet platform.

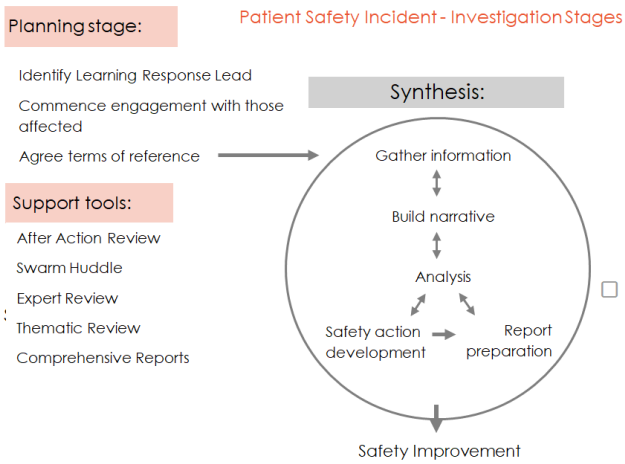
The Director of Audit and Quality, in conjunction with the Governance officer, will then determine the level of response for each event:

- Events with a low score against the above matrix (1-6), will follow our local procedure for learning events and will be subject to a local service review.
- Events with a high score (8-15), will be flagged for the risk register and are likely to follow our normal procedure for learning events and provision of a local service review.
    - However, if there are additional concerns in this (8-15) event, , then the director will escalate this as a patient safety incident for investigation.
- Events with a score of 15+ will be treated as patient safety incident and will be subject to a patient safety incident investigation (PSII), particularly where there has been:
    - harm, or
    - errors, or
    - omissions, where the potential for learning or improvement is great enough to warrant a detailed review and response

Patient safety incident response decision-making

The Director of Audit and Quality, in conjunction with the governance committee, will review Patient Safety Incidents identified with a 15+ to trigger a PSII and will lead and coordinate the approach.

PSIRF provides a variety of resources to support systems-based learning. The following diagram shows the stages of a Patient Safety Incident investigation its simplest form, along with tools to support the process:



Potential use of response tools to support the investigation and which promote use of just culture and a safe space, include the following:

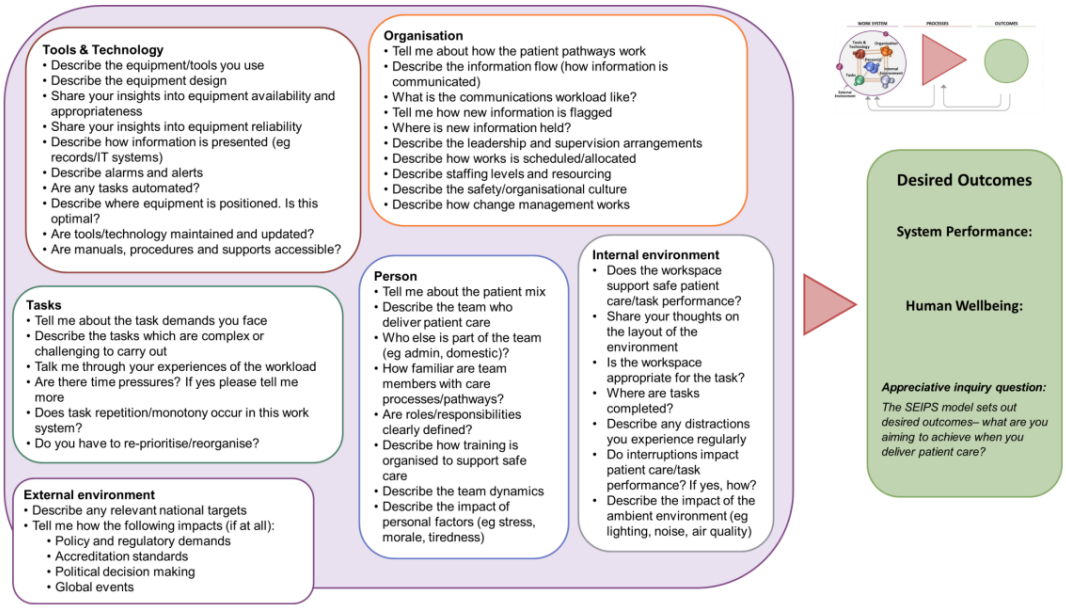
Types of Learning Response Interventions:	

