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Approved by	ICB
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Patient Safety Incident Response Policy and Plan

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Regenerage's (the charity) approach to developing and maintaining effective systems and processes for responding to patients (service user) safety incidents and issues for the purpose of learning and improving service user safety.

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

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

1. compassionate engagement and involvement of those affected by service user safety incidents
2. application of a range of system-based approaches to learning from service user safety incidents
3. considered and proportionate responses to service user safety incidents and safety issues
4. supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to service user safety incident responses conducted solely for the purpose of learning and improvement across Regenerage's NHS health contracts.

Responses under this policy follow a systems-based approach. The safety of service users depends on the entire healthcare system working well together, rather than on any single part alone. 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 service user safety response and are outside the scope of this policy.

Information from a service user safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a service user safety incident response.

Roles and Responsibilities within the Charity

- Chief Executive Officer and Trustee Board have ultimate responsibility for all aspects of service user safety.
- The Integrated Care Board has the responsibility for signing off this policy.
- Chief Operating Officer and Trustee Assurance Sub Committee (ASC) has responsibility for policy setting and implementation of this policy.
- Director of Care Services and Registered Manager has responsibility for embedding this policy and reporting mechanisms.
- Investigation team is a representative from all of the above.

Our Service User Safety Culture

The charity, aims to promote a "Just Culture" for safety of all of our service users whilst within a community setting. All our staff are equipped to a mandatory level of training for the position, or duty delegated to them through each contract.

Our systems have been developed to record every engagement from initial contact to post-engagement/discharge of support, we have a robust method of support in place to assure a safe service to all service users and service user contact, and care.

All of our employee induction processes embed service user safety at the core of the charity, all staff follow a matrix of training which ensures there is the minimum level of competency and structure to the work carried out for and on behalf of the charity. Our structured staff supervision, appraisal and team meeting processes aim to discuss case level, development of support and best practice to ascertain emerging or any gaps in training needs of our employees. We regularly highlight the importance of safeguarding all of our service users throughout their support and step-down to ensure a robust service user safety culture is fostered by all employed through the charity.

Feedback which incorporates concerns, complaints and compliments are welcomed from our service users, carers, partners, stakeholders and commissioners. We have processes to ensure these are invited, logged and acknowledged, and contribute to our consistent approaches to ongoing service design and development.

If an investigation raises concerns we will use the Just Culture Guide (NHS England) to support the organisation through the process.

Service User Safety Partners

All of our work is dependent on strong collaborations and partnerships, the charity has a Trustee Sub Assurance Committee (ASC) who act as overall oversight and support. Incidents and safeguarding are a quarterly agenda item, and our ASC discuss any incidents, reviews, improvement work plans and post action reviews undertaken.

Our internal policy review team meet quarterly to check all of our policies, systems therein and that our risk register is meeting contractual requirements across all of our commitments and services.

Addressing Health Inequalities

The charity recognises the health inequalities faced by population groups/communities and individuals are unfair and that these differences in health across the population, and between different groups within society are avoidable.

Most of our delivery is with older people including those living with dementia and memory concerns, people living in areas of high deprivation, people living with disabilities and those facing inequities; for example from Black, Asian and minority ethnic communities.

The charity recognises that at both a national and local level we have a role to play in reducing and removing health inequalities, which impact on people's outcomes and experiences, and across all our services. In line with the Equality Act 2010 we ensure that no one is disproportionately impacted on the grounds of their specific characteristic.

Our focus is to provide the best care to our service users, regardless of, their skin colour, culture, ethnicity or faith, gender or sexuality, age or if they have a disability and do not tolerate, under any circumstances, any form of racial abuse or discrimination.

Engaging and Involving Service Users, Families and Staff Following a Service User Safety Incident

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

and staff. This involves working with those affected by service user safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Service User Safety Incident Response Planning

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

The charity will take a proportionate approach to its response to service user safety events to ensure that the focus is on maximising improvement. Our approach will align to the principles in the documents "Guide to responding proportionately to Patients safety incidents" and the "Patient safety Incident response standards". Also refer to Duty of Candour Policy.

Resources and Training to Support Service User Safety Incident Response.

