St Peter's Hospice

Patient Safety Incident Response Plan	
Author	Helen Ireland Head of Clinical Governance & Quality
Owner:	Chris Benson Director of Patient Care
Version	1.0
Effective Date:	01 October 2024
Estimated Refresh Date:	April 2026

Contents

Introduction........ 3

Purpose, Scope, Aims & Objectives........ 3

Our Services........ 8

Defining Our Patient Safety Incident Profile........ 9

Defining Our Patient Safety Improvement Profile........ 10

Our Patient Safety Incident Response Plan: National Requirements........ 12

Our Patient Safety Incident Response Plan: Local Focus........ 13

Summary........ 16

Review........ 17

Stakeholder Sign-Off........ 17

Introduction

The NHS Patient Safety Strategy, published in 2019, introduced the Patient Safety Incident Response Framework (PSIRF) as a foundation for change. This framework challenges us to think and respond differently when a patient safety incident occurs, replacing the previous NHS Serious Incident Framework. This document outlines how St Peter's Hospice (SPH) will respond to patient safety incidents.

PSIRF is designed to promote learning and systemic improvement, moving away from the previous serious incident response framework that focused more on process rather than on fostering a culture of continuous improvement in patient safety.

This framework emphasises conducting investigations collaboratively, led by trained individuals. It ensures the involvement of patients, their carers, families, and staff in a system that responds appropriately to the type of incidents and associated factors. It recognises the need to provide a safe and supportive environment for those involved in any investigation, with a focus on systemic improvement.

Analysis of our current systems has enhanced our understanding of patient safety processes and allowed us to use these insights to develop our Patient Safety Incident Response Plan (PSIRP), which is presented here.

Purpose, Scope, Aims & Objectives

Purpose

Many millions of people are treated safely and successfully each year by the NHS and healthcare organisations in England. However, evidence shows that in complex health systems, things can sometimes go wrong, despite the dedication and professionalism of the staff.

When things go wrong, patients are at risk of harm, and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing, and members of the clinical teams can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatments, and potential litigation. Often, these incidents are caused by system design issues, not by individual mistakes alone.

An increased openness to report patient safety issues has led to a growing number of incidents being referred for investigation. Under the serious incident framework,

organisations often spend more time investigating and less time learning and implementing the necessary changes from those learnings.

Many high-profile organisations now identify and describe their rationale for deciding which incidents to investigate from a learning and improvement perspective. While some industry leaders, such as rail and air transport services, take a risk-based approach to safety investigation, others, like the Police, PHSO, and HSIB, list the parameters that guide their decision-making processes.

We need to remove the barriers in healthcare that have hindered the success of learning and improvement following patient safety investigations, such as lack of time, skills, mixed approaches, and arbitrary thresholds. By doing this, we can create an opportunity for continuous improvement by implementing PSIRF within our local organisations.

This PSIRP is a live document that outlines how SPH intends to respond to patient safety incidents over the next 18 months. The plan will be continuously reviewed, with a formal review in line with the lifespan of the current version.

As a third-sector healthcare organisation partially commissioned by the NHS, SPH is committed to being a learning organisation for our own development and improvement and in partnership with the BNSSG ICB and regional hospice colleagues.

SPH Purpose

To give adults in our communities the support, comfort, and dignity they need at the end of their life.
We plan to deliver our purpose through our 3 strategic intentions:

1. Be the best we can be.
2. Be sustainable and resilient
3. Build collaborative services that reach all communities

SPH’s strategic intentions align with the overarching aims of PSIRF which are detailed below.

PSIRF Purpose

This PSIRP outlines how SPH intends to respond to patient safety incidents reported by staff, patients, their families, and carers. This is part of our ongoing work to continually improve the quality and safety of the care we provide. The plan also covers inquiries into issues raised via audit, research, and other data collection methods where learning can be anticipated without an incident occurring. The plan will be continuously reviewed and amended as required, with a formal review after 18 months. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Local Scope

A review of all our patient safety and incident data from 2020 to March 2024 has been conducted to understand the volume of activity in each category by actual harm, potential harm, and combined scores. We also reviewed these and our STeIS reportable investigations over the same period for themes and insights to determine our priorities. SPH serves a large population, primarily in the BNSSG area, with a population just under 1 million. Annually, approximately 3,700 individuals are supported by SPH in some way. From April 2023 to March 2024, this included 252 admissions to the inpatient unit, 2,682 patients referred, and 521 clients collectively cared for by our Clinical Nurse Specialists, Hospice at Home Team, Medical Team, and Patient & Family Support teams, with 3,868 external calls to the 24-hour advice line. Day Services has recently reopened after the pandemic and supported 217 individual patients with 1,080 sessions attended across different groups.

