Patient safety incident response policy

Last Modified December 05, 2025

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Effective date: March 2024

Estimated refresh date: March 2025

Purpose

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

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

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

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement.

This policy should be read in conjunction with:

1. PSIW PSIRF Plan
2. Blackpool Council accident/incident/near miss reporting policy (available on request by email to positivesteps.intowork@blackpool.gov.uk)
3. Blackpool Council accident investigation policy (available on request by email topositivesteps.intowork@blackpool.gov.uk)
4. PSIW safeguarding policy and procedure (available on request by email to positivesteps.intowork@blackpool.gov.uk)

Scope

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

Blackpool Council's Positive Steps into Work Service (PSIW) in respect of any incident involving a PSIW service user who is receiving NHS care (either inpatient or outpatient) and where PSIW's services are being commissioned by the NHS under the NHS standard contract.

It is envisaged that in cases where there is a patient safety incident involving a PSIW service user, who is receiving NHS care, the NHS Trust will take the lead in investigating, in accordance with PSIRF. In those cases PSIW will collaborate with and support the NHS Trust to investigate as required. In cases where the Trust does not lead the PSIRF investigation or it would not be appropriate for them to do so, then PSIW will take the lead in accordance with this Policy and the supporting Plan.

Where incidents occur involving non-NHS commissioned services Blackpool Council's policies and procedures will continue to apply.

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

Just culture

PSIW promotes a climate that fosters a just culture by supporting openness and transparency, supporting staff when things go wrong and supporting staff to learn from patient safety incidents rather than focusing on apportioning blame.

Open and transparent reporting

PSIW staff have monthly caseload supervision meetings at which they can raise any concerns. PSIW can also report and discuss concerns with line managers at any time who will provide support.

Work being done to support the development of a just culture

PSIW supports the use of the NHS Just Culture Guide where queries or concerns arise and will ensure that it is used to support implementation of this policy and alongside any investigations of patient safety incidents.

Patient safety partners

Responsibility for monitoring and oversight of the PSIRF sits with the service manager. PSIW have engaged with, and will continue to engage with, the patient safety team and the contract management team at NHS Lancashire and South Cumbria Integrated Care Board ICB (the "ICB") to ensure development, implementation and monitoring of the PSIRF.

PSIW will engage with its staff and service users to further learning where there are patient safety incidents.

PSIW does not anticipate that it will be the lead organisation in many PSIRF investigations (as it does not provide health care services) and it therefore does not intent to recruit a PSP at this time, which it considers would be disproportionate. PSIW will actively monitor PSIRF by direct liaison with staff, service users, the ICB and NHS Trusts, as appropriate.

Addressing health inequalities

PSIW, as a service that works with individuals that are not in employment, is aware of inequalities generally within the region. PSIW is not a health care provider and so has less knowledge of health inequality specifically.

Through implementation of PSIRF, we will aim to use learning from any investigations to identify actual and potential health inequalities. Where health inequalities are detected we will notify these to the ICB and the trust.

We will engage with service users and families where there is a patient safety investigation to identify any potential inequalities.

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.

Where there is a patient safety incident PSIW will work with the patient, family, staff and will collaborate with the trust and the ICB as appropriate to ensure that learning takes place.

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

The service manager will have responsibility for implementation and oversight of PSIRF for PSIW.

The service manager will co-ordinate PSIW's input into any Patient Safety Incident Investigations (PSII) required. Any staff with knowledge of the service user and/or incident will also contribute and provide support, as appropriate.

PSIW will liaise with the ICB to determine the level of training required for staff (given that PSIW does not provide health care services) and will ensure that its staff receive appropriate training.

All staff will complete the following NHS England e-learning modules by June 2024. New staff will complete this training as part of their induction:

- **Level 1** - Essentials of patient safety for all staff
- **Level 2** - Access to practice 1
- **Level 2** - Access to practice 2
- **Level 2** - Patient safety in the mental health sector

Where an incident has occurred involving a service user and an NHS trust is leading an investigation/learning response in accordance with PSIRF, PSIW staff will contribute where required.

Our patient safety incident response plan

Our plan sets out how PSIW intends to respond to patient safety incidents over a period of 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 12 months.

Responding to patient safety incidents

Patient safety incident reporting arrangements

Incident reporting arrangements will remain in accordance with Blackpool Council's accident/incident/near miss policy.

Any incidents that occur which involve service users that are receiving care from an NHS trust will be reported to the ICB and relevant NHS trust as soon as practicable following notification to PSIW.

Patient safety incident response decision-making

Reporting and investigation of incidents will continue in line with Blackpool Council existing policy and guidance.

Where there is an incident involving a service user who is receiving care from an NHS Trust PSIW will notify the NHS trust and the ICB and will seek guidance in respect of the investigation and learning response. It is envisaged that the NHS trust will lead the investigation and that PSIW will collaborate with the NHS trust to provide support.

Responding to cross-system incidents/issue

PSIW will forward any incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. PSIW will work with the trust and the ICB (and any other relevant organisation) to establish and maintain robust procedures to facilitate free flow of information.

PSIW will defer to the trust and/or the ICB for co-ordination where an incident is too complex to be managed as a single provider.

Timeframes for learning responses

Where a PSII is required the investigation should begin as soon as possible after an incident occurs and should normally be completed within three months. The timeframe may be extended where possible with the agreement of those involved including the patient, family and staff members. A local PSII should always be completed within six months.

All other learning should start as soon as possible after a patient safety incident and be completed within one month.

Safety action development and monitoring improvement

PSIW will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022):

1. Agree areas for improvement
2. Define the context
3. Define safety actions to address areas of improvement -
4. Prioritise safety actions
5. Define safety measures
6. Document safety actions
7. Monitor and review

Safety improvement plans

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

PSIW will review output from learning responses to incidents to ensure sufficient understanding of any underlying, interlinked system issues. Where issues are identified PSIW will consider creating a safety improvement plan to tackle broad areas for improvement (i.e. overarching system issues).

PSIW will work collaboratively with the trust and the ICB to support safety improvement efforts as required.

Oversight roles and responsibilities

Where PSIW is required to contribute to an investigation into an incident involving a service user who is an NHS patient it will follow the PSIRF 'mindset principles' to underpin the oversight of patient safety incident response:

1. Improvement is the focus - PSIRF oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality
2. Blame restricts insight - Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame
3. Learning from patient safety incidents is a proactive step towards improvement - Responding to a patient safety incident for learning is an active strategy towards continuous improvement, not a reflection of an organisation having done something wrong
4. Collaboration is key - A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation - it must be done collaboratively
5. Psychological safety allows learning to occur - Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions
6. Curiosity is powerful - Leaders have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge

Where PSIW is involved in an investigation in accordance with PSIRF it will closely collaborate with the ICB and the trust to monitor improvements made in response to learning from patient safety incidents.

Complaints and appeals

Any complaints and/or appeals arising out of PSIW service's response to patient safety incidents should be addressed to:

Head of service: Peter.legg@blackpool.gov.uk

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