PATIENT SAFETY INCIDENT RESPONSE POLICY and PLAN

Author Title	Emily Taylor, Clinical Governance Manager Daniel Boden, Clinical Governance Lead
Board Sponsor Title	Simon Shepherd, Chief Operating Officer
Date of Issue	Final Working Document June 2024
Review date and frequency	Every 6 months From Issue Date, for a period of 3 years, then once per annum.
Owner Title – Contact for Review	Daniel Boden, Clinical Governance Lead.

Amendment /Version History

Version No:	Date	Details of change made	Amendment made by name and role title
1.	January 2024	New Policy	Emily Taylor, Clinical Governance Manager
2.	April 2024	Updated and Re-viewed	Daniel Boden – Clinical Governance Lead
3.	June 2024	Minor additions following review by Lead Commissioner.	Daniel Boden – Clinical Governance Lead

Consultation and Ratification of Policy

Version No.	Date	Person/Group consulted on during development /amendment:	Committee Ratifying Document:
1.	January 2024	Clinical Governance Leads, Director of Clinical Services, Hospital Directors, Chief Medical Officer, Clinical Director of Outpatients, Chief Operating Officer, Policy Committee Group.	Policy Committee
2.	May 2024	Clinical Governance Leads, Director of Clinical Services, Hospital Directors, Chief Medical Officer, Clinical Director of Outpatients, Chief Operating Officer, Policy Committee Group.	Policy Committee

Table of Contents:

1.0 Introduction:

This policy and plan supports the requirements of NHS England's Patient Safety Incident Response Framework (PSIRF) and sets out SpaMedica'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 and will be continually reviewed and updated during SpaMedica's "Learning from Patient Safety Events" (LFPSE) journey.

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 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.

PSIRF is not a prescriptive set of rules, defining how incidents should be investigated and responded to. PSIRF is a framework which promotes a movement away from a reactive and bureaucratic approach to patient safety to a more proactive and flexible position, encouraging continuous improvement in both quality and safety.

2.0 Purpose:

The purpose of this policy is to set out SpaMedica's overarching approach to the Patient Safety Incident Response Framework. This policy will describe the key principles associated with PSIRF, the duties and responsibilities of key stakeholders, and will give reference to SpaMedica's governance and wider Patient Safety Strategy.

This policy is not intended to be all encompassing and there are several supporting policies, standard operating procedures and documents which ought to be considered in conjunction with this policy. Please refer to the list of references at the end of this document for a list of other relevant documents for consideration.

This policy should ensure that all SpaMedica colleagues working across the organisation:

- Understand the new approach set out by NHS England within the PSIRF.
- Receive training appropriate to their role to ensure that they are able to apply the principles of PSIRF to their daily duties and responsibilities to protect, promote and improve patient safety.
- Understand and adhere to SpaMedica's Patient Safety Incident Response Plan (PSIRP).

- Report patient safety and learning events or any issues relating to safety appropriately, regardless of severity of harm caused to a patient or patients to enable SpaMedica to identify key themes and trends, using thematic analysis to establish event causation and link to quality improvement.

- Ensure patients and their families are fully involved and are at the center of all investigations and learning review process and to ask them what they think about the service and care they have received from SpaMedica.

3.0 Scope:

This policy applies to all SpaMedica colleagues, regardless of employment status, and who are performing a role that relates to the provision of clinical services.

This policy should be applied to all patients of SpaMedica, regardless of the type of service the individual patient is accessing, the circumstances of their referral, or the methods by which they access treatment. Responses under this policy follow a systems-based approach, namely the Systems Engineering Initiative for Patient Safety (SEIPS). This recognises that patient safety is an emergent property of the healthcare system, and that safety is provided by interactions between components, not from a single component. Said components being SpaMedica's work systems, processes, and outcomes. 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. However, considerations are given to human factors theory and methodology.

4.0 Exclusions:

There is no remit to apportion blame or determine liability, preventability, or cause of death in 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 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.

5.0 Definitions

SpaMedica's Patient Safety Incident Response Framework (PSIRF):

Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

SpaMedica's Patient Safety Incident Response Plan (PSIRP):

This document describes how SpaMedica intends to respond to patient safety incidents and learning. Including the methods to be applied and rationale of the same. The PSIRP document:

- Demonstrates thorough Monthly, Quarterly and Annual analysis of relevant organisational data – Thematic Analysis of all Patient Safety, Learning and Experience Measures.

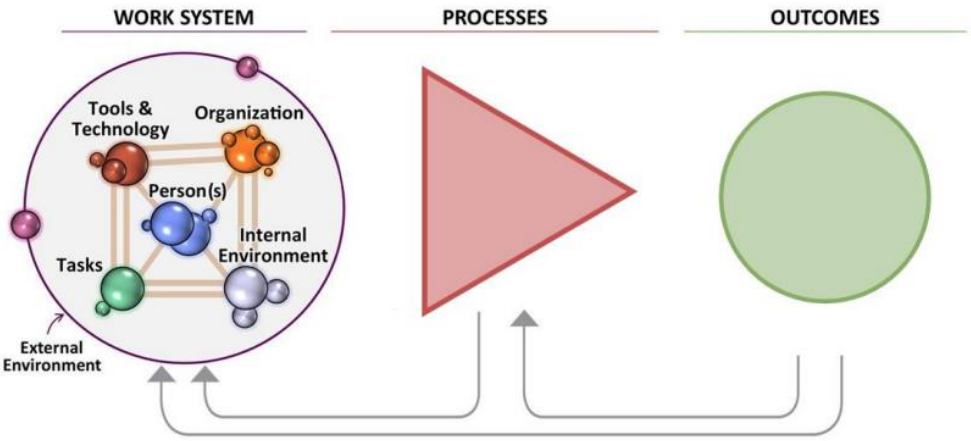
- Demonstrates a collaborative SpaMedica stakeholder engagement process supported by Patient Safety Partners

- Provides a clear rationale for the response and operational delivery to each identified patient safety incident type supported by a patient safety and learning investigation tool kit.
- The PSIRP/P will be updated as required and in accordance with emerging intelligence and improvement efforts.

