BLAKEWATER HEALTHCARE

Policy document

Patient Safety Incident Response Framework (PSIRF) Policy

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Version	Date	Amendments

Contents

1. Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Blakewater Healthcare'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 promotes a data-driven response to patient safety incidents, embedding incident response within a broader system of improvement and fostering a significant cultural shift towards systematic patient safety management.

This policy integrates the four key aims of PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of system-based approaches to learning from incidents.
- Proportionate and considered responses to patient safety incidents and safety issues.
- Supportive oversight focused on strengthening response systems and improving safety measures.

2. Scope

This policy applies to patient safety incident responses conducted solely for the purpose of learning and improvement at Blakewater Healthcare. Responses are system-based and do not focus on individual blame or liability.

Excluded from this policy are processes such as:

- Complaints
- Human resources investigations
- Professional standards investigations
- Coroner's inquests
- Criminal investigations
- Claims management
- Financial audits
- Safeguarding concerns
- Information governance concerns
- Estates and facilities issues

Where applicable, information from patient safety incident responses may be shared with relevant parties handling these areas.

3. Our Patient Safety Culture

Blakewater Healthcare is committed to fostering a just culture where:

- Staff feel safe to report patient safety incidents openly.
- Transparent reporting is encouraged and supported.
- Learning is prioritized over blame, fostering continuous improvement.

4. Patient Safety Partners

We engage patient safety partners in:

- Oversight committees.
- Development of incident response processes.
- Continuous monitoring and improvement of safety practices.

5. Addressing Health Inequalities

Our patient safety processes aim to:

- Identify and mitigate risks disproportionately affecting specific patient groups.
- Use flexible data analysis to inform equitable incident response.
- Ensure diverse patient and staff perspectives are included in safety improvement efforts.

6. Engaging and Involving Patients, Families, and Staff

Following a patient safety incident, Blakewater Healthcare ensures:

- Open and compassionate communication with those affected.
- Adherence to the Duty of Candour.
- Clear signposting to support services.

7. Patient Safety Incident Response Planning

Blakewater Healthcare responds to incidents in a way that maximizes learning and improvement rather than relying on arbitrary harm definitions. Responses are proportionate and context specific.

8. Resources and Training

Blakewater Healthcare maintains a trained workforce capable of responding to safety incidents effectively. Training and development efforts ensure alignment with national standards and best practices.

9. Our Patient Safety Incident Response Plan

Our plan outlines how we will respond to patient safety incidents over 12-18 months. It remains adaptable to specific incident circumstances and stakeholder input.

10. Reviewing Our Policy and Plan

We will:

- Review and update the policy every 12-18 months.
- Conduct a thorough review every four years, engaging stakeholders and analysing relevant data.
- Publish updated plans on our website.

11. Responding to Patient Safety Incidents

All staff are responsible for reporting any potential or actual patient safety incidents to the Practice Manager or Deputy Manager within 24 hours of the incident and will record the level of harm they know has been experienced by the person affected.

Patient safety incidents will be responded to proportionately and in a timely fashion. This should include consideration of Duty of Candour. If there is an incident these could only require local review within the service, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated to the ICB for support where cross system working can support with a collaborative response.

The Practice Manager will act as liaison with external bodies and partner providers to ensure effective communication and point of contact for the organisation.

12. Patient Safety Incident Reporting Arrangements

Blakewater Healthcare has established clear internal and external reporting mechanisms. All incidents must be reported promptly and reviewed in accordance with national guidance. All incidents will be reported through LFPSE regardless of level of investigation required.

13. Decision-Making

Incident response decisions are:

- Based on the patient safety incident response plan.

- Informed by severity, learning potential, and system impact.
- Made collaboratively with relevant stakeholders.

14. Cross-System Incidents

Where incidents impact multiple organisations, we collaborate with external partners to ensure coordinated learning responses.

15. Timeframes for Learning Responses

Response timelines are determined based on proportionality and learning potential.

16 Safety Action Development and Monitoring Improvement

Learning from patient safety incidents directly informs our safety improvement initiatives. Actions are monitored to ensure meaningful implementation and sustainability.

17. Safety Improvement Plans

Blakewater Healthcare employs:

- Organisation-wide safety improvement plans.
- Service-specific improvement plans.
- Thematic reviews to address broader systemic issues.

18. Oversight Roles and Responsibilities

Oversight of patient safety responses includes:

- Board-level governance ensuring alignment with national safety standards.
- Integration with regional safety networks and NHS partners.
- Continuous review of patient safety data to drive improvements.

19. Complaints and Appeals

Individuals dissatisfied with responses to patient safety incidents may access the formal complaints and appeals process. Relevant documentation and guidance are available on our website.
