PATIENT SAFETY INCIDENT RESPONSE POLICY

Created On	February 2025
Next Review Date	August 2026 or when a change to legislation or guidance occurs. This document remains in force after the Review Date if it has not been replaced.
Related Policies/Procedures	Patient Safety Incident Response Plan
	Health & Safety Policy
	Accidents and Incidents Procedures
	Equality, Diversity and Inclusion Policy
	Safeguarding Policy
	Data Protection Policy
Responsible Function	Quality
Version	2025-1

Organisational Responsibilities

The Board of Directors are responsible for the operational management of Colebrook (SouthWest) Limited's policies and procedures.

The Chief Executive Officer is the designated officer on behalf of the Board of Directors responsible for the implementation of the policies and procedures across Colebrook (SouthWest) Limited.

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Introduction

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Colebrook (SouthWest) Ltd'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.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all Colebrook's services:

- Support Services
    - Supported Accommodation Services
    - On Track
    - Tailor Made Support (TMS)
- Community Engagement Services
    - Healthwatch Devon, Plymouth and Torbay
    - Headspace
    - St Budeaux and Barne Barton Wellbeing hub
    - Community Centres

Our Patient Safety Culture

Colebrook believes in providing services that promote and encourage wellbeing. As a third sector organisation, we believe in a person-centred approach to promote reablement and growth in a safe environment. However, we recognise that we need to use a systems-based approach to quality improvement and patient safety in order to provide a just patient safety culture.

We have created an environment through our operating practices, policies and procedures that encourage and support a culture of safety first in everything we do. Our key documents, Health & Safety Policy, Incidents and Accidents Procedures, Equality, Diversity and Inclusion Policy, Safeguarding Policy, Data Protection Policy and Patient Safety Incident Response Policy, provide the background framework to promote a Just Culture.

An important part of promoting a just culture is recognising that there can be many reasons why things go wrong including availability of information, distractions, equipment and workload, not just "human Error". We ensure that we take a systems-based approach when reviewing incidents rather than looking for blame, which can focus on attributing issues to a person to the exclusion of other factors. This can cause distress for the individual as well as not fully reducing the risk of re-occurrence. We ensure colleague monitoring of reviews and investigations at all stages of the response and improvement processes to avoid focusing on individual acts or omissions and look for any evidence of filtering or censorship.

This is supported by training, monthly team meetings and regular individual staff supervision including discussion of wellbeing, health and safety along with a staff forum, stakeholder feedback and "Your Voice for Quality", our user forum. Our user and staff forums have minutes and actions which highlight any patient safety concerns and proposals for development. These are followed up with support from the facilitating managers and reported back to the relevant Senior Managers to be implemented. They are also discussed at Senior Managers' and Board Meetings.

In addition, we use feedback from staff and patients through questionnaires including responses related to safety first and just culture. This, along with monitoring of patient safety incidents and key performance indicators measuring compliments, complaints and satisfaction levels feed into our Quality Effectiveness Monitoring Tool (QUEMT). The QUEMT is reviewed quarterly by Senior Managers and the Board with any areas of concern, development or improvement highlighted and added to the Risk Register for action and progress monitoring. This leads to further improvement in the patient safety culture through discussion and ownership of the actions at all levels of staff and Board Members. We also use managers', staff and

supervision meetings to promote and encourage open discussion and improved reporting of incidents and managers operate an Open Door Policy ensuring that staff can access a manager for support or to raise concerns at any time.

Patient Safety Partners

Our Patient Safety response is led by our voluntary Board of Directors who oversee the processes and monitor all quality and safety systems. The Board also has a lead on user participation and works with "Your Voice for Quality" to provide the patient voice. Your Voice for Quality is a group of current and former service users who meet regularly with a Board Member and Manager to discuss improvements to the service, organise feedback through questionnaires, comment on developments and review key documents.

We deliver Healthwatch locally and feedback and statistics from them are fed back into Colebrook's Board and Senior Management team

Our Senior Management team will lead on review, investigation and improvement activities with support from service managers, Business and Finance Manager and central seniors for HR and Quality and Governance. This includes feedback and statistics from Healthwatch, which we deliver locally. These activities will feed into the ongoing design and development of our incident response processes.