Systems Engineering Initiative for Patient Safety (SEIPS):

A framework to help us understand outcomes within complex socio-technical systems, like healthcare. SEIPS offers a range of tools that can help an investigator to understand why things happen.

Figure 1. Overview of the SEIPS framework



Human Factors:

A multidisciplinary field that focuses on understanding human capabilities, limitations, and behaviors to optimise the design of systems, products and environments. It is also known as human factors psychology and human factors engineering. Human factors principles refer to the study of how people interact with their environment and the tools and systems within it. This includes the relationship between people, their equipment, the environment they work in and their duties and responsibilities. Human factors considerations include learning styles, behaviours, tendencies, values, leadership, and teamwork.

Patient Safety and Learning Events:

Patient Safety and Learning Events are any unintended or unexpected incidents which could have, or did, lead to harm for one or more patients receiving or accessing healthcare.

Learning from Patient Safety Events (LFPSE):

A new national NHS database and service for the recording and analysis of patient safety events that occur in healthcare. Healthcare providers are required to implement systems which allow for their patient safety and learning events to be uploaded and reported to the LFPSE service for national data analysis and review. This data informs national Quality Improvement initiatives.

InPhase:

InPhase is the electronic Risk Management and Patient Safety and Learning system which SpaMedica uses to document, report, and investigate patient safety and learning events. The system is LFPSE accredited, SpaMedica have adopted the following modules from InPhase: Patient Safety Events, Feedback [Patient Experience], Board Assurance Framework, Policy Management, and Requests for Information.

Just Culture:

The fair treatment of SpaMedica Colleagues supports a culture of fairness, openness and learning by making all colleagues feel confident to 'Speak Up' when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated. Weblink - NHS_0932_JC_Guide_A3 (england.nhs.uk)

Health Inequalities:

Unfair and avoidable differences in health across the population and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

Board Assurance Framework (BAF):

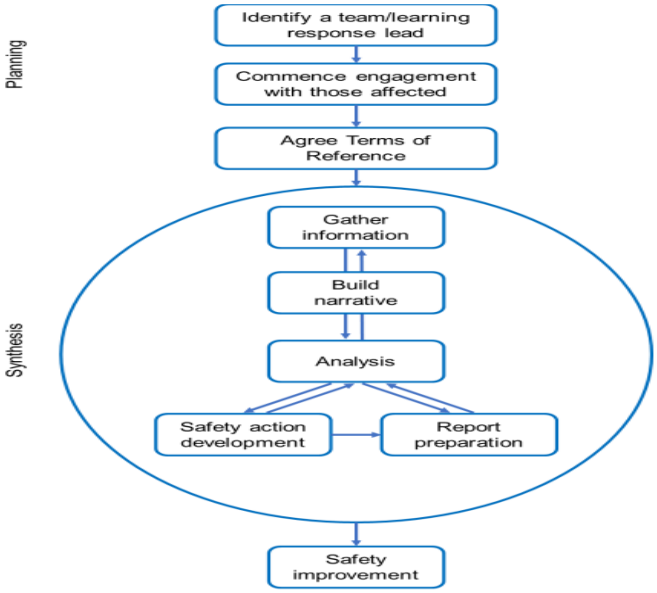
A Framework that brings together all relevant information relating to known or potential organisational risks and is used to support the SpaMedica Board to identify and manage risks and appropriate action is being taken to mitigate them.

Safety Action:

A safety action is an action or improvement taken to reduce the risk of harm reoccurring and improve, increase and sustain the overall level of safety for patients and staff within the organization and within the wider healthcare system.

Patient Safety Incident Investigation (PSII):

A process undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. The PSII process involves numerous stages, **including identifying a team/learning response lead,** engaging with those affected, fathering information, building a narrative and analysis. Once analysis is completed, safety actions can be developed, and this will in turn lead to safety improvement and continual improvement of clinical services.



6.0 Duties and Responsibilities

Roles

Chief Executive Officer:

Is responsible for ensuring there is an organisationally consistent approach to patient safety, learning and quality improvement in line with NHS England policy and standards and that there is a designated Board sponsor for Patient Safety with sufficient **Teams in place to lead and support compliance.**

Chief Operating Officer:

The Chief Operating Officer is the Executive Lead for the PSIRF, Plan and Policy. They are also the responsible and accountable person for Quality and Patient Safety across SpaMedica.

They are also responsible for:

- Ensuring that SpaMedica meets the requirements of the national patient safety incident response standards, and that robust systems and processes are in place to ensure these requirements are maintained.

- Ensuring that the PSIRF is integral to, and informs the organisations overarching safety and governance arrangements, including the requirement for annual overall compliance relating to the PSIRF reporting, response data, is to be presented to the Board on a Quarterly and Annual Basis.

- Ensuring that designated roles are identified/created training, processes accountabilities and responsibilities of colleagues are in place to support an effective organisational response to patient safety, learning and Quality Improvement.

- Ensuring that learning response outputs are quality assured and fully ratified before being shared externally to the organisation.

Director of Clinical Services:

The DCS is the Senior Responsible Officer and National Patient Safety Specialist for SpaMedica. The National Patient Safety Specialist is dedicated to providing expert support to the organisation and is expected to have direct access to the Executive Team, which facilitates the escalation of patient safety and learning issues or concerns. They also play a key role in national and local implementation of the NHS Patient Safety Strategy, supporting the development of a patient safety culture, safety systems and quality improvement activity.

