1 Contents: Patient Safety Incidents Response Framework (PSIRF) Policy

Policy & Procedure Title	Patient Safety Incident Response Policy

1. DOCUMENT CONTROL

Policy Number & Version Number	PC7325	V1.3
Target Audience:	All Staff (including volunteers, agency & temporary) & 3rd parties under contract.	
Approved by and Date:	Director of Nursing, Governance and AHPs / Medical Director / Patient Care Committee / ICB	June 2025
Frequency and date of next review.	Annually initially	August 2025
Author	Yvonne Waterfield, Quality Standards & Patient Safety Officer	
Policy Owner(S)	Director of Nursing, Governance and AHPs and Medical Director	

2. POLICY REVIEWERS

Those people who must be involved in the review of this documentation

Name	Job Title	Review Date
Patient Safety Team	NHS Lancashire & South Cumbria ICB	February 2025
Tracy Earley	Director of Nursing, Governance and AHPs	May 2025
Sarah Morrison	Trustee, Patient Care Committee	June 2025

3. REVISION HISTORY

Date	Version	Author	Description	Changes to EIA?
Dec 2024	0.1	YW	New policy using ICB guidelines	

April 2025	1.1	TE	Training plan approval & PSP approach agreed with Patient Care Committee	
28/05/2025	1.2	SM	Updated section 4 to include action in case of intentional or neglectful acts that contradict codes of professional practice.	
03/06/2025	1.3	YW/TE	Added link to PSIRF Information Leaflet for Patients.	
				Yes ☐ No ☐

1. INTRODUCTION

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

It explains the way that patient safety incident investigations (PSII) are responded to and how patient safety investigations are undertaken at SCH.

The Learning from Patient Safety Events (LFPSE) service and PSIRF are the new approach adopted by healthcare organisations, including the NHS and hospices, to manage and learn from safety events. LFPSE replaces the National Reporting and Learning System (NRLS) and PSIRF replaces the old Serious Incident Framework (SIF) (2015) and makes no distinction between 'PSIIs' and 'Serious Incidents'. As such, it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to PSIIs by ensuring resources allocated to learning are balanced with those needed to deliver improvement. Unlike SIF, it is not an investigation framework.

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

2. PURPOSE

This policy sets out how SCH will approach the development and maintenance of effective systems and processes for responding to PSIIs and issues for the purpose of learning and improving patient safety.

SCH supports the development and maintenance of an effective PSII response system that integrates the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by PSIIs.
- Application of a range of system-based approaches to learning from PSIIs

- Considered and proportionate responses to PSIIs and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement.

This policy should be read in conjunction with the Patient Safety Incident Response Plan (PSIRF).

Our PSIRF sets out how SCH intends to respond to patient safety events over a period of 12 to 18 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 event occurred, and the needs of those affected as well as the plan.

A copy of our PSIRF can be located on both our internal policy platform and our website (click www.stcatherines.co.uk/PSIRF)

3. SCOPE

Those leading PSII responses (PSII leads) and those involved in the oversight of learning and improvement emerging from the PSII response require specific knowledge and experience.

Responses under this policy will 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 (e.g., people, tasks, equipment, environment (internal and external)), and not from a single component.

Responses to PSIIs will 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 responses to PSIIs that are conducted for the purpose of learning and improvement.

There are some circumstances where intentional or neglectful acts contradict codes of professional practices and may require human resource policy intervention. It is expected this will be limited to a very small number of cases where individuals have purposefully moved away from codes of professional practice or values of their professional bodies and SCH values and policies.