External Partner Organisations

We work with partners with whom we regularly share best practice including MHM and other mental health service providers, the Plymouth Alliance, Wellbeing Hub delivery organisations, Engaging Communities South West, Citizens Advice and local safeguarding teams. In addition, MHM and Colebrook undertook a joint peer review, which found some areas of patient monitoring and information recording that could be updated. Any findings through these processes are added in to discussion at Senior Manager and Board Meetings as part of incident response monitoring.

Addressing Health Inequalities

A commitment to addressing inequalities and delivering inclusive services is reflected in all our policies and procedures. Our approach to a patient safety incident response aims to:

- Reduce any barriers to involvement
- Support accessibility and meaningful involvement
- Identify areas for improvement that address heath inequalities
- Consider individual client needs in responding to incidents
- Monitor incident reporting considering equality.
- Ensure actions and follow up from incidents consider client risk, characteristics and accessibility needs

Organisational paperwork will include prompts and reflection to support health equalities at each stage.

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.
- an effective patient safety incident response system prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff).

- 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 is essential.
- Engagement with patients, families and staff is important to ensure the full details, experiences and impact of the incident along with understanding any areas of improvement or preferred outcomes are recognised and included in the response.

Colebrook also recognises the PSIRF 9 Engagement Principles:

1. Apologies are meaningful
2. Approach is individualised
3. Timing is sensitive
4. Those affected are treated with respect and compassion
5. Guidance and clarity are provided
6. Those affected are 'heard'
7. Approach is collaborative and open
8. Subjectivity is accepted
9. Strive for equity

Colebrook's approach to engagement, in relation to any incident, will be flexible in the following ways:
Appointed members of staff will

- Arrange to meet with those involved at a time and place driven by the needs and wishes of the patient and staff. Engagement will be led by them.
- Communicate progress and updates via preferred methods of communication, using accessibility services as needed.
- Consider any reasonable adjustments needed to effectively engage the patient
- Offer flexibility and alternatives
- Identify any further support needs or follow up, such as supervision, debrief, counselling, referral to other services, welfare checks.
- Liaise with colleagues and partner agencies to oversee any actions needed.
- Oversee all recording and sign off any action plans.
- Feed outcomes and learning into service and management meetings.

During this process, Colebrook's incident response procedures seek to

- Understand the situation and how those involved are affected.
- Take responsibility for incidents, acknowledging the organisation's role where appropriate.
- Deal with all incidents on an individual basis
- Track and monitor the stages of engagement
- Use our knowledge of individuals, and organisational resources, to promote accessibility
- Communicate progress in a timely way
- Treat everyone involved (and their views) with respect and empathy

These are cascaded within the organisation through staff induction and training at all levels, including training for managers responding to, and resolving, incidents. Management training in dealing with conflict and having difficult conversations supports a sensitive approach.

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

Our Senior Management team will lead the patient safety incident response and will work with their teams to identify staff involved.

A response to a patient safety incident may include a number of people in the organisation listed below alongside their potential capacity, and any training and experience:

Position	Capacity	Training	Experience
Board Oversight	2 hrs monthly	Patient Safety Syllabus, Healthwatch Enter and View, Introduction to Health & Safety for Managers,	CQC inspector, solicitor, Quality Assurance, incident investigation, incident management, incident monitoring, engagement and involvement
CEO – Executive Lead	7 hrs monthly	Patient Safety Syllabus, IOSH Managing Safely,	Quality Assurance, Risk Assessment, patient safety incident shadowing, incident investigation, incident management, incident monitoring, engagement and involvement
Support Services Manager Community Engagement Manager Senior Managers Safety Experts & Incident Reviewers	10 hrs monthly 6 hrs monthly	Patient Safety Syllabus, IOSH Managing Safely, Healthwatch Enter & View, Health & Safety Certificate for Managers, Risk Assessment	Quality Assurance, patient safety incident shadowing incident investigation, incident management, incident monitoring, engagement and involvement
Business and Finance Manager Support Services Quality Assurance Manager Central Senior – Quality & Governance Central Senior – HR	2 hrs monthly 6 hrs monthly 2 hrs monthly 2 hrs monthly	Patient Safety Syllabus, IOSH Managing Safely, Health & Safety Certificate for Managers, Risk Assessment, Working Safely (dependent on role)	Quality Assurance, patient safety incident shadowing, incident investigation, incident management, incident monitoring, engagement and involvement

Service Managers (x5)	6 hrs monthly (x5)		
Staff involved in individual incidents	Our rota team will create individual staff capacity in response to an incident. Capacity will be flexible depending on the needs and involvement of each staff member.		Patient Safety Syllabus, Working Safely

All staff will have awareness of the patient safety incident response as part of their induction. The need for individual training, coaching and shadowing will be considered for staff not previously involved as assessed on a case by case basis. .