Clinical Governance Leads:

The CGL's perform the role of Regional Patient Safety Specialists within SpaMedica. They lead and support the local implementation of the NHS National Patient Safety Strategy, lead and support patient safety 'insight,' 'involvement' and 'improvement' activity. They ensure that systems-based thinking, Human Factors understanding, and Just Culture principles are embedded in all patient safety processes.

Patient Safety and Experience Lead:

The PSEL is responsible for identifying, managing and escalating local, regional and national themes and trends relating to Patient Safety, Experience and Learning Events to the Clinical Governance Leads as required or on a Monthly, Quarterly and Annual basis They ensure that submissions to LFPSE are valid, accurate and in keeping with our PSIRF Policy and Plan. They support Local and National Patient Safety Investigators and Supervisors by overseeing the application of SEIPS methodology, Human Factors principles, in addition to the overarching quality of Patient Safety and Learning Event Investigations, outcomes and actions.

The Patient Safety Lead, supported by the Clinical Governance Manager is to embed the PSIRF and engage those affected by Patient Safety events in the process of learning. They are responsible for the design and configuration of the Learning Events and Feedback module of the InPhase reporting system.

Clinical Governance Manager:

The Clinical Governance Manager has responsibility, supported by the Patient Safety and Experience lead in collating Monthly data of national themes and trends arising from patient safety events, experience, audit and clinical effectiveness and Medico-Legal claims and presenting these to the Monthly Learning From Patient Safety and Quality Improvement Group. The Clinical Governance Manager will ensure all learning and datasets are shared and discussed at all relevant committees and meetings such as Medication Management Committee, Health and Safety and Infection Prevention and control.

Supported by the Director of Clinical Services and wider Clinical and Quality Improvement teams review, develop and ensure that PSIRF and Policy are embedded across The Patient Safety Manager acts as operational owner of risk pertaining to any patient safety, experience or other related risks on the Corporate Risk Register.

Patient Safety Administrator:

The Patient Safety Administrator supports the wider Clinical Governance Team in achieving their objectives of excellent clinical quality and patient safety. They support the administration of the Learning from Patient Safety Events and Quality Improvement Committee, and InPhase including: the management of clinical documentation such as policies, SOPs and Investigation Templates,

supported by the Patient Safety and Experience Lead, oversee the management of user access to the system, and oversight of the validity and appropriateness of submissions made to NHS England through LFPSE.

Data Protection Officer:

The Data Protection Officer is the module owner for Requests for Information on InPhase. They are responsible for establishing and maintaining a standard practice, and assurance process relating to the management of Information Security related Learning Events and has overall responsibility for the reporting and escalation of these incidents to relevant external bodies such as the Information Commissions Office.

Hospital Directors:

Responsible for ensuring that Area Managers, Hospital Managers and related operational teams are sufficiently resourced to attend the necessary training and remain compliant with the national PSIRF and local PSIRP and to promote a consistent positive culture relating to patient safety, openness and transparent ways of working. Hospital Directors are responsible for managing performance and quality issues relating to non-compliance.

National Patient Safety and Learning Investigators/Team:

The National Patient Safety Investigators are the persons who are identified as the lead investigator or team, relating to patient safety and learning events as agreed and directed by the organisations Learning from Patient Safety Events and Quality Improvement Committee.

The National Patient Safety and Learning Investigators, supported and directed by the organisations LFPSE and QI Committee are responsible for investigating and managing overall responses to key Patient Safety and Learning Events where the value in learning, regardless of harm has been identified as requiring a level of review. The National Patient Safety and Learning investigators will, with support from the overarching committee agree scope of investigations, investigations tools and methodologies to be used.

Regional Patient Safety and Learning Supervisors:

They are responsible for overseeing the daily and operational management of all patient safety and learning events within their scope of employment and to ensure Local Patient Safety leads are compliant and aligned to policy and process. They are required to ensure that they are familiar with SpaMedica's internal and external reporting requirements and managing patient safety and learning events in line with these responsibilities.

Regional Patient Safety and Learning Supervisors must ensure that individual responses to patient safety events are proportionate, based on the individual event or events. This includes thematic analysis of local learning events, robust and evidential system and process relating to Quality Improvement and Grouping, Theming and Trending of learning events and that they are linked to National Quality Improvement Drivers and workstreams.

All Patient Safety and Learning Events where Moderate Harm and Above or aligned to National Frameworks such as Never Events are required to be escalated once identified.

They are responsible for reviewing, quality assuring and approving local investigations They must ensure that local Patient Safety Investigators are appropriately trained and supported, and are managing themes and trends in events appropriately, proportionately and in line with this policy.

Local Patient Safety and Learning Investigators:

They are responsible for the daily and operational management of all patient safety and learning events within their scope of employment. They are required to ensure that they are familiar with SpaMedica's internal and external reporting requirements and managing patient safety and learning events in line with these responsibilities.

Patient Safety Investigators must ensure that individual responses to individual patient safety events are proportionate, based on the individual events are appropriate. This includes thematic analysis of local learning events, robust and evidential system and process relating to Quality Improvement and Grouping, Theming and Trending of incidents that are linked to Quality Improvement Drivers.

All Patient Safety and Learning Events where Moderate Harm and Above or aligned to National Frameworks such as Never Events are required to be escalated once identified.

All SpaMedica Clinical Colleagues:

All SpaMedica Clinical Colleagues are required to engage in all patient safety and learning event reviews, where required, and to provide their individual clinical expertise to support non-clinical leaders in their investigations where necessary.

All SpaMedica Colleagues:

All SpaMedica Workers are responsible for engaging in all patient safety and learning event reviews and complete actions assigned to them. They must provide recollections and material input into reviews where requested by the lead investigator.