The processes listed below exist for the purpose of learning and improvement and are outside the scope of this policy:

- Human resources investigations into employment concerns.
- Medical Examiners – including Coroner, Medical Examiner
- Legal
- Police
- Information governance concerns
- Complaints (except where a patient safety concern is highlighted)

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

- Data Security & Data Breach Management Policy
- Safeguarding Adults Policy and Safeguarding Children Policy

- Management and Reporting of Medication Errors Policy and Medicines Management Policy
- Tissue Viability Policy
- Falls policy
- Complaints Management Policy
- Risk Management & Strategy Policy
- Disciplinary Policy
- Privacy Statement
- Vantage: Accidents, Incidents & Near Misses Procedures (includes Duty of Candour & RIDDOR)
- Freedom To Speak Up Policy
- Safety, Health & Environment Policy
- Zero Tolerance Policy
- Privacy Statement

4. Our patient safety culture

SCH defines a positive safety culture as one where the environment is collaboratively crafted, created, and nurtured so that everybody (all service users including staff (& volunteers), patients, families, and carers) can provide continuous safe care by:

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all.

SCH recognises that effective learning can only take place in a non-threatening environment and that fear of disciplinary action may deter staff from reporting an incident. This message should be reiterated to staff and managers wherever possible. To this end, managers who are reviewing an incident will be supported to apply *Just Culture* principles (in line with the NHS Just Culture Guide) where a potential concern regarding an individual action is identified. This will support consistent, constructive, and fair evaluation of the actions of staff involved in PSIIs.

5. Our patient safety partners (PSPs)

SCH will engage (and will continue to engage) PSPs in our PSII response policy and plan development and maintenance.

PSPs are a new and evolving role developed to help improve patient safety. These new roles will evolve over time to help improve safety concerns in healthcare in the UK including smaller providers of adult social care such as SCH. We will mainly use it to be a voice for the patients and community members who use our services and to ensure that patient safety is at the forefront of all that we do.

Roles for PSPs can include patients, carers, family members or others e.g. staff from other organisations.

SCHs PSPs will communicate rational and objective feedback focused on ensuring that patient safety is maintained and improved. As the role evolves, we may ask our PSPs to:

- Attend governance meetings
- Review patient safety, risk and quality and being involved with contributing to documentation including policies, investigations, and reports
- Participate in the investigation of patient safety events.
- Assist in the implementation of patient safety improvement initiatives.
- Assist with the development of patient safety resources which will be underpinned by training.
- Ensure our PSP has the essential tools and advice they need. This would be specific to this new role in collaboration with the patient safety team.

The PSPs will be supported in their honorary role by the PSIRF investigating managers and Learning Response Leads (LRLs) for the hospice who will provide expectations and guidance for the role.

Our PSPs will have regular scheduled reviews and regular one-to-one sessions around training needs which will be agreed together based on the experience and knowledge of each PSPs. As the PSPs placements are on an honorary basis they will be reviewed after one year to ensure we keep the role aligned to the patient safety agenda as this develops.

6. Addressing Health inequalities

SCH will address health inequalities. SCH has a duty to reduce inequalities in health by improving access to services and tailoring those around the needs of the patients and families that we care for across Chorley, Preston and South Ribble in an inclusive way and we are committed to delivering on its statutory obligations under the Equality Act, (2010).

Engagement of those involved (patients, families/carers, and our staff (& volunteers) following a patient safety event is crucial to our patient safety learning responses.

Information resources produced by SCH can be made available in alternative formats, such as easy read or large print and may be available in alternatives languages upon request or when using SCH websites. These requests can also be made to our internal communications team.

SCH endorses a zero tolerance of racism, discrimination, and unacceptable behaviours from and towards our staff (& volunteers), our patients, carers, and families.

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

The PSIRF recognises that learning and improvement following a PSII can only be achieved if supportive systems and processes are in place. It supports the development of an effective PSII response system that prioritises compassionate engagement and involvement of those affected by PSIIs (including patients, families, and staff). This involves working with those affected by PSIIs to understand and answer any questions they have in relation to the incident and signpost them to support as required.

SCH is 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 PSIIs 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.

SCH recognises that patients, families and staff may be significantly affected by PSIIs, and we are committed to supporting individuals accordingly.

