HS22 Patient Safety Incident Response Policy

Effective date: February 2026

Estimated refresh date: February 2029

	NAME	TITLE	DATE
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Authoriser	**Board of Trustee's**		**March 2026**

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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and describes St Teresa's Hospice approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues. Creating the right foundations for effective incident response is critical and the systems and processes outlined in this policy will assist learning following a patient safety incident. This policy also incorporates the systematic management of low level non-clinical incidents for the Hospice.

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 safety incident responses conducted solely for the purpose of learning and improvement across all services provided by St Teresa's Hospice.

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, that exist for that purpose include:

- claims handling
- complaints management
- human resources investigations into employment concerns
- professional standards investigations
- coronial inquests
- criminal investigations.

The principle aims of each of these responses differ from those of a patient safety response and are therefore outside the scope of this policy.

Response types that are outside the scope of this policy include, complaints, people and culture investigations, professional standards investigations, criminal investigations, audits, safeguarding concerns, information governance concerns and estate and facilities issues.

Learning response methods are used to support learning and improvement in relation to safety event types through our incident management tool which is used to effectively record, manage and report our organisations events. These are reported via the Safety Improvement and Assurance Group to the Clinical Governance Sub Committee and Board. Other non-patient safety incidents are also recorded within the same tool to collate trends and themed analysis, again via Clinical Governance Sub Committee and Board.

This policy applies to all staff; it does not stand alone and should be read in conjunction with St Teresa's wider risk management policies and framework.

This policy is based on NHS England's Patient Safety Event Response Framework (PSIRF).

This policy reflects the move from NHS Serious Incident Framework (SIF) to NHS England's Patient Safety Event Response Framework (PSIRF) 2023.

This safety event response policy is published on our website.

Our patient safety culture

St Teresa's Hospice supports and promotes a culture of fairness, openness and learning and actively encourages its staff to report incidents and to speak up when things go wrong without fearing unjust blame (Just Culture, NHS England A just culture guide). We do this through consultation, committees, staff surveys, audits and Freedom to Speak up/Whistleblowing procedures.

We encourage incident and Good Save (near miss) reporting where a staff member feels something has happened, may happen or caused/may cause harm to patients or staff members.

St Teresa's conduct patient safety incident responses for the purpose of leaning and identifying system improvements to reduce risk. While the organisational values and systems in place support a strong safety culture, the implementation of PSIRF is anticipated to improve this further. The new procedures being implemented as part of PSIRF will support the improvement of the organisation's safety culture through compassionate engagement and sharing of learning responses and through monthly safety, learning, improvement, patient safety incident meetings and monitoring improvement.

The organisation is transparent with patients and families when something goes wrong through complying with Statutory and Professional Duty of Candour. There is a Duty of Candour policy and mandatory training for clinical staff. Professional Duty

of Candour states every healthcare professional must be open and honest with patients and their families when something goes wrong with their treatment or care and causes, or has the potential to cause, harm or distress.

This means all healthcare professionals must:

- Tell the patient (or, where appropriate, the patients advocate, carer or family) when something has gone wrong
- Apologise to the patient (or, where appropriate, the patients advocate, carer or family)
- Offer an appropriate remedy or support to put matters right (if possible)
- Explain fully to the patient (or, where appropriate, the patients advocate, carer or family) the short- and long-term effects of what has happened.

Our Mission

To provide appropriate care to any person in the terminal phase of their illness and to support the whole family during this time and in bereavement.

Our Vision

All in our community facing the end of their life are supported to live life to the full and die with dignity in a place that is right from them, knowing their loved ones are supported.

Our values and our core beliefs

- A welcoming space
- Dedicated to care
- Compassion in all we do
- Support at every stage
- Excellence in everything

With reference to the just culture guide, when analysing events, referral for individual management/performance review or disciplinary action only occurs for acts of wilful harm or wilful neglect.

Patient safety partners (PSPs)

The PSP is a new and evolving role developed by NHS England to help improve safety across healthcare in the UK, including small providers within adult services such as St Teresa's Hospice. This is part of the new Patient Safety Incident (Event) Response Framework (PSIRF).