They are also responsible for reporting any patient safety and learning event that they become aware of, whether that be an incident, risk, outcome, or good care example.

Committees and Meetings:

- National Learning from Patient Safety Events and Quality Improvement Committee – Group
- Weekly LSPSE Review – Operational
- National Clinical Governance Committee
- Policy Committee
- Clinical Effectiveness Group Meeting
- Hospital Manager Update Meetings
- Risk, Health and Safety Committee
- Risk Assurance Committee
- Medicines Management Committee
- Infection Prevention and Control Committee
- Medical Advisory Committee

7.0 Implementation:

7.1 Our Patient Safety Culture:

SpaMedica recognises the importance of patient care, safety, and satisfaction. Our company-wide values are Safety, Integrity, Kindness and Transparency. SpaMedica promotes a positive patient safety culture by embedding the principles of a just culture and promoting psychological safety throughout our ways of working.

Principle:	**What this means:**
Fair Treatment	Treated with kindness and empathy when a patient safety event occurs.
Appropriate and Timely fulfillment of Duty of Candour	Told the truth about what is known at the time the event is recognised, and appropriately informed about our patient safety incident response processes.
Engaged with Responses	Are encouraged to be fully involved in the response/review process if they choose to be, with their thoughts, viewpoint and concerns built into the response plan and improvement plans.
Transparency of Written Responses	Are allowed to read, in full, any written responses to the incident, gathered as part of the response.
Material Contributions to learning outputs	Encouraged to contribute to any actions which could improve safety where the learning response shows that these are required.

Developing a Just Culture:

SpaMedica promotes a climate that fosters a just culture by: -

- Sharing key safety learnings across a variety of channels, including employee newsletters, governance meetings and the company forum.

- Routinely carrying our national hospital peer review program which gathers feedback from hospital staff and patients on patient safety culture, leadership, effectiveness, and responsiveness at each of our hospital sites.
-
- Ensuring our teams have access to quality patient safety and experience training which is in keeping with national standards and guidelines, and prioritising this as a mandatory requirement for all staff members.
-
- Have appointed Clinical Quality Leads who have responsibility for developing best practice standards for all aspects of the SpaMedica patient journey, and who review clinical training standards to ensure our staff are supported and are equipped to meet clinical competencies.

- Hold a regular clinical effectiveness group meeting, chaired by the Chief Medical Officer which aims to ensure that learnings and actions taken from patient safety and learning investigations are rolled out nationally, as standard practice.

- Our Learning from Patient Safety and Experience System [InPhase] is designed to ensure that there is a focus on systems-based learnings rather than placing blame on an individual staff member.

7.2 Open and Transparent Reporting:

SpaMedica understands that without open and transparent reporting, we do not have an accurate viewpoint of the themes and trends in both the types of patient safety and learning events that are reported, but also the learning outputs, and improvement actions which arise from the reporting and investigating of those events.

At SpaMedica, we promote open and transparent reporting by allowing any member of staff to report a patient safety or learning event. Staff can report by completing our Anonymised Incident Form, hosted via InPhase. This form can be accessed on any device, both professional and personal either by clicking the link, which is available as standard on their personal desktop, visiting the webpage of the online form, or scanning one of the incidents QR codes available in staff only areas of our hospitals. The form is interactive, easy to use and does not require any log-in details for a reporter to gain access.

SpaMedica's Clinical Governance Team and Patient Safety Specialists are accessible to all staff for advice, guidance, and support. There is a 24/7 Management on-call process, where there are two senior Managers on call for all teams. Our Operational and Clinical Governance Teams review Patient Safety, Learning and Experience themes and trends on a daily, monthly quarterly and annual basis. key data such as the total number of reports made at different locations and within different departments across the business, theme, trend or individual events that have value for learning identified as to proactively mitigate an event from occurring.

7.3 Patient Safety and Patient Safety Partners:

NHS England and Don Berwick 'Creating 'patient safety partners' (PSPs) is, we believe, the right way to make real, for when "patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of trusts." Where Patient Safety and Quality Improvement Partners can support with the development of the three strategic aims supporting the development of both the SpaMedica Patient Safety Culture and Patient Safety Systems and to support the National Patient Safety Strategy. The three key aims are.

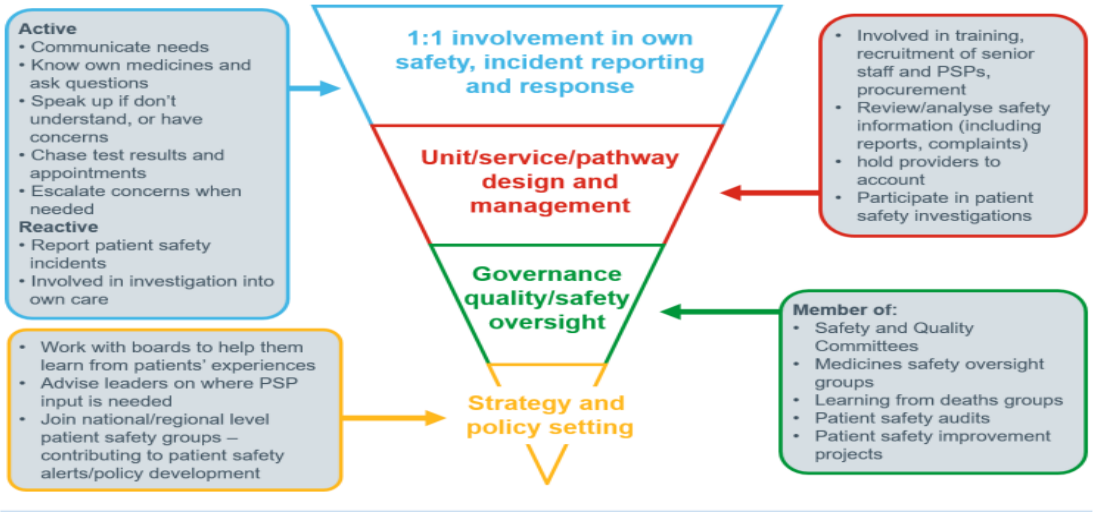
a) Improve SpaMedica understanding of safety by drawing intelligence from multiple sources of patient safety information **(Insight)** – Move from NRLS to LFPSE, PSIRF [different tools to support investigations] and to share wider insight from medical legal claims/triangulation of patient safety and other quality information/learning.

