NHS
Mildmay Hospital

Patient Safety Incident Response Policy

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1. Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and outlines Mildmay Mission Hospital'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 coordinated 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 the 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

The PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Instead, organisations are now able to balance effort between learning through responding to incidents or exploring issues and improvement work.

2. Other Related Policies and Procedures

- Adult at Risk Policy
- Adult at Risk Procedure
- Being Open and Honest – Duty of Candour Procedure
- Child Protection Policy
- Child Protection Procedure
- Code of Conduct
- Complaints Policy
- Complaints Procedure
- Health and Safety Policy
- Quality Assurance Policy

3. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Mildmay's inpatient services and each of its care pathways.

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 to incidents, therefore, should not focus on the actions of individuals or 'human error', even when these are reported to be 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, coroner's 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.

4. Our Patient Safety Culture

Mildmay Mission Hospital aims to promote a climate that fosters a just culture. This is at the forefront of our hospital's values and underpins the delivery of all our care pathways and clinical services, as well as any new projects which are implemented within our facility.

Mildmay Mission Hospital encourages and supports incident reporting where any member of staff, volunteer or student feels comfortable and able to report actual occurrences as well as near misses, including any incidents which may harm visitors, staff, students, volunteers or contractors as well as the patients who use our service. We aim to promote a transparent and open culture, balancing high-quality care with staff well-being and continuous learning, a key part of Mildmay's ethos. Staff Surveys, staff engagement meetings, Away Days, regular supervisions, a comprehensive training package, an Open-Door culture and access to counselling services and a Speak Up Guardian all promoting the culture of transparency and support.

It is recognised that it is the professional responsibility of all staff at all levels to report incidents and near misses accordingly. However, the management team and supervisors must also promote a safe, blame-free, transparent culture of learning where staff feel able to report and discuss any concerns or untoward events openly. Mildmay aims to promote a culture of continued learning and improvement.

5. Patient Safety Incident Response Planning (PSIRP)

Please refer to the separate ‘Patient Safety Incident Response Plan’ document, for detailed information on Mildmay’s Patient Safety Profile, including national requirements, Mildmay’s local focus, resources allocated to PSIRP as well as Mildmay’s planned response to incidents and the anticipated improvement routes.

6. Oversight Roles and Responsibilities

Mildmay's Board of Trustees is responsible for overseeing the PSIRF for provider organisations. With the support of the Clinical Lead Nurse and Registered Manager, the CEO and Medical Director are responsible for the effective monitoring and oversight of PSIRF. The ‘Responding to Patient Safety Incidents’ section above also describes some of the more operational principles underpinning the approach.

Mildmay recognises and is committed to close working in partnership with the local ICB (Integrated Care Board) and other national commissioning bodies as required. Oversight and assurance arrangements will be developed through joint planning, and arrangements must incorporate the key principles detailed in the guidance above, as follows:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Policy, planning and governance
- Competence and capacity
- Proportionate responses
- Safety actions and improvement

It is important that under PSIRF there is a paradigm shift from monitoring of process, timescales and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients. It should be noted that ICB’s roles will also focus on oversight of PSIRF plans and priorities and monitoring progress with improvements. There will no longer be a requirement to ‘declare’ an SI (Serious Incident) and have individual patient safety responses reviewed and ‘signed off’ by commissioners. However, commissioners will wish to seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety. The metrics, measures and evidence required to do this will need to be defined within the PSIRP for each priority, which will be in discussion with the ICB.

It is recognised that under PSIRF, staff in oversight roles should be inquisitive with sensitivity, be able to apply human factors and systems thinking principles and be able to assess both qualitative and quantitative information from a wide range of sources. They should be able to constructively challenge the strength and feasibility of safety actions in order to improve underlying system issues.

They should also be able to recognise when safety actions following a patient safety incident response do not take a system-based approach.

7. Complaints and Appeals

Mildmay Mission Hospital values feedback on the care and services it provides, recognising that complaints can be as valuable as positive comments since they may highlight areas for improvement. Mildmay emphasises patient experiences as well as clinical and rehabilitation outcomes.

Complaints can be made either informally (usually verbally) or formally (usually written) or via the website - https://www.mildmay.nhs.uk/contact-us.

Complaints, comments and concerns can also be emailed to info@mildmay.org. Alternatively, complaints can be posted to the Registered Manager, Mildmay Mission Hospital, 19 Tabernacle Gardens, London E2 7DZ. The Complaints Policy and Procedures are available upon request and will be made available on Mildmay's website in due course.

8. Board Responsibilities

The ultimate responsibility for ensuring the Patient Safety Incident Response Policy rests with the Board of Trustees, which delegated this Responsibility to the Chief Executive Officer.

The Board will ensure sufficient time and financial resources are available to implement this policy, which will be formally adopted and recorded in the minutes of a meeting of the Board of Trustees.

The Board will review this policy at least every two years.

9. Change History Record

Issue	***Description of change***	***Approval***	***Date***
1.0	Initial issue	Board of Trustees	17/11/2023