North East and North Cumbria Hospice Collaborative have developed a Patient Safety Incident Response Plan. National reporting is required following local investigation and escalation through Learning From Patient Safety Events (LFPSE), CQC and ICB Quality and Safety Committee.

In respect to death or more serious injuries of a patient (thought more likely than not due to problems in care) which require a full Patient Safety Incident Investigation (PSII), there is to be long term action plan to be monitored by Clinical Governance Sub Committee for oversite and escalation to Board.

PSII reporting arrangement are via CQC portal and ICB via LFPSE. All incidents are also shared with both ICB partners at the Service Quality Performance meetings.

Area for development

St Teresa's Hospice are committed to offering safe services, we welcome PSPs to work alongside our staff, those using our services, and population to influence and improve safety across our services by sharing their experiences and skills and providing a level of scrutiny. PSPs can be people, carers, family members or other lay people. Whilst not currently in place formally, this is an area for further development for the hospice in the coming months.

Addressing health inequalities

St Teresa's Hospice has a duty to reduce inequalities in health by improving access to services and tailoring those around the needs of our population in an inclusive way. Widening access to all in our offer of palliative and end of life care services is essential, irrespective of diagnosis and circumstances. St Teresa's Strategic Plan reflects the work and statement of this policy.

Through our learning responses we will seek to support health equality and the reduction of inequalities and will apply a more flexible approach to how we use data to help us better identify any disproportionate risks to patients with specific characteristics.

Our engagement with patients, families and carers through our Friends and Family survey and following a patient safety investigation; must recognise diverse needs, ensure inclusivity and consider different needs (also see Duty of Candour policy). Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families. These issues will then be incorporated into the Hospices developing safety action plans.

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 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.

Managers and /or leaders should demonstrate their commitment to compassionate engagement and involvement in their words and actions. Engagement and involvement must be communicated as a genuine priority and not a formality.

It is recognised patients and families may have different perspectives, questions or needs arising from the circumstances around patient safety incidents. This policy

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

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

Our aim will be to involve and support patients and families in any patient safety event reporting, ensuring duty of candour and to feedback and ask them about their experience of the process.

Just Culture

A just culture considers wider systemic issues where things go wrong, enabling those operating the system to learn without fear of retribution. In a just culture we attempt to understand why failings have occurred and how the system led to sub-optimal behaviours. However, a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts.

Duty of Candour

St Teresa's Hospice believes that the organisation and its staff should be open and candid about all events involving the health, safety and clinical care of individuals. Being open is part of a 'no blame' culture, which is striven for at St Teresa's, and this culture is fundamental to learning.

St Teresa's Hospice recognises that as part of Care Quality Commission Regulations, it is a requirement to ensure that people and/or families are told about safety events that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences. An individual affected by an event should be notified (their nominated significant other if capacity concerns, or at request of the person) at the earliest opportunity.

CQC clearly identified within Regulation 20:

- The duty of candour is a general duty to be open and transparent with people receiving care from you.
- It applies to every health and social care provider the CQC regulates
- The duty of candour requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines 'notifiable safety events' and specifies how registered persons must apply the duty of candour if these events occur.

Freedom to Speak Up

St Teresa's Hospice hopes staff feel comfortable raising any concerns about this policy being applied openly and locally. Staff may, however, wish to refer to the Freedom to Speak Up Policy (HR05 Whistleblowing Policy). This details routes for raising concerns including via our confidential services. If a genuine concern is raised, staff will be supported and will not suffer any detriment, reprisal or be at risk.

St Teresa's Hospice will further develop the foundations of a system that supports compassionate engagement and involvement of those affected by patient safety incidents.

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

St Teresa's Hospice will take a proportionate approach to its response to patient safety incidents ensuring the focus is on maximising learning and improvement.

Resources and training to support patient safety incident response

PSIRF training is being provided to our workforce who require the skills and competencies to undertake learning responses. This approved training programme, additional to the National Patient Safety Syllabus, will equip a designated cohort of staff appointed as investigators with the skill and expertise to support high quality learning responses.