b) To equip SpaMedica patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system **(Involvement)** – patient safety training and safety syllabus, appointed patient safety specialist roles/networks and ensure a whole system approach that is joined up, and fully engaged in the wider patient safety agenda.

c) To design and support SpaMedica programmes that deliver effective and sustainable change in the most important areas **(Improvement)** – National Quality Improvement programmes and drivers such as improving health access and outcomes for individuals with Learning Disabilities and or Autism that migrate to all organisations, build on key Quality Improvement drivers/workstreams and organisational resilience to Quality

Improvement with established 'Test of Change' to ensure change has been adopted and sustained.

Involvement – Patient Safety and Quality Improvement Partners:



Potential roles within SpaMedica for Patient Safety and Quality Improvement Partners

Patient Safety & Quality Improvement Partners will be actively engaged within the following:

- **SpaMedica Service and pathway design.** Patient Safety and Quality Improvement Partners will be involved in service and pathway design, even if it is not always practical for them to be involved. If patient representatives identify patient safety concerns, accessibility of service or any EDI concern then they may seek advice from a PSQIPs on how to address this with relevant staff members in the service redesign team.

- **SpaMedica Safety governance**. PSQIPs can contribute and add value to safety governance by, for example, sitting on relevant committees to support compliance monitoring, responding to safety issues, reviewing data and reports, and providing appropriate challenge to ensure learning and change. NHSE believe PSQIPs will be most effective where there are at least two whom sit on key safety committees together to provide peer support.

- **SpaMedica Strategy and policy**. PSQIPs could ensure patients' perspectives are considered and provide valuable insights on the risks to patients; for example, where transitions in care and integration of care pathways are being considered. PSP skills PSPs should have knowledge and understanding of patient safety issues. Once appointed all PSPs should receive training based on the national patient safety strategy.

Support for SpaMedica Patient Safety and Quality Improvement Partners:

- Appointed a National Patient Safety and Quality Improvement Partner lead who will act as main point of contact for all partners and ensure 1.1 coaching, support, education, development, and training is in place.

- Designated Regional Support provided by Regional Clinical Governance Leads who also act as regional Patient Safety Specialists.

- Develop a National Patient Safety and Quality Improvement Partner Forum, to be chaired by a nominated Partner for all Patient Safety and Quality Improvement Partners across the organisation.

- Review all Patient Safety and Quality Improvement Partner contracts every 12 months to ensure all parties are happy to proceed for a further 12 months, or to allow an opportunity for Patient Safety and Quality Improvement Partners to standdown from their role if they so wish.

7.4 Addressing Health Inequalities:

SpaMedica is committed to addressing Health Inequalities and ensuring all services, and sites are accessible as possible and informs the overarching organisational objective, and strategy when extending the provision of Ophthalmic Services across the country. Specific actions that SpaMedica are taking to address health inequalities include:

- Developing an overarching organisational patient Equality, Diversity, and Inclusion strategy.
- Building an overarching Quality Improvement workstream regarding Health Inequalities that drives improvement activity.
- Fostering and creating local, regional, and national stakeholder relationship initiatives to link in with National Charites, Key Advocates, Patient Support and Advisory Groups and wider to identify and address any unknown organisational barriers that may inadvertently prevent or restrict accessibility of service.
- Promote and welcome patients with specific lived experiences to test and review our services on a regular basis to ensure that fully meet their needs.
- Ensuring key demographic representation via our Patient Safety Partner platform.
- Launched key ‘Clinical Hubs’ with adapted facilities and services that directly support patients with additional needs to enable them to access services provided by SpaMedica.
- Ensuring, Dementia, Learning Disabilities and Autism training is provided to all staff, including best practice around reasonable adjustments, accessible information, capacity, consent and best interest decision making.

7.5 Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident:

The PSIRF recognises that learning and improvement following a patient safety event can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves 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 as required.

PSIRF has openness and honesty at its heart, and this aligns with SpaMedica’s values of honesty and integrity. When a patient safety incident occurs, it is vital that those involved or affected by the incident are appropriately engaged and communicated with. SpaMedica recognises that no

two patients are the same, and every patient/relative/carer that we come into contact with has a different background, belief system and morals. As such, a standardised method of communicating with and involving persons affected by patient safety events cannot be put into place. However, we can collaborate with those persons affected to agree a personalised and tailored plan for their involvement in our response following the realisation that a patient safety event has occurred.

SpaMedica is developing a detailed PSIRP which includes designated guidance on how we promote openness, honesty and transparency with patients, their families and our staff members throughout a patient safety incident response. This plan will set out a minimum standard for ways in which we will promote engagement with our responses, including: -

- Standard processes, templates and literature on Duty of Candour.
- Standardised investigation templates and tools which cover the involvement of persons affected by the event, throughout the entire response process.
- Agreeing terms of reference for investigations with the persons involved.
- Including any questions or desired outcomes which are expressed by the persons involved, within the incident response.
- Agreeing communication methods with persons involved.
- Agreeing an appropriate timeline for the response.

