



# **Patient Safety Incident Response Policy**

Company No: 07789175

## **This is a controlled document**

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### Updates and Changes:

26/06/2025 – Minor changes made to include LLR PCL direct contract provision and LLR LLR PCL changed to LLR PCL.

08/07/2025 – Change made to reflect the Policy Sign Off Group as the policy sign off governance.

## Table of Systems

Description referred to in the policy	Current system utilised by LLR PCL
Employee HR Platform	Breathe HR

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## **Purpose**

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Patient Care Locally (LLR PCL) 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.

## **Scope**

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across LLR PCL.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, 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.

## **Our Patient Safety Culture**

LLR PCL has strived over the years to build and maintain a restorative culture, not just within the organisation but with the providers that we work closely with.

The LLR PCL Senior leadership have embraced this work and have been instrumental in establishing the restorative culture and encouraging engagement with all staff members.

The main goals of restoration when an incident has happened have been outlined as follows.

- Moral engagement
- Emotional healing
- Reintegration of the practitioner
- Organisational learning
- Prevention

PSIRF will enhance these by creating much stronger links between a patient safety incident and learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – providers, staff, patients, families, and carers to arrive at such learning and improvement within the culture we hope to continue to foster. This will continue to increase transparency and openness amongst our staff and providers in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoid-ability or cause of death.

Our safety culture has also progressed in a positive way with reporting of patient safety incidents improving over time and the introduction of a new incident management system in March 2023 which will simplify the analysis of incidents.

To enhance our safety culture, safety discussions are carried out at every contract review meeting, with emergent risks discussed and insights offered from incidents that have occurred with an opportunity to share learning.

We will utilise findings from our staff survey and provider feedback survey to assess if we are sustaining and improving our safety culture.

## **Patient Safety Partners**

LLR PCL does provide direct patient care within the vaccination programme but subcontracts the majority of care out to providers. Where possible we aim to include the providers Patient Safety Partners in the set-up of new services and in any quality improvement programmes that we undertake with our providers.

## **Addressing Health Inequalities**

LLR PCL recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

LLR PCL as a community interest company, is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. The introduction of a new incident management system will allow for incidents to be analysed by protected characteristics to give insight into any apparent inequalities.

We will directly address if there are any particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

We will also address apparent health inequalities as part of our safety improvement work. We understand that our services provide care to significant numbers of the Core20PLUS5 population cohort identified by NHS England and Improvement (2021). In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy. We consider this as an integral part of the future development process.

Engagement of patient, families and staff following a patient safety incident is critical to review of patient safety incidents and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

## **Engaging and Involving Patients, Families and Staff following a Patient Safety Incident**

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, providers 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.

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.

Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.

As well as meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident.

## **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**

LLR PCL has 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.

LLR PCL will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff. Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All managers will work within our just and restorative culture principles and utilise other resources/agencies such as Health and Wellbeing to ensure that there is a dedicated staff resource to support such engagement and involvement.

## **Training**

LLR PCL has implemented a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows

- Level one

National – E-Learning for Health patient safety syllabus module.

All staff, clinical and non-clinical are expected to undertake these on induction and to repeat each three years.

- Level two  
National – Health Education England patient safety syllabus module (Access to Practice) – this is to be undertaken by all members of the senior management team who have the potential to support or lead patient safety incident management.

## **Learning Response Leads Training and Competencies**

Learning response leads must have complete Level one and two of the national patient safety syllabus.

Learning response leads will undertake appropriate continuous professional development on incident response skills and knowledge.

At LLR PCL we expect that those staff leading learning responses are able to:

- a. Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
- b. Summarise and present complex information in a clear and logical manner and in report form.
- c. Manage conflicting information from different internal and external sources.
- d. Communicate highly complex matters and in difficult situations.

## **Oversight Roles Training and Competencies**

Those with an oversight role on our Senior leadership team (i.e., executive leads) must have completed the appropriate modules from the national patient safety syllabus - Level one - essentials of patient safety and essentials of patient safety for boards and senior leadership teams.

All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge.

We expect staff with oversight roles to be able to

- a. Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
- b. Apply human factors and systems thinking principles.
- c. Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
- d. Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
- e. Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).

- f. Summarise and present complex information in a clear and logical manner and in report form.

## **Our Patient Safety Incident Response Plan**

Our plan sets out how LLR PCL intends to respond to patient safety incidents over a period of 6 to 12 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

## **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 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 6 to 12 months.

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

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our 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 wide review of organisational data, for example, Patient Safety Incident Investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

## **Responding to Patient Safety Incidents**

### **Patient Safety incident Reporting Arrangements**

All staff and all providers are responsible for reporting any potential or actual patient safety incidents to the Quality and patient safety team. This can be done via monthly quality returns for providers, unless moderate or severe harm has occurred, in which case it must be reported in real time. LLR PCL staff can report incidents via email, or by telephone to the Head of Nursing, Quality and Patient safety or report directly into the local risk management system.

The Head of Nursing, Quality and Patient Safety will hold oversight for providers and review the incidents as they are reported to ensure a timely and proportionate response occurs. This will include consideration and prompting of providers where Duty of Candour applies. Most incidents will only require local review at provider level. However, for some where it is felt that the opportunity for learning and improvement is significant, these will be escalated to the Head of Quality and Patient Safety and reviewed through the Governance Board.