We will ensure those affected know who their point of contact is within the hospice. The initial point of contact from the hospice may not be the same as the person who subsequently maintains contact throughout the engagement process (refer to section 10.7.2 below).

- Our Support team are available to provide counselling and bereavement support to families.
- Our Compassionate Community team work with partners in the community to empower people and communities in Central Lancashire to help themselves and each other, through palliative or end of life care and bereavement.
- Our staff (& volunteers) can access support through the Employee Assistance Programme (EAP) or occupational health services.

A 'Patient Safety Incident Investigation Leaflet' will be handed to patients or the representatives in the event of a PSII. It is also available to download from our website www.stcatherines.co.uk/PSIRF or on request. Language and accessibility options are available.

If families or staff do not wish to be contacted directly to discuss a PSII, our bereavement service will be offered to act as an intermediary, including communicating responses to questions those affected may have, updates on the progress of an investigation, and to request checking of the draft report factual accuracy.

Our Vantage: 'Accidents, Incidents and Near Misses Procedures' describes how we will meet our professional and regulatory requirements in relation to the statutory Duty of Candour, which requires that we are open and transparent with people who receive care from us and our RIDDOR obligations.

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

PSIIs relevant to their context and the populations they serve rather than only those that meet a certain defined threshold. Our PSIRF (as noted in section 2 above) is set for the next 12 to 18 months and will be reviewed continually.

8.1. Resources and training to support patient safety incident response.

Delivery of the PSIRF is accommodated within our existing SCH staffing resource.

To meet the PSIRF standards we must ensure that:

- Learning responses are only led by staff who have completed the relevant training and who have an appropriate level of seniority and influence within SCH and that training for specific roles is undertaken.
- SCH have in place sufficient governance arrangements to ensure that learning responses are not led by staff who were either involved in or affected by the PSII itself, or by those who directly manage those staff.
- Training for specific PSIRF roles. A training needs analysis has been developed and will be monitored on an ongoing basis, to ensure those with responsibility for, responding to and supporting patient safety events remains up-to date. This training will be delivered by our Knowledge Exchange team. The timeline for education delivery is detailed in the PSIRF.

These standards will be overseen by our Clinical Quality and Governance Committee.

8.1.1. Training

SCH has implemented a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to PSIIs and to the PSIRF Policy as follows:

Training available for staff to support PSIRF.

General	Course / Topic	Staff group / Role	Training Available	Provided by:
Patient Safety mandated	Essentials of patient safety for all staff, clinical staff, learning response leads (LRLs)	All Staff (priority those in engagement, learning response and oversight roles. (Clinical & non-clinical))	Online course	eLearning for healthcare
	Level 1 Essentials for Patient Safety for Boards and senior leadership teams	Senior leaders, medical staff and trustee (oversight roles)	Online course	
	Level 2 - Access to Practice 1 and Access to Practice 2	PSIRF Director & Deputy (LRLs*) and all medical staff	Online course	
	Patient Safety in the management and administrative sector	All clinical management, HR &	Online course	

		Finance (oversight roles)		

NOTE: All courses to be undertaken at induction and 3 yearly thereafter (except, where noted below).

Learning Response Leads:

- Will lead and support the implementation of the NHS Patient Safety Strategy and work closely and collaboratively with those within the Hospice who have specific patient safety responsibilities, including at operational level.

- Where indicated * in the above table, will have had a minimum of two days formal training and skills development in learning from PSIIs and experience of patient safety response.

- Will be supported by the investigating managers of each incident allocated to them and must have completed levels one and two of the national patient safety syllabuses.

- And Investigation Managers will undertake appropriate continuous professional development on incident response skills and knowledge.

- Will need to contribute to a minimum of one learning response per year, dependant on incident trends and themes. Records for this will be maintained by the Quality and Governance Committee and the Leadership team will support this.

Records of all PSIRF training will be maintained by the Knowledge Exchange team as part of the general education training matrix.