SpaMedica will also produce literature aimed at all persons who have been affected by a patient safety event, which will cover: -

- What our responses to patient safety events are.
- What support is available to the people affected.
- How individuals and their relatives/carers can be involved in our responses to the event.
- Guidance on how the processes we follow can be tailored to suit their individual desired outcomes and objectives.

8.0 SpaMedica Patient Safety Incident Response:

The National PSIRF supports organisations to respond to patient safety and learning events and safety issues in a way that maximises potential in learning and to allow time and resource to be focused on Quality Improvement, and ensuring learning is embedded rather than basing responses on arbitrary and subjective definitions of harm.

Beyond nationally set requirements, organisations can explore patient safety and learning events relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

Some events in healthcare require a specific type of response as set out in policies or regulations. These responses may include mandatory patient safety incident investigation (PSII) which are required in some circumstances, depending on the nature of the event. Those circumstances are outlined below.

8.1 Nationally Mandated PSII Reporting:

Event:	Action Required:
Deaths thought more likely than not to be due to problems in care (incidents meeting the learning from deaths criteria for PSII)	It is very unlikely to occur in services provided by SpaMedica. However, if they did occur, these would be investigated Nationally by an assigned lead or team and reported via PSII .
Incidents meeting the Never Events criteria	Never Events would be investigated Nationally by an assigned lead or team and reported via PSII.
Deaths of Persons with Learning Disabilities	It is very unlikely to occur in services provided by SpaMedica. However, if they did occur these would be investigated Nationally, and the organisation would align to learning disability mortality review process and report via a PSII.
Safeguarding Incidents in which: - Babies, children or young people are on a child protection plan; looked after plan or a victim of willful 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 FGM, PREVENT, modern slavery, human trafficking or domestic abuse/violence.	These events would be referred to the national safeguarding lead and investigated at national level and reported through the relevant channels or reported via a PSII.
Candour and Formal Duty of Candour:	All Patient Safety Events or Events where Moderate Harm has been assigned and attributed to care, service or delivery of care provided by SpaMedica remains a legal responsibility and duty that is required to be discharged. The three stages of DOC: 1. **Initial Verbal Apology -** and conversation with the patient, partner of representatives [With Consent from the patient where appropriate] to ensure full understanding of next steps, how the patient would like to be involved in the investigation and what format [Consider Reasonable Adjustments and Accessible Information] they would like the outcome to be shared, including face to face. 2. **Written Response** – a clear written Duty of Candour Letter outlining and agreeing all points, as outlined, and agreed during verbal apology.

	3. **Sharing of Investigation Response** - Documented evidence that investigation outcomes have been shared as outlined in points 1 and 2. **Candour:** Any Patient Safety Events where No Harm or Low Harm is attributed to any aspect of care, service or delivery of care on behalf of SpaMedica all patients need to be informed and conversation clearly written in patients clinical notes or within InPhase.

8.2 SpaMedica Operational Delivery and Oversight of our Patient Safety Incident Response Plan:

Other than the above, the PSIRF does not set out any further national rules or thresholds to determine what method of response should be used to support learning and improvement and can be managed and agreed by each individual provider of NHS contracted care. Therefore, SpaMedica Patient Safety Incident Response Plan [PSIRP] is outlined below with key aims of.

a) To ensure and provide an objective and balanced effort between learning through responding to incidents or exploring issues.

b) Daily operational management of Patient Safety and Learning Events.

c) Local, Regional and National operational oversight and management of Patient Safety and Learning Events.

d) Clear systems and process in place relating to thematic analysis and data interrogation of all Quality, Safety data and outcomes linked to Monthly, Quarterly and Annual Quality Reporting and drivers of Quality Improvement Activity.

Operational Management of Learning Events and Experience:	Aims/Objectives:
All Learning and Experience Events to be Reviewed, Quality Assured with a focus on compliance with National LFPSE requirements and each event proportionally managed and investigated and aligned to an event via InPhase: **Key Questions:** 1. Overall has there been any Harm caused because of the event ?. 2. Have we discharged Duty relating to Candour? 3. Do we need to discharge our Duty relating to Formal Duty of Candour for all events Moderate Harm and Above? 4. What Statutory Reporting Applies? 5. Is there any identified learning that that has not already been identified/learnt or is that the learning? 6. If People and Culture – HR Process, If Legal – Legal Process If mortality, coroner. 7. Celebrating Excellence – normal process **[All Safeguarding Events are to be managed in line with Safeguarding Policy and Process]**	General incidents 'Low Level of Learning' can be operationally managed and closed in a timely manner thus reducing focus and operational burden of daily management – proportionate level of investigation based on event – Focus on Improvement. Identify clear and concise event causation, drivers, contributory and human factors from a Systems and Process review. Clear Quality Improvement projects, linked to identified and assured incident causation learning that enables clear tangible and demonstrable links to evidence/Risks. Thematic Analysis and oversight at all levels across the organisation from Hospitals to Board, and from Board to Hospitals. A joined up and inclusive response to Safety and Learning that fosters an open and safe culture. Key focus on **Significant and New** Learning that enables proportionate levels of investigation based on event/s to ensure new learning and improvements are identified and the focus being on sustained improvement. Triangulation and agreement of appropriate investigation model and reduces risk of overlap.
All Patient Safety and Learning Events, to be Quality Assured, triangulated [is the event Patient Safety? Experience? Medico Legal? Other? Maybe aspects of all? All **Nr Misses**, **No Harm** and **Low Harm** Events/Cluster review where no significant value in **new** learning has been identified must be **Reviewed, Actioned as required then Grouped, Themed, Trended, Closed, and linked to Quality Improvement Plan** – Link to QI plan to be saved in InPhase and Investigation summary to include Annually Agreed Project Stance for Each' and closed. for example: ***'This event has been Quality Assured, no/low harm, no identified new learning and has been linked to our 2024/2025 Quality Improvement Project relating to, for example, Cancellations, as to inform local and national learning.*** All Patient Experience Reviews – align to wider learning investigations and key Quality Improvement workstream/s created – Patent Experience – please refer to SpaMedica Complaints and Concerns Policy. Any Individual or Cluster learning outcomes where new and significant learning has been identified requires initial post event huddle and escalation via Regional and National Clinical Governance, Operational and Patient Safety and Experience Lead.	