The safe, effective, and high-quality care these patients receive is supported by the Clinical Governance Policy, process, and procedures. Although the risk profile for SPH is at the lower end when looking at our incident and other data, there is, as in all healthcare organisations, significant potential for patient safety issues and risks. Therefore, vigilance and learning from events are essential for the sustained and improved safe care our patients receive.

SPH Patient Safety Response Plan Scope

There are many ways to respond to an incident. This plan covers the responses conducted solely for the purpose of organisational and system learning following clinical incidents, events and outcomes from other clinical governance processes.

Patient safety incidents are any unintentional or unexpected incidents which could have, or did, lead to harm for one or more patients receiving healthcare.

Clinical governance processes include routine enquiry methods such as audit, research, data analysis, patient/service user/client feedback, staff survey and ad hoc inspections.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning. Naturally during the investigation or enquiry process, staff or related people may be identified as having learning or behavioural adjustment needs that should be followed through separately using the appropriate policy and process e.g. Disciplinary Policy via the line management structure.

Responses covered in this plan include:

1. Patient Safety incident investigation (PSII)
2. Patient safety reviews (PSR)
3. Rapid Incident Review (RIR)
4. Thematic review (TR)

There are other types of responses to deal with specific issues or concerns. Examples include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners' inquests, or criminal investigations. The primary aim of these responses differs from the aims of a patient safety response and are outside the scope of this plan.

To be effective in their intended purpose, these other responses can be referred to and categorised as follows:

- Human resources (HR) including those that involve referral to professional regulators – Case investigation
- Legal
- Medical Examiners – including Coroner, Medical Examiner
- Police
- Complaints & Concerns management

There are many tools staff can use whilst exploring patient safety events and completing a response, these include:

- Swarm huddles
- SEIPS based formal learning reviews
- Multidisciplinary team meetings
- Critical conversations
- Notes review
- Brief walk-through analysis
- Link analysis
- Conduct observations
- After action reviews
- Horizon scanning
- Timeline mapping
- Workstream scan
- SHARE debrief tool

PSIRF Strategic Aims

The overarching aims of PSIRF are to:

1. Improve the safety of the care we provide to our patients.
2. Enhance the experience for patients, their families, and carers whenever a patient safety incident occurs.
3. Optimise the use of valuable healthcare resources.
4. Improve the working environment for staff in relation to their experiences of patient safety investigations and reviews.

This is enabled through the following:

1. Compassionate engagement (in line with the NHS Just Culture Guide) and involvement of those affected by patient safety incidents.
2. Application of a range of systems-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

SPH Objectives in Context of PSIRF Aims

SPH has specific objectives that align with the overarching aims of PSIRF.

Overarching Aims	Specific Objectives
Improve the safety of the care we provide our patients.	Develop a culture that supports a just culture (in line with the NHS Just Culture Guide) and an effective learning response to patient safety incidents. Respond to patient safety incidents purely from a patient safety perspective. Provide a suite of enquiry measures in addition PSII to allow more effective, efficient and less onerous review allowing more time to deliver any changes needed. Consider the safety issues that contribute to similar types of incidents. Develop organisational and system improvement plans across aggregated incident response data to produce improvements. Better measurement of improvement initiatives based on learning from incident response.
Improve the experience for patients, their families and carers wherever a patient safety incident occurs.	Act on feedback from patient, families, carers and staff about their concerns with patient safety incident responses. Support and involve patients, families and carers in incident response, for better understanding of the issues and contributory factors, promoting duty of candour. Being an open, honest and transparent organisation which is proactive and learns.
Improve the use of valuable healthcare resources	Transfer the emphasis from quantity of investigations completed with an arbitrary deadline to a higher quality response to patient safety incidents and the implementation of meaningful actions that lead to demonstrable change and improvement. Be LFPSE compliant and active to assist wider system and national level learning. Active participation in the ICB quality group Responsible and accountable relationship with ICB quality leads. Responsible and accountable relationship with CQC
Improve the working environment for staff in relation to their experiences of patient safety investigations and reviews.	Act on feedback form staff about their concerns with patient safety incident responses in the organisation. Support and involve staff in patient safety incident response for better understanding of the issues and contributory factors. To provide staff with the education and tools to proactively manage patient safety incidents and to engage with wider learning processes.

Our Services

Our Services - Explanation

SPH is an independent healthcare charity that is partially NHS commissioned. We provide adult hospice care for a large mostly urban population. SPH serves a large population, predominantly in the BNSSG area whose population is just under 1 million.