- Overview of PSIRF training requirements – NHS podcast which focuses on the training NHS organisations should ensure staff undertake as part of their preparation for implementing the PSIRF.
- https://resolution.nhs.uk/wp-content/uploads/2022/06/PSIRF-NHSR-Presentation-Slides-17.03.22.pdf
- https://being-human.org.uk/psirf-courses/
- PSIRF Early Adopter Interview: Acute healthcare provider perspective - https://youtu.be/k3RrjK4VUpo?si=aw2SVg1KchK35eOy
- PSIRF Early Adopter Interview: Patient safety incident investigator perspective - https://youtu.be/opU-Qcpi4CA?si=ZUdQeJtpVCYnno_Z
- Introducing the Patient Safety Incident Response Framework (PSIRF) learning response toolkit - https://soundcloud.com/nhsengland/introducing-the-patient-safety-incident-response-framework-psirf-learning-response-toolkit
- Engaging and involving patients, families and staff following a patient safety incident - https://soundcloud.com/nhsengland/engaging-and-involving-patients-families-and-staff-following-a-patient-safety-incident
- General PSIRF Resources - https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/#podcast

Safety Culture

- Improving Patient Safety Culture – A Practical Guide
- NHS England – Safety culture: learning from best practice
- NHS Employers – Safety culture

Our Service User Safety Incident Response Plan

Our plan sets out how the charity intends to respond to service user safety incidents within 3 months from the first issue of this policy. 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 service user safety incident occurred and the needs of those affected, as well as the plan.

The aim of this plan is to:

- To ensure staff and contracted partners are aware of their obligation to report significant events
- To create an open and transparent environment where staff feel supported in reporting
- To facilitate learning and improvement from reported events
- Ensure service users, friends and families feel listened to, supported and incidents dealt with robustly at all times

Steps

Initial Report:

- Staff should submit a Safety Alert within 24 hours of identifying the event. This alert is picked up by the COO.

Escalation:

- The COO) is responsible for escalating the report to the CEO and Chair of the ASC within 48 hours of receiving it.

Initial Review:

- The COO will conduct an initial review of the report to determine the severity and impact of the incident.

Investigation Team:

- For major events, an investigation team will be assembled to conduct a more in-depth analysis.

Employee Interviews:

- Staff involved may be asked to participate in interviews or provide additional information.

Learning and Improvement Review:

- Following the investigation, the COO and ASC will review the findings and identify opportunities for learning and improvement.

Learning and Improvement:

- Feedback will be provided to all staff involved in the incident as well as the wider organisation, as appropriate.

Training and Development::

- Where necessary, additional training sessions will be scheduled to address any skills or knowledge gaps identified.

Supporting Staff & Contracting Partners:

- All reports will be treated with utmost confidentiality

Supporting Resources:

- Staff involved in a significant event will be offered support to access external counselling and other support resources.

No Blame Culture:

- The focus of reporting and investigating significant events is learning and improvement, not assigning blame.

Monitoring and Review:

- This policy and plan will be reviewed annually by the COO and ASC as part of the Policy Review ensure its effectiveness and relevance. Changes will be communicated to all staff members

Concluding Remarks:

- The effectiveness of this policy relies on the willingness of all staff and contracting partners to report significant events and to engage in subsequent learning and improvement processes. Their cooperation is not just encouraged; it is essential for the betterment of our charitable operations and commitments

Defining Our Service User Safety Incident Profile

The charity, has seen an increase in vulnerabilities of our service user groups and ascertained that the potential for a service user safety incident to be increasingly likely, and we need to be equipped with a consistent model for continuing assessment of need and incident.

Through active stakeholder engagement, we will continue to collaborate with a mixture of service users (former and current), family members of and professionals to ascertain the service user safety issues most pertinent to include in our planning structures.

We continue to engage with local forums, Housing Associations, Healthwatch, our carers group, community groups Frailty teams, Falls teams, Memory Assessment Service.

We use all relevant data available to us to assess likelihood and consequence of low to high-risk incidents to service user to safety. This policy and plan will enable us to embed, capture, respond and learn from any incidents that we may encounter going forward.

Consultation

Regular quarterly consultation with our commissioners will enable us to keep abreast of needs and priorities of this policy, both on a local and national level. We are committed to ensuring maximum safety and risk assessment assurance for all service users to our services, as well as the follow-up incident review processes.