The capacity shown above is based on existing time earmarked for activities involved in responding, learning and improving patient experience, health, safety and quality and is a combination of fixed and flexible time to allow for ad-hoc demands. We ensure that cross-training across roles and responsibilities adds to this flexibility with dynamic re-distribution of staff in response to need whilst continuing to deliver other services. This ensures that we have the capacity to respond quickly to any internal needs of a response as well as ensuring we have the ability to participate in any multi-agency response and build any learning into our improvement plans.

On average 11 hours of time is used per incident in investigation and review and 27.5 hours in improvement.

Colebrook's incident procedure forms part of staff's induction and mandatory organisational training. Management competency in incident response occurs through tailored training and coaching from more experienced staff.

Learning from incidents occurs at team, management and Board level through our organisational monitoring.

Our Patient Safety Incident Response Plan

Our plan sets out how Colebrook (SouthWest) Ltd intends to respond to patient safety incidents over a period of 12 to 18 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.

The plan can be accessed here Key Policies – Colebrook

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 to 18 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 to 18 months.

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

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our 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 (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to Patient Safety Incidents

Patient Safety Incident Reporting Arrangements

All patient safety incidents must be reported to the Line Manager within 24 hours of the incident. They should then be reported to the Service Manager and Central Team within 72 hours.

Further to this any incident resulting in death, life threatening or life altering injuries, along with other never events must be reported immediately to Senior Managers and CEO, who will in turn inform the Chair of the Board of Directors at the earliest opportunity and within 24 hours.

At this stage the appropriate proportionate response to the incident and any need for external reporting will be identified and actioned. When considering a proportionate response, we recognise that not every incident involving moderate or more severe harm will need an individual learning response to inform our improvement work.

Patient Safety Incident Response Decision Making

The initial decision making within the patient safety incident response lies with the line manager and / or Service Manager. Emergent issues not covered within the patient safety incident response plan will be discussed with the Senior Manager and resources allocated from within those identified in the resources section.

Emergent issues are identified through our organisational quality monitoring reviewed at quarterly intervals by senior managers and Board, or outside of that, as identified. These discussions will consider the need for an organisational response outside of the individual incident response and allocate priority and resources accordingly.

Responding to cross-system incidents/issues

Most of Colebrook's involvement supporting patient safety incident responses have been as part of a cross-system approach to learning, contributing our organisational experience to understand a situation.

Service managers responding to incidents are best placed to recognise or respond to requests for involvement in cross-system learning, identified as part of our incident monitoring procedure.

Timeframes for Learning Responses

Timeframes will be agreed by the Senior Management team and reviewed on a quarterly basis.

Safety Action Development and Monitoring Improvement

Safety actions will be monitored on a quarterly basis by the Senior Management team in conjunction with the Board of Directors as part of the quality improvement process for the Organisation.

Safety Improvement Plans

Patient Safety improvement plans will form part of the QUEMT. This system provides a quarterly review of quality improvement across the organisation and informs and updates the Risk Management process including the Risk Register.

Oversight Roles and Responsibilities

Colebrook's PSIRF executive lead will be Vicky Shipway, CEO, with responsibility for liaising with the ICB. Oversight will be provided by the Board and the Senior Managers are our Safety Experts. The Senior Management team will be responsible for liaison with individual commissioners as detailed in the relevant contracts and following existing communication channels.

Reviews will be signed off by the CEO, following review by the Board.

Complaints and Appeals

The process for complaints and appeals relating to the Organisation's response to patient safety incidents follow Colebrook's Complaints Policy and Procedure, which is available here Key Policies – Colebrook

Implementation, Monitoring and Review of this Policy

The Chief Executive Officer has overall responsibility for implementing and monitoring this Policy, which will be reviewed regularly following its implementation and additionally whenever there are relevant changes in legislation or to our working practices. Any queries or comments about this policy should be addressed to the CEO.