Response/Skill Set	Plan
NHS Professionals – Incident Response (2 days) **TBC**	Director of Clinical Services Senior Clinical Specialist Nurse Finance Manager Clinical Services Manager Facilities Manager
e-Learning for Health Patient Safety Syllabus Training - Level 1 Essentials of patient safety for boards and senior leadership teams	For all board and senior leadership team.
e-Learning for Health Level 2 – Access to Practice Part 1: Systems thinking and risk expertise. Part 2: Human factors and safety culture (Inc Self-Assessment).	Senior Clinical Leadership Team
e-Learning for Health Level 1 – Essentials Patient Safety	For all staff

In addition to the above, Health Services Safety Investigations Body also provide courses for:

- Involving those affected by patient safety incidents in the learning process
- Demystifying thematic Analysis
- Investigative Interviewing.

These will be explored in full alongside e-Learning for Health courses.

St Teresa's Hospice Patient Safety Incident Response Plan

<table>
<tr><td rowspan="4">Patient Safety Event Occurs</td><td rowspan="4">Patient Safety Incident Investigations</td><td rowspan="3">National Priorities</td><td>Event → </td><td>Approach → </td><td>Improvement</td></tr>
<tr><td>Incidents meeting the Never Events Criteria

Death thought more likely than not due to problems in care</td><td>Patient Safety Incident Investigation (PSII)

Reporting to CQC via the portal and ICB's via LFPSE.</td><td rowspan="2">Respond to recommendations from external referred agency/organisation as required.</td></tr>
<tr><td>Safeguarding incidents meeting criteria</td><td>Reported to Safeguarding Lead</td></tr>
<tr><td>Hospice Priorities</td><td>St Teresa's Priorities:
• Medication
• Admission issues (Skin and Meds)
• Tissue Viability/Pressure Ulcers</td><td>Thematic Review</td><td>A monthly internal meeting with members of the multidisciplinary team meet to review all incidents reported that month. To ensure all learning has been gained and to improve feedback to teams. This is recorded on the incident spreadsheet.</td></tr>
<tr><td>Local Level</td><td>Incidents resulting in moderate or severe harm to patient.</td><td>Statutory Duty of Candour.

Patient Safety Incident Investigation (PSII)

Reporting to CQC via the portal and ICB's via LFPSE.</td><td>A monthly internal meeting with members of the multidisciplinary team meet to review all incidents reported that month. To ensure all learning has been gained and to improve feedback to teams. This is recorded on the incident spreadsheet.</td></tr>
</table>

			No/low harm patient safety incident.	Confirmation of facts at local level – thematic analysis.	A monthly internal meeting with members of the multidisciplinary team meet to review all incidents reported that month. To ensure all learning has been gained and to improve feedback to teams. This is recorded on the incident spreadsheet.

The above plan sets out how St Teresa's Hospice intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. The Hospice 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

St Teresa's Hospice patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 24 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 24 months.

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

Patient safety incidents will be reviewed monthly by the Safety Improvement and Assurance Group (Senior CNS(Chair), CNS's, CSM, IPU Sister, Finance Manager, Senior HCA (H@H). In addition, the daily admissions meeting with Senior Clinicians will capture any emergent concerns in respect to patient safety incidents that require immediate management/action.

This meeting will provide a quarterly report to Clinical Governance Sub-Committee with onward reporting to Trustee Board.

As detailed in the above table, national reporting arrangement for patient safety incidents which require PSII will be reported via CQC portal and LFPSE. In addition, there is a requirement for quarterly reporting via the contract meetings.

St Teresa's Hospice will continue to comply with the Hospice UK Patient Safety Programme – Clinical Benchmarking for Hospice Care. Data is submitted quarterly via Metrics, Categories and Definitions. The final quarter contain the data reported from all four quarters creating the annual HUK report and historic data which facilitates analysis. Reported data includes but not limited to pressure ulcers, fall and medication levels of harm.

Patient safety incident response decision-making

PSIRF itself sets no further national thresholds to determine what method of response should be utilised for learning and improvement. The Hospice will continually develop a range of response mechanisms to balance the efforts between learning and exploring emerging issues alongside ongoing improvement work. Responses will be proportionate to patient safety incidents and safety issues.