Service User Safety Incident Response Plan: National Requirements

The charity will support Acute and Mental Health Trust through cross working when complying with the following national event response requirements:

Event	Action Required	Lead Body for Response
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally-led PSII	The Trust
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally-led PSII	The Trust
Incidents meeting the Never Events criteria 2018, or its replacement	Locally-led PSII	The Trust
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	As decided by the RIIT
Maternity and neonatal incidents meeting Healthcare Services Safety Investigation Branch (HSSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Refer to HSSIB or SpHA for independent PSII	HSSIB (or SpHA)
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery • and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local Safeguarding adults boards	Refer to your local designated professionals for child and adult safeguarding

Our Service User Safety Incident Response Plan: Local Focus

The charity will be flexible with its investigative approach, informed by the national and local priorities detailed within this plan and agree the most appropriate response based on the potential for learning, improvement and systemic risk.

Service user safety incident type or issue	Planned response	Anticipated improvement route
IG/Information Sharing breach	• Immediate action to mitigate impact • Discussion within the charity to learn from event and plan for strengthening process • After action review	• Robust measures in place • Identify greatest potential for learning
Safeguarding adults /children	• Report to the charity's Safeguarding lead via the QR code for reporting • Report to Local Authority (LCC) Safeguarding team • Dependent on circumstances report to CQC	• Update of safeguarding training and governance as required through the identification of greatest potential for learning
Inappropriate or delays in referrals to support services	• Review of internal processes after action review	• Reduction in delays • Appropriate support for service users • Learning identified and actioned

Reviewing Our Service User Safety Incident Response Policy and Plan

Our service user safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to service user safety incidents. We will review the plan every 12 months to ensure our focus remains up to date; with ongoing improvement work our service user 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 18 months.

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

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with the 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.

Responding to Service User Safety Incidents

Investigation Reference		Date Started	
Organisation	Role	Stakeholder Name	Contact Details