8.2. Our patient safety incident response plan

This policy should be read in conjunction with our PSIRF.

Our PSIRF sets out how SCH intends to respond to patient safety events over a period of 12 to 18 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 event occurred, and the needs of those affected as well as the plan. A copy of our PSIRF is located on both our internal policy platform and our website (click www.stcatherines.co.uk/PSIRF).

8.3. Reviewing our patient safety incident response policy and plan

Our PSIRF is a “live document” that will be appropriately amended and updated as we use it to respond to patient safety events. We will review the plan regularly, and at least annually to ensure our focus remains up to date, with ongoing improvement work, our patient safety profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

Updated PSIRF and policy will be published on our website, replacing previous versions as required.

A planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our lead Integrated Care Board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include our response capacity, mapping services, a wide review of organisational data (PSII reports, improvement plans, complaints, staff survey results, mortality reviews, inequalities data and any other relevant reporting data) and wider stakeholder engagement.

These should be audited and accommodated within the existing clinical governance audit schedule.

9. Responding to patient safety events

9.1. Patient safety incident reporting arrangements

All our staff (and volunteers) are responsible for recording and reporting potential or actual patient safety events on the 'Vantage Incident Reporting system'. The reporter will record the level of harm they believe to have been experienced by those affected. Each patient safety record will be reviewed by the investigator (usually the reporting team's manager and allocated to the relevant team member(s) for review, response, feedback to the reporter and closure.

SCH has corporate oversight of all patient safety events and teams have their own mechanisms in place to ensure patient safety events are responded to proportionately and in a timely manner. This will include consideration of Duty of Candour. Most events will require a local review and learning response (if necessary), undertaken by the individual teams. Those events where the opportunity to learning and improvement would be of greatest value, will be led by relevant team manager and Safer Care Group and escalated to the Clinical Quality & Governance Committee as required.

Events and/or incidents highlighted that appear to meet requirements for reporting externally will be handled by the LRLs and this will be recorded on the relevant Vantage Incident Record. There will be occasions where events require the efforts of cross-system working with relevant partners, the Integrated Care Board (ICB) will support a collaborative approach with these arrangements if required.

Other external sources include:

- Care Quality Commission (CQC)
- Controlled Drugs Local Intelligence Network (CD LIN)
- NHS England
- Health and Safety Executive (HSE) for patients involved in Reporting of Injuries, Diseases, Dangerous occurrence Regulations (RIDDOR) incidents.
- NHS Digital via Information Governance
- Medicines and Healthcare Products Regulatory Agency (MHRA)

- Patient Safety Events (LFPSE) Service

Our internal sources include:

- Board of Trustees
- Executive Team
- Safer Care Group which includes, Infection Prevention Lead, Falls Lead and Tissue Viability Lead
- Medicines Management Group
- Safeguarding Lead and the PiPoT
- Information Governance Lead
- Safety, Health & Environment Advisor
- Learning Response Leads
- Accountable Officer

Refer to Appendix 1: PSIRF Incident Management Flowchart for reporting SCH incident reporting.

9.2. Patient safety incident response decision-making

The reporting of incidents will continue in line with existing SCH policy and guidance.

PSIRF itself sets no national rules or thresholds to determine what method of response should be used to support learning and improvement.

SCH have arrangements in place to meet the requirement to review patient safety events under PSIRF and have developed our own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work. Some of these reviews will require a mandatory PSII response, others will require review or referral to another body and/or team depending on the event. These are set out in our PSIRF plan.

Those clinical and operational managers who are members of the Clinical Quality & Governance team and enforce the review process ensure the following arrangements are in place:

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends or clusters of incidents within a specific service or type of incident e.g. falls, pressure ulcers, medication errors.
- Identification of incidents that required external reporting e.g. Never Events, RIDDOR, National Deaths

Regular reports are provided to the Patient Care Committee to identify and track emerging themes and trends outside of normal variation. This information is reviewed against our identified priorities in the PSIRF (page 5).