As outlined above the Safety Improvement Assurance Group will provide monthly decision making to review all accidents and incidents and to identify those incidents that appear to meet the need for further exploration due to the possibility of meeting the criteria for a full review. The group will provide the oversight and scrutiny of incident response decision making and the application of learning response

approaches, ensuring these are proportionate and reflect any required external reporting thresholds. Any reviews of a specific incident or themes will be led by a member of the team who has completed their level 2 PSIRF Training (HSSIB Level 2: A system approach to investigating and learning from patient safety events).

Responding to cross-system incidents/issues

Where data and /or intelligence identified an incident and/or an emerging theme that requires a cross-system learning response this will be communicated through our locality clinical meetings, Joint Clinical Governance Group (Chaired by Acute Trust) and onwards to the ICB who will support and facilitate the management of any incident that impacts upon more than once provider.

This will ensure that the learning response considers the view of all applicable organisations, and that clarity is sought for the management of patients/family engagement as appropriate (including Duty of Candour). St Teresa's Hospice will co-operate with any learning response that crosses organisational boundaries.

Commonly this will include local/neighbouring NHS Trusts, Primary Care, Ambulance services and private providers and the learning response will be led by the organisation best placed to investigate the concerns, which will reflect capability, capacity and remit.

Timeframes for learning responses

St Teresa's Hospice will seek to ensure that patient safety learning responses start as soon as practicable after the incident is identified. Learning response timeframes will be agreed in discussion with those affected, particularly the patient(s) and/or carer(s) where they wish to be involved in such discussions.

Timeframes for completion will be agreed with those affected, as part of setting the terms of reference; a balance will be drawn between conducting a thorough review, the impact extended timescales can have on those involved and the potential for a delay in reporting to adversely affect safety.

Timeframes will be agreed in conjunction with those affected and the Safety Improvement Assurance Group as part of the agreement of the terms of reference and the learning response approach/method to be adopted.

Safety action development and monitoring improvement

St Teresa's Hospice acknowledges any form of patient safety learning response will allow the circumstances of an event or set of events to be understood, but this may only be the beginning. To reliably reduce risk, robust safety actions are required.

Safety actions will be developed to address areas of improvement arising from learning responses where it is meaningful to do so. A central repository of safety actions will be held by the Safety Improvement Assurance Group and routinely discussed at the Clinical Governance Sub-Committee that meets quarterly and is chaired by the PSIRF Executive Lead for St Teresa's Hospice.

Safety improvement plans

There are no thresholds for when a safety improvement plan should be developed. St Teresa's Hospice will seek to create an organisation-wide safety improvement plan derived from knowledge gained through the learning response process and other relevant data. This plan will summarise improvement work and collectively review output from learning responses. This plan will align to the Clinical Governance Sub-Committee and stand as an agenda item at this committee.

Oversight Roles and Responsibility (Accountability)

Ultimate responsibility is held by the **Chief Executive**. Along with the SMT they will, within their area(s) of responsibility ensure that:

- this policy and its associated procedures are implemented.
- A positive reporting culture is maintained.
- Any improvement recommendations are suitably progressed.
- All events are appropriately investigated.
- At least two Directors and the CEO are aware of serious events with moderate or higher harm.

First line responsibility is held by the PSIRF Senior Management Lead/**Registered Manager**. They will ensure initial local responses to PSI's are in accordance with PSIRF and organisational policies. They will take assigned accountability to ensure the PSI investigator(s) autonomy is respected and supported to ensure effectiveness of the investigation. Ensure that all notifiable serious events are reported to CQC via the relevant statutory notification form, within 24hrs as per regulations (Regulation 18 CQC (Registration) Regulations 2009 (Part 4) and to the relevant ICB. To ensure that the CQC is provided with regular updates during and at the end of the analysis, or as and when appropriate.

All staff members have a responsibility for ensuring that the principles outlined within this document are universally applied. They will be required to identify and report PSI and any non-clinical incidents following the adverse event and incident reporting procedure. They will supply as much supporting information at the time of making the report to prevent vital information becoming lost.