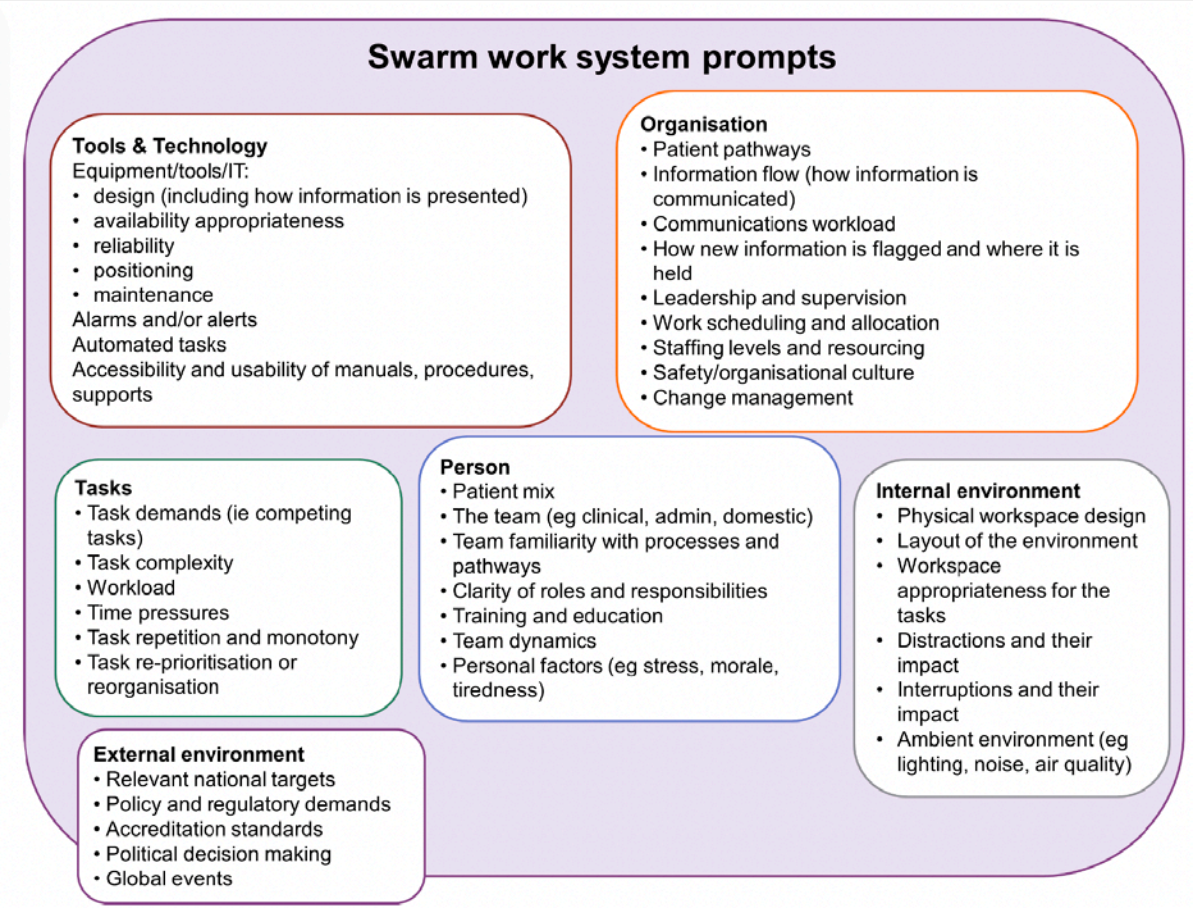
After Action Review

A guide to conducting an After Action Review (AAR):

1. **Define Purpose**: Clarify the incident or activity being reviewed and the purpose of the AAR.
2. **Gather Participants**: Include everyone involved in the event, ensuring a range of perspectives.
3. **Facilitate Open Discussion**:
    - **What happened?** Review events objectively.
    - **What went well?** Identify successes and strengths.
    - **What could be improved?** Discuss areas needing change or improvement.
    - **What will we do differently?** Establish actionable steps to prevent future issues.
4. **Document and Share**: Summarise findings, actions, and responsible individuals. Share the report with relevant stakeholders.
5. **Follow Up**: Check in on action items to ensure improvements are implemented.

This approach promotes accountability, continuous improvement, and a focus on learning.

Swarm Work System Prompts

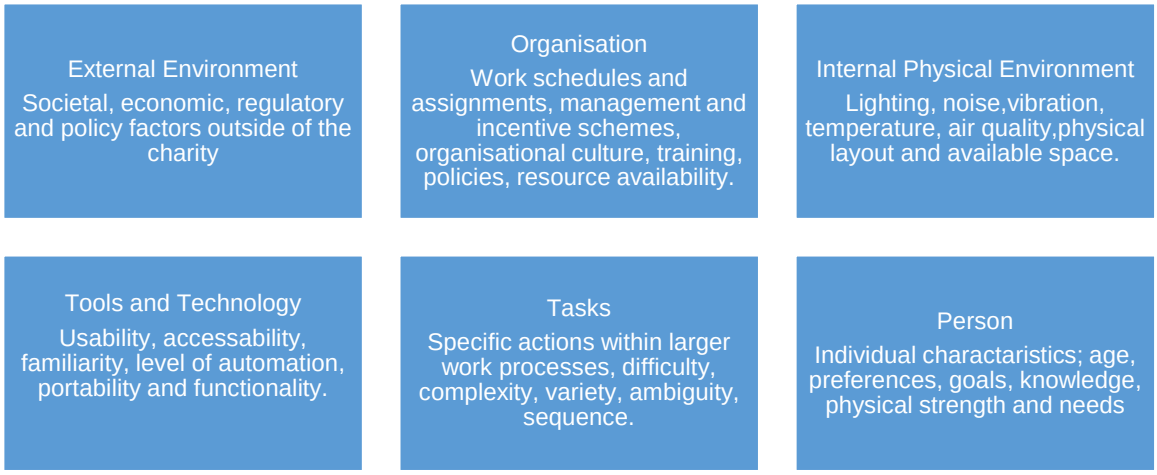


Further information on Swarm: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Swarm-huddle-v1-FINAL.pdf