Our services include:

- **Inpatient unit** – 15 beds. Split between consultant and nurse-led beds.
- **Hospice at Home**
- **Clinical Nurse Specialists (CNS)**
- **24-hour Advice Line**
- **Patient and Family Services (PFS)** including social work and spiritual care
- **Psychological Therapy Team (PTT)** – Therapy and bereavement services
- **Day Services** – including therapies
- **Medical team** – a team that works within the inpatient, community and advice line settings.
- **Clinical Volunteers**
- **Clinical Education**

These key clinical services are supported by the following services:

- Facilities, including catering, maintenance and domestic services
- Infection Prevention and Control
- Human Resources (HR)
- Patient Safety & Quality (PSQ) Team
- Clinical Education
- Safeguarding
- Senior Management Team
- Learning and Development
- Volunteer services
- IT
- Finance
- Health & Safety
- Project Management
- Fundraising and Income Generation teams
- Retail teams

SPH has a Clinical Education team who work closely with the Patient Safety & Quality (PSQ) Team. The PSQ Team are responsible for the content of the PSIRF training and information whilst the Clinical Education Team will assist with design and delivery as well as managing the recording of training on the Knowledge Centre database. The

Clinical Education team is also responsible for providing reports to the Clinical Governance Committee on training performance for the separate clinical services and the clinical organisation as a whole for PSIRF/incident response training and eLFH patient safety training.

Defining our Patient Safety Incident Profile

Patient Safety Risk Analysis at SPH

The patient safety incident risks for SPH have been profiled using organisational data between April 2020 and March 2024 with reference to the preceding 2 years data.

We have analysed data from the following main sources:

- Incident reports
- Complaints and concerns
- Safeguarding data
- IP&C data
- Current workstreams
- Audit and other clinical surveillance
- Mortality reviews
- Staff survey results
- STeIS, RIDDOR, SI, Charity Commission submissions

To ascertain the risk profile at SPH, all incidents were reviewed and categorised within the following classifications:

- Former SI incident categorisation. Never events, RIDDOR, STeIS.
- Pressure injuries that reached the former STeIS reportable threshold.
- NPSA level 3 consequence grading
- NPSA level 2 consequence grading
- NPSA level 1 consequence grading
- Combined risk scores – Low, moderate, high, extremely high

Using the data we were able to determine the volume of risk in each category.

We also examined each incident type, noting risk grading, volume, and recurrence rate to create our top five local patient safety risks, which are detailed below. These top risks for SPH are detailed with intended investigation response types.

Additionally, we have specified our criteria for selecting risks for a PSII response

Defining our Patient Safety Improvement Profile

Risk Analysis, Data and Stakeholder Engagement

The patient safety incident risks for SPH have been profiled using organisational data between 2020 and 2024 from the following data sources:

- Patient safety incident reports and investigations
- Clinical Governance data, oversight reviews and context including workstreams
- Mortality thematic reviews
- Staff surveys
- Complaints and concerns

Incident types, recurrence and severity were explored, together with careful consideration of patient safety and quality improvement opportunities and knowledge, as well as plans that are already in place and action.

A range of clinical staff and managers, including the PSQ and Directorate of Patient Care teams, were consulted and a and a prioritised list of incident themes were agreed upon.

Criteria for Defining Top Local Patient Safety Risks

Criteria	Considerations
Potential for harm	People (including patients, carers, family/friends): physical, psychological, loss of trust. Service delivery: impact on the quality and or safety of delivery of health care services, impact on capacity to deliver. Public confidence and reputation: including political attention and media coverage.
Likelihood of occurrence	Persistence of risk. Frequency. Potential to escalate. Potential high risk.

The current local top 5 patient safety risks at SPH have been identified via the process explained above:

	Incident type	Description	Specialty	Response Type
1	Documentation	Incidents where documentation issues negatively impact patient safety.	All services	FULL PSII
2	Communication	Complaints and concerns regarding staff/organisation communication. Incidents where communication impacted patient negatively.	All services	FULL PSII
3	Falls	Incidents of Inpatient falls with potential for significant learning.	IPU, Day Services	FULL PSII
4	Medication	Medication incidents that have significantly impacted on patient outcomes.	All services	FULL PSII
5	Pressure Injuries	Hospice acquired Category 3 pressure ulcers and above, with potential for significant learning	IPU	FULL PSII

Our Patient Safety Incident Response Plan: National Requirements

Local Patient Safety Risks that Fall within National Priorities

	National Priority	Incident Type	Team	Response Type	Anticipated Improvement Route & Shared Learning
1	Never events	All	All	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication
2	Learning from deaths	Where patient death is more likely than not due to problems in care	All	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication
3	Safeguarding incidents	Safeguarding provider enquiry reports. Statutory reviews	All	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication
4	Deaths of persons with learning disabilities	Work with LeDeR through information for each death for learning	All	Participate in LeDeR review. PSII as with learning from death	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication

Our Patient Safety Incident Response Plan: Local Focus

Incident Type	Detail	Planned Response	Anticipated Improvement Route

1	Documentation	Incidents where documentation issues negatively impact patient safety. Thematic analysis shows high frequency.	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication ICB and CQC
2	Communication	Complaints and concerns regarding staff/organisation communication. Incidents where communication impacted patient negatively	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication ICB and CQC
3	Falls	Incidents of Inpatient falls with potential for significant learning.	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication ICB and CQC
4	Medication	Medication incidents that have significantly impacted on patient outcomes.	PSII	Clinical Governance Committee (CGC) PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication ICB and CQC
5	Pressure Injuries	Hospice acquired Category 3 pressure ulcers and above, with potential for significant learning	PSII	Clinical Governance Committee (CGC) Tissue Viability Group PSQ meeting Service quality and safety assurance meetings Team meetings Organisational communication

Clinical Education and Training

To deliver the plan we need to devise and execute a suite of training to build our skills base at SPH. The PSQ team have been and are continuing to develop their own skills base in order to lead and train the organisation. Below is an assessment of the training needs gap which provides the context for a detailed plan being formulated to deliver.

Response/ Skills Set	Current Resource	Plan	Target Resource
PSII – Level 2 training	3	Patient Safety and Quality Team Head of Clinical Governance and Quality	4
PSIRF Oversight- HSSIB Learning Responses	0	DoPC, MD, DOPC Senior managers, PSQ Team, Lead Nurse Specialist, Lead Hospice at Home Nurse and Inpatient Unit Band 7.	14
Other responses - Patient Safety Review/Rapid incident review/thematic review & enquiry tools	0	Plan to deliver training and documentation to all clinical staff in a step wise delivery plan starting with those with line management responsibility. Head of Clinical Governance & Quality and PSQ team to cascade to organisation in next 12 months. Staff will be divided into 5 categories with bespoke level training developed for each: • Senior management including Medical Director/ Community Lead Nurses/ PSQ Team and Inpatient Band 7's. 1. Band 7, medics 2. Band 6 & line managers 3. Band 5 & equivalent in AHP • HCA and admin staff	90%
Level 1 & 2 patient safety training	95%	On mandatory education list for all clinical staff. Added to LFPSE and complaints and concerns management. Aim for 95% compliance	All staff – 95%

Education planning and allocation will happen between September 2024 and April 2025.

Staff will be allocated into 3 cohorts, colour coded to denote with the level of training.

Staff will be allocated a cohort that provides suitable training that is suitable for their allocated persona profile. PSII training is bespoke and offered for a group of staff in addition to their cohort training.