SWARM/ Huddle	When:
	• Immediate or as soon as possible
	Who:
	• All colleagues involved in the incident
	Purpose:
	• Identify immediate actions:
	  o To prevent recurrence
	  o For learning that may be required
	• To identify immediate support for those involved (opportunity for provision of primary supportive role)

After Action Review (AAR)	When: • As soon as possible after the incident Who: • All colleagues involved and those who have insight Purpose: • Provision of a safe space to discuss what happened, what should have happened, what could have been different, is there any learning identified etc. • Can be used for older incidents
Further AAR (if required)	When: • At any time Who: • Wider stakeholders and subject matter experts to identify wider learning. Purpose • A more in-depth multidisciplinary learning conversation for organisational wide complex incidents.
Clinical Expert and Multi-disciplinary Review	When: • At any time Who: • Clinical expertise and support • HR support Purpose: • Insight into what may have occurred/should happen or could be different • External to service where possible to reduce bias
Patient Safety Incident Investigation - Thematic reviews and comprehensive reports.	When: • 1-3 months • Up to 6 months (in extenuating circumstances) Who: • Led by the appointed lead investigator What: • Compilation of all responses, data, feedback, other similar incidents, to provide a comprehensive report and lessons learnt report.

PSIRF resources take account of systems-based approaches, which assist in the synthesis stage of the model, moving away from blaming a person or attributing an incident to human error. One example is the System Engineering Imitative for Patient Safety (SEIPS) framework that takes account of the person and the incident within the operating system:

Systems Engineering Imitative for Patient Safety (SEIPS)



Example questions within the model contribute to information gathered and help to build the narrative to inform safety actions. The investigation stages can be iterative to inform the eventual PSII report. This information adds to our patient safety profile.

The governance committee is responsible for quality, patient safety, and oversight of all events and trends. It will review progress of the PSII to completion and will oversee follow-through on actions.

The committee categorises Patient Safety Incidents and low-level learning events that are subject to local service review, to monitor patterns and types of incidents effectively, with follow-up audits conducted to assess the effectiveness of implemented changes. These are shared at governance meetings, whose membership includes all service and support managers

All patient safety incidents and learning events are reviewed and audited annually by the Director of Quality and Audit to ensure completeness. The results are reported to the Governance Committee, and feedback on areas for improvement is provided to individual service managers.

Following this, service improvement plans are drawn up by individual manager. These are submitted to the governance committee and are followed up in subsequent quarterly review meetings by the Director of Quality and Audit.

There are opportunities to share learning and to provide further training on TeamNet, which has the functionality to provide announcements and for colleagues to respond once read.

It is important to note that PSIRF is a new and evolving framework and as SAFH reflects and learns from this policy and updates our plan, there are likely to be changes. The policy will be updated to reflect this as required. We continue to liaise with internal and external stakeholders during any changes and updates.

External reporting:

There is a requirement within the NHS Standard Contract and for PSIRF to report patient safety incidents (PSI) on the Learning from Patient Safety Events (LFPSE) system. All patient safety incidents are reported via StEIS to the ICB.

The governance officer and the Director of Audit and Quality coordinate all external reporting relating of patient safety incidents, via the above systems, along with any other requirements to provide any other external safety notifications to other statutory agencies.

Responding to cross-system incidents/issues

Our services interface both with patients' registered GP practices and with community and secondary care services. One of our prime goals is to provide accurate records of care and follow-up actions to the correct GP practice or for onward transfer of care to other providers, and this feature highly in our patient incident review plan. We have processes and systems in place to ensure that this happens, and we audit record trails to other providers to confirm safe transfer.

For all patient safety incidents, the relevant stakeholders who are essential to maximising learning will be identified and approached for collaborative discussions. A designated lead will be assigned to provide effective communication. Stakeholders may include, but are not limited to:

- The Integrated Care Board
- Sub-contracted partners
- Patients, families and carers
- Local GPs
- Community services
- Secondary and tertiary care
- CQC.