Pros/cons	How	Tips
Can be used to: • inform the design of work procedures • identify hazards in existing procedures or tasks • identify everyday work hassles, frustrations and irritations. **Pros** • Process can be stopped at any time to ask questions, review documentation, devices or decisions being made, seek more detailed clarity. • Quick and low cost – all that may be need is pen and paper • Flexible approach that can be used as part of any learning response method. **Cons** • Not observing 'real' behaviour, but can be combined with observation data to further contextualise understanding of the process. • Requires access to team member(s) experienced in the process. • Best applied 'in situ', which may limit when you can access certain environments (eg may not be usable this method during busy periods).	Four steps: 1. Define the process: walkthrough analysis begins by defining the process under evaluation. 2. Describe the process: divide the process into component parts (tasks) that are clearer/simpler to understand. 3. Perform a walkthrough of the process with a user representative of the workforce. Ask representative users to 'think out loud' (ie verbalise their thoughts) as they simulate going through their tasks (either in situ or in a simulated environment). Example questions to ask: • "I noticed that you did _____. Can you tell me why?" Follow-up on any interesting behaviour you observe to get a better idea of the thought process behind the actions: • "Is there another way to complete that task?" (try to determine why they did one thing instead of another) 4. Summarise re-design opportunities and examples of good practice identified. This can be used to define potential areas for improvement.	If the process is too complex to describe in list format, a diagram can be used instead. Hierarchical task analysis can help to unpick complex processes. Record the walkthrough (sound or video where feasible) and/or contemporaneous notes taken by the learning response lead. Use prompts from the 'systems considerations' below. Learning response leads may wish to seek multiple perspectives from team members to understand how tasks are performed. General questions to consider: • What makes tasks difficult? • What surprises you? • What can go wrong? • What can be improved and how? Use the task and tool matrix table below to generate further detail as part of your analysis.

System Considerations

Person(s)	Tasks	Tools and technology	Environment	Organisation at work	External
• Who are the people doing the work? Are they familiar with it? • Height and physical strength requirements • Are roles defined? • Are people trained to complete the task? • Team dynamics (team structure/skill mix) • Explore impact of personal factors (eg stress, morale) • Fatigue influence (distances travelled, cognitive fatigue, reliance on short-term memory) • Communication barriers • Influence of inequalities	• Complexity/ demands of the task • Are tasks repetitive (variety, monotony)? • Are tasks conducted in a particular order (sequence)? • Workload • Workarounds • Time pressure	• Usability: are there 'supports' (eg signs of poor design such as sticky notes to guide use)? • Presentation of information • Quality of alarm design (eg recognition and response) • Positioning of equipment – how is it grouped (eg in relation to task requirements)? • Level of automation • Reliability of equipment • Appropriateness of equipment for the task • Are tools/technology maintained/updated? • Maintenance requirements • Availability (eg is there an adequate supply)	• Distractions • Interruptions • Business • Ambient environment, including lighting, noise, air quality • Environment layout • Where are tasks completed? • Is this space appropriate for the task? • Visibility of patients, staff, equipment	• Information flow (eg high communications workload, poor phrasing or low communication standards) • How is new information flagged? • Where is this information held? • Leadership and supervision • Inadequately defined roles and responsibilities • Work scheduling • Staffing levels, resourcing • Safety culture • Change management	• National targets • Policy and regulatory demands • Accreditation standards • Political decision-making • Global events



Service User Safety Incident Reporting Arrangements

The Charity will report all service user safety incidents quarterly to the ASC.

Service User Safety Incident Response Decision-Making

Planning enables the proactive allocation of resources for responding to safety incidents involving service users. However, a reactive approach will always be necessary as part of the response. Every incident related to service user safety—especially those indicating unexpected risks or potential learning opportunities—should be evaluated for a response, even if they fall outside the specific issues or incidents outlined in the organisation's plan.

Responding to Cross-System Incidents/Issues

The charity will work with partners and the ICB to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents.

Timeframes for Learning Responses

A learning response will be started as soon as possible after the service user safety incident is identified and will be completed within one to three months of their start date. We will ensure that no learning response will take longer than six months to complete.

Safety Action Development and Monitoring Improvement

Following a service user safety event, we will agree and generate safety actions in relation to defined areas for improvement. Following this, the charity will have measures to monitor any safety action and set out review steps. These actions will be overseen by the Chief Operating Officer and Safeguarding Lead

Safety Improvement Plans

Safety improvement plans bring together findings from various responses to service user safety incidents and issues. They can take different forms. For example:

- creating a charity-wide safety improvement plan summarising improvement work
- creating individual safety improvement plans that focus on a specific service, pathway or location
- collectively reviewing output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues
- creating a safety improvement plan to tackle broad areas for improvement for example an overarching system issues.

The charity would use a mix of the above based on available data, stakeholder views, improvement priorities, service user safety incident profile and insight from service user safety incident responses.