Contribute to discussions with management regarding possible solutions to prevent a recurrence of the event via case review as necessary.

Safety Improvement Assurance Group will:

- Review incidents monthly
- Receive reports on significant trends and obtain relevant assurances that appropriate actions plans are in place.
- Monitor progress of recommendations following the outcome of an analysis into an event.
- Ensure that lessons learned from events are appropriately communicated to those who may benefit from information.
- Report quarterly to Clinical Governance Sub-Committee.

Integrated Care Board (ICB)

Reporting will align with the St Teresa's NHS Contract via LSPSE.

Care Quality Commission (CQC)

St Teresa's will inform the CQC of:

- Never Events

- death thought to be more likely than not due to problems in care
- incidents resulting in severe harm
- high profile and complex incidents

There is also reporting provided by statutory notifications required by the Health and Social Care Act (2008), and as set out in CQC's guidance on statutory notifications.

CQC will apply PSIRF, and associated patient safety incident response standards, as part of its assessment of the strength of the organisation's systems and processes for preparing for and responding to patient safety incidents.

The oversight of PSIRF implementation and compliance will reside with the Clinical Governance Sub-Committee.

Complaints and appeals

St Teresa's Hospice recognises that there will be occasions when patients, families and carers are dissatisfied with the aspect of care and services provided by them.

It is important to recognise the distinction between complaints and concerns, as the use of the word complain should not automatically mean that someone expressing a concern enters the complaints process. Please see HM03 Complaints Policy

Glossary

CQC The **Care Quality Commission** is an executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England.

H@H **Hospice at Home** is an integral component of community end of life care bringing the skills, ethos and practical care associated with the Hospice movement into the home environment; putting the patient and those who matter to them at the centre of the care.

HSSIB The **Health Services Safety Investigations Body** is a fully independent arm's length body of the Department of Health and Social Care. It investigates patient safety concerns across the NHS in England and in independent health care settings where safety learning could also help to improve NHS care. It aims to produce rigorous, non-punitive, and systematic patient safety investigations and to develop system-wide safety recommendations for learning and improvement.

ICB An **Integrated Care Board** is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.

MDT A **Multi-disciplinary Team** is a group of individuals, from multiple disciplines who meet to pursue a common goal, such as recommending a treatment plan and developing the individual treatment pathways for patients.

NHS The **National Health Service** is the publicly funded healthcare system of the United Kingdom.

NHSE **NHS England** provides national leadership for the National Health Service. They promote high quality health and care for all, and support NHS organisations to work in partnership to deliver better outcomes from patients and

communities, provide the best possible value for taxpayers and to continuously improve the NHS.

PSII The **Patient Safety Incident Investigation** is undertaken when an incident or near-miss (good saves) indicates significant patient safety risks and the potential for new learning. Investigations explore decisions or actions as they relate to the situation.

PSIRF The **Patient Safety Incident Response Framework** sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patients' safety.

PSIRP A **Patient Safety Incident Response Plan** is a requirement of each provider delivery NHS-funded care. The PSIRP sets out how an organisation will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of their work to continually improve the quality and safety of the care they provide.

PSP The **Patient Safety Partner** is a new and evolving role developed by NHS England to help improve patient safety across health care in the UK. The main purpose of the role is to be a voice for the patients and community who utilise health care services and ensure that patient safety is at the forefront of all that is done.

QI **Quality Improvement** aims to make a difference to patients by improving safety, effectiveness, and experience of care by using and understanding our complex health care environment, applying a systematic approach, and designing, testing, and implementing changes using real time measurement for improvement.

SEIPS **Systems Engineering Initiative for Patient Safety** is the system-based framework endorsed by PSIRF. It is a framework for understanding complex systems which can be applied to support the analysis of incidents and safety issues more broadly.

SIF The **Serious Incident Framework**, which preceded PSIRF, was designed to inform staff providing and commissioning NHS funded services in England who may be involved in identifying, investigating or managing a serious incident. It also sought to support the NHS to ensure that robust systems were in place for reporting, investigating and responding to serious incidents so that lessons were learned and appropriate action taken to prevent future harm.