Additionally, any of these stakeholders may independently approach us to collaborate on a patient safety investigation. In such cases, we will make every effort to accommodate their requests and share insights on a case-by-case basis.

Timeframes for learning responses

The resolution of a Patient Safety Incident Response Investigation needs to be appropriate and timely to reassure patients, families and others involved. The process should not be hurried, but as a general guide, it can take 1 to 3 months or up to 6 months to complete.

The governance committee will continue to monitor all actions until satisfied that they are complete.

Safety action development and monitoring improvement

Once areas for improvement are identified and agreed, we will define safety actions focused on the system rather than individuals.

We will:

- Engage with colleagues involved to discuss the feasibility of safety actions and service improvement plans, and to obtain feedback on the process
- Engage with patients, families and carers impacted where appropriate to discuss safety actions
- Obtain agreement and sign off with local and regional organisations
- Sign off with the governance committee and at board level to agree organisational accountability to quality improvement plans.
- Use TeamNet to update action plans linked to incidents and to share updates

Incidents recorded on TeamNet are structured to ensure that actions relating to learning outcomes, amended processes and the identification and implementation of staff training are included. These actions are not closed until they are completed and have received final sign off by the Governance Committee.

Events data can be downloaded and analysed. The Director of Quality and Audit provides an annual audit of events for ongoing monitoring, makes recommendations for improvement and provides training to ensure that events reporting can be improved.

Safety improvement plan

While this policy describes our approach to the Patient Safety Incident Response Framework, we have also developed an overarching Patient Safety Incident Response Plan detailing our improvement priorities.

The incident response plan describes how we will ensure that patient safety incidents are investigated in a holistic and inclusive way, to identify learning and safety actions that reduce risk, and improve the safety and quality of our services.

All safety improvement plans are entered into the TeamNet management system as "action plans," each assigned to an accountable owner with a deadline for completion. These action plans are continually updated with progress, comments, and tasks, enabling straightforward monitoring and the generation of monthly reports.

Plans are implemented by each service and are supported by directors where necessary. TeamNet ensures action plans are managed at the local level while maintaining oversight.

Following patient safety investigations, TeamNet announcements are created and shared with relevant services to showcase the investigations conducted and the lessons learned, forming part of our approach to shared learning for improvement.

Before patient safety investigations can be finalised, all safety improvement plans must be reviewed and approved both on the governance committee and at board.

Improvement plans are also shared with the Integrated Care Board to provide transparency and secure external support. The ICB is invited to attend appropriate meetings concerning improvement plans as needed. These safety improvement plans contribute to the annual patient safety strategy and patient safety response plan.

For more details, please see SAFH's Patient Safety Incident Response Plan.

Oversight roles and responsibilities

Responsibility for oversight of the Patient Safety Incident Response Framework for all provider organisations sits with the Board as outlined in the NHS England guidance: Oversight Roles and Responsibilities Specification

The Director of Quality and Audit at Southport and Formby Health has responsibility for the effective monitoring and oversight of the Patient Safety Incident Response Framework and the accompanying Patient Safety Incident Response Plan.

The Director of Audit and Quality, as designated patient safety lead, will, in conjunction with the Medical Director, assign any incident reported as moderate harm or above for director and Governance Committee review and agreement of a plan and actions within the Patient Safety Incident Response Framework process for the company.

Incidents and learning outcomes will be reported to the Integrated Care Board to consider system-wide learning outcomes.

Complaints and appeals

Southport and Formby Health recognises that there are occasions when patients, families or carers may be disappointed with aspects of care and services provided. When this happens, they may wish to raise an informal concern, or to raise a formal complaint.

We have a duty to listen to concerns and complaints, to investigate them fully in a timely and responsive manner, to provide a full and appropriate response, and to seek resolution.

Formal complaints from patients or families can be made using Southport and Fomby Health's complaints procedure: Feedback and Complaints

Complaints relating to this policy, or its implementation can be raised with the Director of Audit and Quality, who, in conjunction with the Governance Committee, will aim to resolve concerns as appropriate.

Additional support and advice can be provided by:

Healthwatch Sefton: Sefton - Complaints & Advocacy service

Cheshire and Merseyside PALS: Patient Advice Liaison Service