9.3. Responding to cross system events/issues

The LRLs will assist in the coordination of these events identified to other providers directly, via each organisations reporting processes. Where required summary reporting can be utilised to share insights with other providers about their patient safety profile.

SCH will work with partner providers and relevant ICB to establish and maintain robust procedures to facilitate flow of information and minimise delays to joint working on cross-system events. The patient safety team (as noted in our PSIRF) will act as a single access point for such working arrangements and hold supportive procedures to ensure this is effectively managed.

SCH will refer to their ICB to assist with the coordination where a cross-system event is felt to be complex to be managed by a single provider, we anticipate the ICB will provide support and advice with identifying a suitable reviewer, should this circumstance arise.

9.4. Timeframes for learning responses

A timeframe for completion will be agreed with those affected, as part of setting the terms of reference; this remains subject to them willing and able to be involved in that decision. A balance will be drawn between conducting a thorough review, the impact extended timescales can have on those involved and the risk of delaying findings may adversely affect safety.

In exceptional circumstances (i.e., when a partner organisation requests a pause, or processes of external bodies delay access to information) SCH can consider whether to progress and determine whether new information would indicate the need for further review once this is received. The decision for this would be made by the LRLs.

Where a full PSII is indicated (as defined in the PSIRF for both local and national priorities), this will be started as soon as practically possible following the identification and completed within three months. Locally led PSIIs should not exceed six months.

There may be occasions where a longer timeframe is required for completion, in this case, all extended timeframes will be agreed between SCH and those affected.

9.5. Safety Action Development and Monitoring Improvement

SCH acknowledges any form of patient safety learning response will allow the circumstances of an event or set of events to be understood.

Using our ‘Vantage Incident Reporting' system SCH can implement and monitor safety actions. SCH will generate safety actions in relation to each of those areas defined for improvement. Following this, we will have measures to monitor safety actions and set milestones for review.

Patient Safety Learning Responses should not describe recommendations, as this can lead to premature attempts to devise a solution. To achieve successful improvement, a safety action plan will be completed. Safety actions are outlined as follows:

- Agree areas for improvement: specify where improvement is needed, without defining solutions.
- Define context: this will allow agreement on the approach taken to safety action development.
- Define safety actions to address areas of improvement focuses on systems in collaboration with those teams involved.
- Prioritise safety actions to decide on testing for implementation.
- Define safety measures to demonstrate if actions are influencing what is intended.
- Write safety actions: document in a learning response report or safety improvement plan, including details of measurement and monitoring).

All safety actions will be added to the relevant PSII record on SCHs incident reporting system, Vantage, so that implementation can be monitored. Monitoring reports will be presented to the Clinical Quality & Governance Committee.

9.6. Safety Improvement Plan

Safety improvement plans bring together findings from various responses to patient safety events and issues. Our PSIRF has outlined local priorities (pages 5 & 6) for focus or response under the PSIRF.

SCH may

- Create a hospice-wide safety improvement plan summarising improvement work.
- Create individual safety improvement plans that focus on a specific service, pathway or location.
- Collectively review output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues
- Create a safety improvement plan to tackle broad areas for improvement (i.e. overarching system issues).

Whichever approach is taken the rationale for that approach will be fully explained in the learning response process and agreed upon with stakeholders.

9.7. Monitoring Compliance and Effectiveness

9.7.1. Complaints and Appeals

SCH recognises that there will be occasions when patients, services users and carers are dissatisfied with aspects of care and services provided. We listen and respond to patients, patient families, carers and staff (including volunteers) to help improve the services we deliver.

If patients, relatives and or carers have a concern or complaint in relation to how a patient safety learning response has or is being handled, they should contact the Hospices nominated Patient Safety Specialist in the first instance. Every effort will be made to address specific concerns.