Any incident that meets the criteria for external reporting will be highlighted. This will allow LLR PCL to work in a transparent and collaborative way with our ICB teams if an incident meets the national criteria for a PSII or a supportive cross system learning response is required.

The Head of Nursing, Quality and Patient Safety will act as liaison with external bodies and partner providers to ensure effective communication via a single point of access.

## **Patient Safety Incident Response Decision-Making**

LLR PCL will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan.

PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. LLR PCL has developed its own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work. All PSII's will include the Medical Director for LLR PCL, with relevant information reported to the governance board and included on the risk register if deemed relevant.

In the work to create our plan we have considered what our incident insight and engagement with key internal and external stakeholders has shown us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety incidents.

## **Responding to Cross-System Incidents / Issues**

LLR PCL will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to the organisation themselves.

LLR PCL will work with providers and the relevant ICBs to establish and maintain robust procedures to facilitate the flow of information and minimise delays to joint working on cross system incidents. The Head of Nursing, Quality and Patient Safety will act as a liaison point for such working and will ensure that this is effectively managed.

LLR PCL will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

## **Timeframes for Learning Responses**

### **Timescales for Patient Safety PSII**

Where a PSII for 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 one to three months of their start date. No local PSII should take longer than six months.

The time frame for completion of a PSII 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 PSII, 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.

In exceptional circumstances (e.g. when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) LLR PCL can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the LLR PCL and those affected.

## **Timescales for Other Forms of Learning Response**

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete.

## **Safety Action Development and Monitoring Improvement**

LLR PCL acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed.

LLR PCL will have systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of LLR PCLs working systems where change could reduce risk and potential for harm – areas for improvement. LLR PCL will generate safety actions in relation to each of these defined areas for improvement. Following this, LLR PCL will have measures to monitor any safety action and set out review steps.

## **Safety Action Monitoring**

Safety actions must continue to be monitored to ensure that any actions put in place remain impactful and sustainable. Reporting on the progress with safety actions including the outcomes of any measurements will be made to the ICB.

For some safety actions with wider significance, this may require oversight by the Strategic Quality Improvement Group or the Strategic Patient Safety Group.

## **Safety Improvement Plans**

Safety improvement plans bring together findings from various responses to patient safety incidents and issues.

LLR PCL patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

LLR PCL will use the outcomes from existing patient safety incident reviews (SI RCA reports) where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work.

Monitoring of progress with regard to safety improvement plans will be overseen by reporting by the designated lead to the Governance Board and Board of Directors.

## **Oversight Roles and Responsibilities**

Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.

Alongside our NHS regional and local ICB structures and our providers regulator, the Care Quality Commission, we have specific organisational responsibilities with the Framework.

In order to meet these responsibilities, LLR PCL has designated the Medical Director to support PSIRF as the executive lead.

### **1. Ensuring that the organisation meets the national patient safety standards**

The Medical Director will oversee the development, review and approval of LLR PCL's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the restorative just working culture that LLR PCL aspires to.

To define its patient safety and safety improvement profile, LLR PCL will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders.

### **2. Ensuring that PSIRF is central to overarching safety governance arrangements**

LLR PCL Board will receive assurance regarding the implementation of PSIRF and associated standards to ensure that the Board has a formative and continuous understanding of organisational safety. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.

LLR PCL will source necessary training such as the Health Education England patient safety syllabus and other patient safety training across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years to comply with LLR PCL guidance on policy development, alongside a review of all safety actions.

## **Complaints and Appeals**

LLR PCL recognises that there will be occasion when the patients, families or carers are dissatisfied with aspects of the care provided.

It is important to understand that there is a distinction made between complaints and concerns as the use of the word concern should not automatically mean that someone expressing a concern enters the complaints process.

Complaints are defined as expressions of dissatisfaction from a patient, family or carer, a person acting as their representative or any person who is affected or likely to be affected by the action, omission, or decision of LLR PCL or our providers and requires a formal review.

Complaints will be managed 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.

Outcomes and recommendations from a complaint will be shared with the providers to ensure that changes can be considered and implemented where appropriate.

The first point of contact for a complaint is usually with the provider of the service, LLR PCL will support with resolution of the concern. It is important to address any issue raised at the earliest opportunity and may reduce the risk of escalation and increases the possibility of finding a satisfactory resolution to the problem. It may be more appropriate to deal with and resolve in a more immediate and timely manner as long as this is with the agreement of the person raising the concern.

If a concern cannot be resolved and the complaints team are undertaking a formal review, the complaints team will contact the complainant and can be contacted directly 07939 849 551 [sarahmabbott.llrLLR.PCL@nhs.net](mailto:sarahmabbott.llrLLR.PCL@nhs.net) or via [llrLLR.PCL.qualityteam@nhs.net](mailto:llrLLR.PCL.qualityteam@nhs.net)

## **Process for Version Control, Document Archiving and Review**

This document will be reviewed on an annually yearly basis unless earlier revision is required following internal audits/external guidance. LLR PCL Head of Nursing, Quality and Patient Safety will be responsible for initiating the regular review of this policy.

Following sign off by LLR PCL Policy Sign Off Group, new versions of this document will be uploaded onto the Employee HR Platform and previous versions archived. Staff will be able to access this document through the Employee HR Platform.