There are no thresholds for when a safety improvement plan should be developed; for example, after completing a certain number of learning responses. The decision to do so will be based on knowledge gained through the learning response process and other relevant data.

Oversight Roles and Responsibilities

Our PSIR oversight team aims to:

- Ensure the charity meets national service user safety incident response standards
- Ensure PSIRF is central to overarching safety governance arrangements
- Quality assure learning response outputs

Our lead officer will ensure that:

- Service user safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress are discussed at senior leadership meetings, and ASC where relevant.
- Roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to incidents.

All co-design sessions with stakeholders will aim to provide:

- Engagement and involvement of those affected by service user safety incidents
- Policy, planning and governance
- Competence and capacity
- Proportionate responses
- Safety actions and improvement

A crucial step in enhancing the charity's learning from service user safety incidents is incorporating external peer review for a sample of insights. This external review not only raises the quality of learning but also helps avoid isolated, potentially biased perspectives. By examining existing systems and associated risks, it can also identify potential future issues. Furthermore, by analysing incident findings, improvement areas, and safety actions developed by other organisations, providers can assess their own practices to determine if similar issues could arise in their context.

The following ‘mind-set’ principles should underpin the oversight of service user safety incident response:

- Improvement as the Primary Goal: PSIRF oversight should prioritize enabling and tracking improvements in care safety, rather than simply assessing the quality of investigations.
- Blame Hinders Insight: Oversight should emphasize learning by identifying systemic factors contributing to safety incidents, rather than assigning blame to individuals.
- Learning Drives Improvement: Responding to a safety incident for learning is a proactive step toward continuous improvement, not an indication of organisational failure.
- Collaboration is Essential: Effective oversight cannot be achieved by individuals or organisations in isolation—it requires collaborative efforts.
- Psychological Safety Promotes Learning: Oversight should foster a climate of openness to encourage diverse perspectives, discussion of vulnerabilities, and openness to solutions.
- Curiosity as a Tool for Leaders: Leaders have the unique ability to inspire improvement by using curiosity to understand rather than judge, making questioning a powerful aspect of oversight.

Feedback and Complaints

Positive feedback is valued as a compliment and is shared with the relevant individuals and their managers to reinforce good practices. Negative feedback is treated as a complaint; if there is a concern or dissatisfaction with any aspect of the charity, it is welcomed as an opportunity to address issues, learn, and improve.

Feedback Policy Principles

The principles of the Feedback Policy are that we want to ensure:

- Communicating feedback is as easy as possible
- Feedback is treated seriously and we respond back where appropriate or requested to do so.
- Our communication is prompt and polite.
- We learn from feedback and use it to improve.
- We respond in the right way, e.g. with an apology where things have gone wrong, with a thank you where you have complimented us or with an explanation, or information, as appropriate.
- We always respond positively and effectively to complaints and put right any shortcomings that are within our control so that any complaint is resolved satisfactorily and speedily

How to Submit Feedback to the Charity

It is usually best to contact the person who is providing the service or the person concerned since they are best placed to respond.

If there is a complaint, or problem, try in the first instance to resolve the problem with the service or person concerned. They will often be able to put things right very quickly and simply.

If the individual does not know who to contact, or do not feel comfortable raising it in the way suggested, then please phone the organisation’s Feedback Officer,, on 01772 552858 or email feedback@regenerage.org.uk, or write to: Feedback Officer, Regenerage, Beech House Lancastergate, Leyland PR25 2EX

Or scan this code

Response to Feedback

The way in which we respond to feedback will vary according to its nature. For example, a compliment might not need a written response.

If a formal complaint is made, we will send an acknowledgement letter within five working days. It may be necessary for us to contact the individual for further information. After sending an acknowledgment letter our aim is to fully investigate the complaint, gather any further information needed and respond within 10 working days of the date of the acknowledgement letter to provide the individual with the outcome of our investigation. Where this timeframe is not possible, we will let them know when they will receive a full response.

All complaints will be treated with an appropriate degree of confidentiality and information will only be shared with staff and volunteers as necessary to assist in understanding what has happened and respond accordingly. This is the final stage of the charity's response.

We record formal and informal feedback and reports are submitted to the Board of Trustees summarising the feedback received, both positive and negative, and identify trends.