SCH is committed to dealing with any complaints that may arise quickly and as effectively as possible.

Our complaints process is not directly covered in this policy however they 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 and concerns can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services.

A Complaints, Concerns & Compliments leaflet is available upon request.

Please ask to see the Hospice Complaints Management Policy & Procedures (or click on stcatherines.co.uk/complaints for a copy of our leaflet and policy).

Staff members can provide feedback about our approach to the SCHs PSIRF process through:

- Identified leads conducting a learning response.
- A Line Manager
- Freedom to Speak Up guardians.
- Executive lead for PSIRF (Patient Safety Specialist)

Emerging PSII risks will be considered for escalation through our governance process. Resulting discussions and actions may include a range of options:

- Ongoing data collection and monitoring
- Review findings, agree next steps and discuss whether or not existing PSIIs will remain unchanged, if additions are required or if further improvement work is needed.

9.7.2. Oversight roles training and competencies.

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission, SCH have specific organisational responsibilities with PSIRF. To meet these responsibilities, the hospice has designated the Director of Nursing, Governance & AHPs (& Medical Director as deputy) to support PSIRF as the executive leads (Patient Safety Specialists).

Roles and responsibilities specific to PSIRF are as follows:

Board of Trustees

Trustees will be responsible and accountable for effective patient safety incident management across SCH clinical services.

The Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Patient Care Committee.

The Director of Nursing, Governance & AHPs will lead to support PSIRF as a Patient Safety Specialist. This ensures:

- That SCH meets the national patient safety standards.
- PSIRF is central to overarching safety governance arrangements.

- Quality assuring learning response outputs.

The Director of Nursing will provide direct leadership, advice, support in complex/ high profile cases, and liaise with external bodies, as required.

The Director of Nursing (or Medical Director) and Clinical Development Lead (or Deputy) have the overarching responsibility for the quality of patient safety learning responses and PSIIs.

The Medical Director is overall accountable for patient safety for SCH.

The Head of Clinical Education has the overarching responsibilities for safety learning and improvement. They will liaise with the Clinical Development Lead (or deputy) to support and facilitate the delivery of all relevant training, provide advice and support with regards to planning, promotion and management of identified training requirements, as requested and to facilitate any specialised training sessions as required to satisfy compliance.

Each Executive Director are equipped with the training and professional development as described in the national patient safety incident response standards.

Clinical Development Lead is responsible for:

- Ensuring all incidents are managed correctly
- Monitoring the completion of learning plans arising from PSIIs
- Overseeing the development, review and approval of the PSIRF
- Reviewing any PSIIs with the Director of Nursing, Governance & AHPs / Medical Director
- Reporting patient safety events, trends and responses via the quarterly Clinical Quality & Governance Committee escalating to the quarterly Patient Care Committee.

All clinical managers must ensure that their teams are aware of and understand the incident reporting procedures, encourage a culture of reporting, and provide support to staff in the reporting process.

All staff with oversight roles (e.g.HR, Finance, Administration, Medical Secretaries, etc)

are responsible for reporting incidents and near misses promptly and accurately, participating in subsequent investigations, as required using the Vantage Incident Reporting system.

They must also complete levels 1 and 2 of the patient safety e learning training modules.

10. Further Information

For more information, click here:
NHS England » The NHS Patient Safety Strategy
NHS England » Patient Safety Incident Response Framework
NHS England » A just culture guide

NHS England » Learn from patient safety events (LFPSE) service

NHS England » Framework for involving patients in patient safety: Appendices

B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf

11. References

11.1. External Organisations to whom we may need to report an incident:

- NHS Lancashire and South Cumbria Integrated Care Board, associate Director of Patient safety. Email: Caroline.marshall9@nhs.net, Mobile: 07917 211454 &/or lscicb-el.patientsafety@nhs.net

- Health and Safety Executive (HSE) The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), HSE Books. www.riddor.gov.uk (reporting of injuries, diseases and dangerous occurrences)