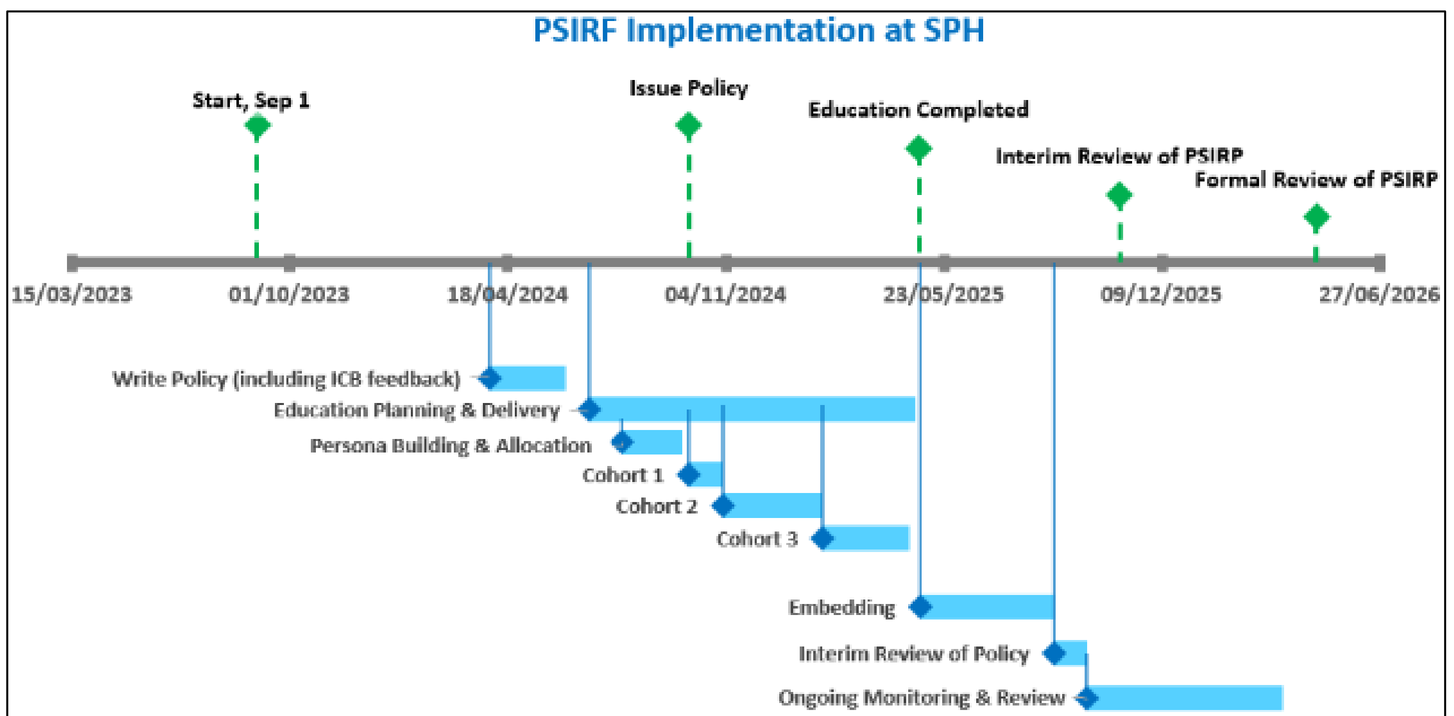
Training of the cohorts will take place between September 2024 to April 2025.

The Head of Clinical Governance & Quality will work with the PSQ team to develop the training content and deliver the sessions. They will also liaise with the Clinical Education team for support with delivery planning. The cohort groups and a timeline are presented below:

Cohort Groups

Cohort	Training included	Staff groups
(Red)	PSIRF + PSR, RIR, TR and whole tool kit	DoPC, MD, B8 senior managers, ACP PSQ Team, B7, medics and Service Leads
(Yellow)	PSIRF + RIR and associated tools	Band 6-line managers, B5 and equivalent AHP roles
(Blue)	PSIRF + Incident immediate actions and associated tools	HCAs, facilities and admin staff
PSII	2-day PSII training (external)	Head of Clinical Governance & Quality, PSQ Manager, Practice Improvement Leads.

Timeline



Roles and Responsibilities

In order to ensure that SPH has the skills throughout the organisation to realise the potential of PSIRF as an essential approach to managing patient safety and the learning from incidents and data, it is important to have capability at the right levels.

As above there will be a cohort of staff who will be able to perform all levels of incident investigation. These staff, who will have completed their PSII training as well as the red cohort of internal incident investigation training, will be able to appraise any incident and investigate in the most appropriate way. This group of staff will also be able to support and facilitate other staff with incident investigations.

The group of staff whose ceiling of training is the red cohort will be able to perform all levels of patient safety investigation outside of the formal PSII investigation. This group of staff will also be able to support staff with incident investigations within their competence.

A group of staff educated within the yellow cohort will be trained to provide rapid incident reviews following an incident.

The group of staff within the blue cohort will be trained to gather information after an incident and what processes occur afterwards to contextualise their actions within the larger process.

Stakeholder Engagement

The SPH Executive Team and Trustees have been kept informed of the development and implementation of PSIRF and this plan. The BNSSG Integrated Care System (ICS) Quality Lead has also had sight of the data and risk assessment for SPH and has supported its content. Following the completion of this plan and supporting policy these will both be sent to the Clinical Services Trustees, Executive Team and ICS/ICB for final sign off.

Summary

This plan outlines how SPH will respond to patient safety events over the next 18 months. The review identified the organisation's highest risk areas and how we plan to address them to learn and continually improve practice. Although the risk profile

for SPH is at the lower end when looking at our incident and other data, there is, as in all healthcare organisations, significant potential for patient safety issues and risks. Therefore, vigilance and learning from events are essential for the sustained and improved safe care our patients receive. We intend to focus on events as well as aggregated data and thematic review to constantly inform our approach, inquiry, and response. This plan should be read in conjunction with the PSIRF Policy and Incident Management Policy.

Review

Check in review at 1 year: October 2025

Full review in 18 months: April 2026

Stakeholders Sign-Off

Stakeholder	**Date of Sign-Off**	**Signature**
SPH Executive Team		
SPH Clinical Services Committee		
ICB Executive Team		