- Data Protection Act 2018 and UK General Data Protection Regulations (GDPR), 2016 - https://ico.org.uk/for-organisations/report-a-breach/

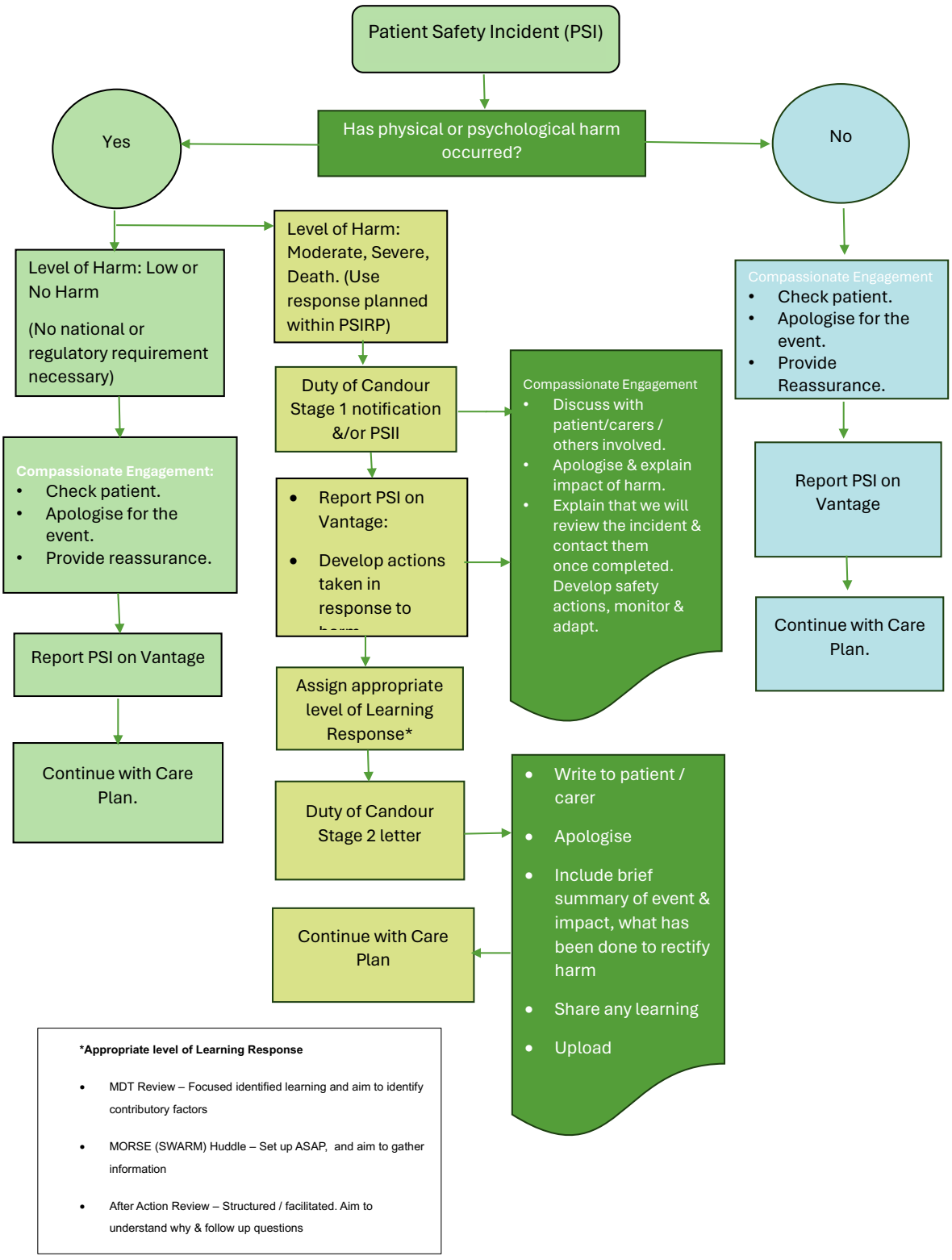
- Care Quality Commission (Registration) Regulations 2009, Regulation 18 (Part 4) – Notification of Other Incidents www.cqc.org.uk/content/regulations-service-providers-and-managers

- The Medicines and Healthcare products Regulatory Agency regulates medicines, medical devices and blood components for transfusion in the UK. www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency

11.2. External Organisations with whom we may need to liaise with when dealing with an incident:

- Lancashire Care Foundation Trust (LSCFT) – patient.safety@lscft.nhs.uk
- North West Ambulance Service - nwasnt.NWASPatientexperience@nhs.net or patient.experience@nwas.nhs.uk
- gtd Healthcare **-** GTD.governance@nhs.net
- Lancashire Teaching Hospitals Trust (LTHTr) - datix@lthtr.nhs.uk
- Community pharmacy incidents **-** clare.moss1@nhs.net

12. Appendix 1: PSIRF Incident Management Flowchart



13. Appendix 2: Definitions, terms and abbreviations used within this policy.

After Action Review (ARR)	A method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future. We use the Vantage Incident Response Module to capture this data.
Duty of Candour	A regulatory requirement for care providers to be open and transparent with service users and includes situations where things have gone wrong with care or treatment. The requirements span communication, support, truthfulness and an apology (see Guidance: Duty of Candour, 2020 on the GOV.UK website).
Integrated Care Board (ICB)	• Collaborative with SCH in the development, maintenance & review of SCHs PSIRF & PSIRF • Agree SCHs PSIRFs • Oversees & support effectiveness of systems to achieve improvement following a PSII • Support coordination of cross system learning responses • Share insights and information across organisations / services to improve safety.
Just Culture	This guide encourages managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way.
Learn from Patient Safety Events (LFPSE) Service	This is a national NHS system for the recording and analysis of patient safety events that occur in healthcare. It replaced the National Reporting and Learning System (NRLS).
Learning Response	Any response to a patient safety incident that incorporates a system-based approach to capturing learning to inform safety actions for improvement. This may be a patient safety investigation, but other methods can be used such as an after-action review or MORSE[1] huddle, multi-disciplinary team debriefs and thematic analysis.
MORSE Huddle (Referred to as SWARM Huddle in NHS Guidance)	This allows for the rapid review of an incident – staff huddle to discuss (where possible at the location of the incident) it and explore it on a systematic basis and to support those immediately involved.
Multi-disciplinary Team Review (MDT)	An MDT review involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations.
Never Event	Individual safety events that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
Oversight	An approach that allows organisations to demonstrate improvement rather than compliance with prescriptive centrally mandated measures.
Patient Safety Incident (PSI)	A PSI is any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare.
Patient Safety Incident Investigation (PSII)	PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multi patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are

[1] Please note that SCH refers to the NHS term SWARM huddle as a MORSE huddle.

	then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.
Patient Safety Incident Framework (PSIRF) includes Policy and Plan	This is a national framework and builds on evidence gathered and wider industry best-practice. It is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.
Patient Safety Incident Plan	A local plan that sets out how St Catherine's Hospice will carry out the PSIRF locally including our list of local annual priorities.
Systems Engineering Initiative for Patient Safety (SEIPS)	This is a framework that can be used in understanding inter-relationships across the structures, processes and outcomes in healthcare. It is used alongside PSIRF learning response tools to ensure that the system learning is identified.
St Catherine's Hospice (Lancashire) Ltd (SCH)	SCH is an independent charity which supports local people affected by life-shortening conditions to have quality of life, to the end of life.
Thematic Review	A review of a cluster of incidents or investigations that aim to understand common links, themes or issues. The aim of a themed review is to understand key barriers or facilitators to patient safety.