8.3 Specific Investigation Methods/Tools:

Within our PSIRP, SpaMedica have established what is believed to be an effective method of investigating and responding to patient safety and learning events, irrespective of the severity of harm caused by the event, identification of themes or trends in the type or event which has occurred and the calculated risk of recurrence and likelihood of harm. This allows SpaMedica to choose very specific patient safety incidents which have occurred the most frequently to investigate in greater depth, even if they have caused no or low harm.

There are National Learning Response methods set out by PSIRF, these methods fit best with types and categories of incidents. Ultimately, it is the responsibility of the Lead Investigator to assign what they feel is the most appropriate learning response method for any individual incident. However, SpaMedica has set out guidance to encourage a standardised methodology so that learning outputs and actions can be easily tracked across all locations and areas of the business. The four National Response Methods are set out below: -

Investigation Response Method:	**Description:**	**Roles and Responsibilities:**
Patient Safety Incident Investigation (PSII) **[Replaces Historical RCA Report Process]**	Offers an in-depth review of a single patient safety and learning event incident or cluster of incidents, as to understand what happened and how.	For use where a national or mandatory response is requested or required. **This will be directed and agreed by the National Learning from Patient Safety Events and Quality Improvement Committee** For example when a Never Event has occurred or event or events where there is significant learning identified. This process will also include nominated Patient Safety and Quality Improvement Partners.
Post Incident SWARM:	Designed to be initiated as soon as possible after an event and **involves all the team or persons involved within the event or as an MDT** where an open discussion using methods of appreciative enquiry are used. **Key Aims:** • Gather information about what happened. • Why the event happened [Thinking SEIPs/Human Factors/Technology]. • Gather insight from other sources wherever possible. • Agree immediate Patient Safety Actions. • Agree how the outcome of the SWARM and or subsequent wider review	**To be used by ALL SpaMedica Colleagues Responsible for undertaking Patient Safety and Learning Reviews across the organisation.** General SWARM document/ Methodology to be used for investigating all Incidents across SpaMedica. *[Staff Statements and Reflective Practice are **NOT** to be used within the Patient Safety review process as an evidence base].* Specific SWARM documents are to be used relating to known national SpaMedica safety issues such as. • **Endophthalmitis SWARM** • **Cannula Detachment SWARM** • **Post Falls SWARM** • **Code Blue Events SWARM** • **Wrong Eye – Surgical Site Marking/Medication** •

	will be feedback to all key parties. • Should include a SpaMedica Patient Safety and Quality Improvement Partner.	All Specific SWARMs are to be presented/reviewed via the National Learning from Patient Safety Events and Quality Improvement Committee. All generic SWARMS to be added to IP and or escalated in line with findings or national requirements.
After Action Review (AAR) ***[Will be reviewed once SWARM methodology is embedded across the organisation]***	AAR is a is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future It is based around four questions: - What was the expected outcome/what was expected to happen? - What was the actual outcome/what happened? - What was the difference between the expected outcome and the event? - What is the learning?	SpaMedica's National Learning from Patient Safety Events and Quality Improvement Committee including Patient Safety and Quality Improvement Partners will act as the overarching advisors and support when and when an AAR maybe suitable and agree nominated facilitator to support the wider teams for all learning events across the business this could be a Hospital Director or Area Manager. ***[Will be reviewed once SWARM methodology is embedded across the organisation]***
Multidisciplinary Team (MDT) Review	An investigation involving multiple different teams and specialties which supports learning from patient safety incidents by conducting a gap analysis of the key contributory factors which impact on safe patient care. An MDT Review may be site specific, regional or national dependent on the circumstance of the patient safety events being reviewed, and may include announced or unannounced inspections, peer review reports, reviews of regulatory body inspections, and a review of any other governance or assurance key performance indicator.	SpaMedica's National Learning from Patient Safety Events and Quality Improvement Committee including Patient Safety and Quality Improvement Partners will act as the overarching MDT for all learning events across the business.

9.0 LFPSE Governance Overview:

LFPSE Governance Overview:

National Level

[Monthly] - National Learning from Patient Safety events and Quality Improvement Committee:

Purpose – The committee will review all Patient Safety, Experience, Audit and Medico-legal claims learning and outputs [Triangulate Data] and ensure key quality and patient safety drivers are identified, embedded and sustained using key learning, audit and quality improvement methodologies across the organisation 'Test of Change':

The Committee will agree/and.

- Convene as operationally required/directed by emergence of key identified learning or Experience theme - Monthly /Sooner
- Agree level of investigation required for any event /theme/cluster that triggers a broader investigation that sits outside of agreed national quality improvement workstreams
- The scope of the learning review
- The tools and methodologies best suited to enable a proportionate level of response/investigation
- Assign and agree regional patient safety and learning teams to conduct wider review [Peer Review/Investigation]
- Manage and oversee **National**, **Regional** and **Local Quality Improvement drivers** [Agree and assign QI projects]
- Monthly, Quarterly, Annual assurance reporting received via Regional Clinical, Quality and Patient Safety Committee/Functions
- Monthly/Quarterly assurance reported provided to SpaMedica Board
- Support Organisational Annual Quality Account

[Chair – Director of Clinical Services]
[Deputy Chair – Chief Medical Officer]

Regional /National Patient Safety and Learning Team/s:

- Regional Clinical Governance Lead//s - Patient Safety Specialist – Lead Investigator – Patient Safety and Learning
- Regional Hospital Director

Supported by:

- Regional/National Optometrist
- Regional/National Ophthalmic Consultant
- Regional/national Registered Nurse/ODP Lead
- Regional/National Patient Coordinator Lead
- Hospital Manager
- Regional /National Quality and Patient Safety Partner

[Assigned SPA/Time for Patient Safety/Experience]

Patient Experience and Learning Reviews:

- National Patient Safety and Experience lead – Lead Investigator
- Regional/ Area Manager
- Regional Hospital Manager
- Regional Optom

Regional Level:

- Operational oversight and management of National Quality Improvement Programs/Drivers
- Quality Assurance and oversight of local learning reviews and management
- Assurance reporting and oversight to National Learning and Quality Improvement Committee
- Weekly LFPSE Review Groups
- **[Chair – Regional Clinical Governance Lead]**
- **[Deputy Chair – Regional Hospitals Director?]**

Lead:

- Regional Clinical Governance Lead
- Regional Hospital Director

Supported by:

- National Patient Safety and Experience Lead
- All Regional Leads
- All Regional Hospital Manager

Local Level:

- Operational Management of all Learning and Experience metrics raised via InPhase or other avenue
- Review, Action/Escalate, Group, Theme and Trend Learning Outcomes and link to Local, Regional and National Quality Improvement Drivers/Programs of work including Risk Registers
- Lead initial post event learning SWARMS/Plan on Page for National Learning and Quality Improvement Committee
- Escalate key learning and outcomes in line with National Never Event Framework and SpaMedica LFPSE Plan/Policy.
- Identify, lead and manage local Quality Improvement Workstreams including ' You Said, We Did'
- Provide Monthly Quality and Assurance Reports and oversight of local thematic analysis and 'So What's
- Celebrate and report excellence!
- Showcase and present Quality Improvement projects at local and Regional Clinical, Quality and Patient Safety Committee
- Lead Candour and Formal Duty of Candour process./responses
- Support Regional and National L:earing and Safety review
- Ensure robust sharing and learning events at local level

Investigation Lead:

- Hospital Manager/CQC Registered Manager
- Area Manager

Supported by:

- National Patient Safety and Experience Lead
- Regional Clinical Governance Lead
- Local Hospital Optometrist
- Local Ophthalmic Consultant
- Local registered Nurse/ODP Lead
- Local Patient Coordinator Lead
- Local/Regional Quality and Patient Safety Partner

[Assigned SPA/Time for Patient Safety/Experience]

10.0 Learning Profile, Quality Improvement Based on Learning From Patient Safety:

SpaMedica's general learning profile has supported and informed the creation of our current SWARM/Huddle process. Its hope that this will allow us to continue to test the new SWARM/Huddle system, refine our approach and embed the SWARM/Huddle methodology across the organisation, and to test and review other approaches/learning tools during 2024/2025.

In October 2023, SpaMedica Invested in a new electronic Risk and Incident Management System, called InPhase. The electronic system, not only supports and meets all requirements of LFPSE, but will also allow the organisation a greater ability to Group, Theme, Trend [Thematic Analysis] and aggregate our learning data/outcomes. This increased oversight, and increased data analytics functionality, will enable SpaMedica, supported by an on-going review of previous learning outcomes from 2023/2024 across all key quality metrics, to create an overarching Quality Improvement Strategy, Work Plan driven by data for 2025/2026 Quality Year [Example Below] as well as aligning overarching governance systems and processes to support delivery of our plan and policy.

The expectation is that by 2025/2026 Quality Year SpaMedica will have a Quality Improvement and Delivery plan for all key learning outcomes, with focus on Quality Improvement, sustained and embedded Improvement driven by insight obtained from key quality metrics.

EXAMPLE of SpaMedica's Quality Improvement Plan 2025/2026 Quality Improvement Workstreams/Pillars of Improvement [Linked to Quarterly Reporting to ICB]				
Surgical Site Infections	**Cancellations**	**Cannula Detachment**	**Medication Management**	**Locum and Agency Induction Process**
Lead:	Lead:	Lead:	Lead:	Lead:
Deputy Lead:	Deputy Lead:	Deputy Lead:	Deputy Lead:	Deputy Lead:

11.0 Resources and Training to Support Patient Safety Incident Response

Resource:

Please refer to the duties and responsibilities section of this policy to review the resource and individual role responsibilities relating to patient safety incident responses, and our overarching capacity to respond to incident responses.

The organisation assigns key roles and responsibilities to these roles for the reviewing and investigation of patient safety events, learning and Quality Improvement.

.

Training:

All staff across SpaMedica, including Board Members and the Senior Leadership Team are nominated to complete:

- Level 1 and Level 2 of the Essentials for Patient Safety Training.

All staff members who either have responsibility for investigating patient safety incidents, or who have oversight responsibilities to investigate Patient Safety Incidents are nominated to complete the Level 2 – A systems approach to learning from Patient Safety Incidents, provided by HSSIB.

Training Compliance:

Compliance of training is tracked and monitored through our 'EyeLearn' electronic learning system. All persons who must complete HSSIB training, must upload a copy of their certificate to this system for ease of access and for governance assurance purposes.

12.0 Responding to Patient Safety Incidents:

Our PSIRP sets out full guidance on our guidance and processes for responding to Patient Safety Incidents. We have also produced a tool, template and guidance document to accompany each form of national learning response (Swarm, AAR, MDT, PSII). In addition to this, we have also produced set templates for communicating with patients throughout the Patient Safety Incident Response Process. These include: -

- A Duty of Candour Letter
- A Person Involved Engagement Form
- PSII Outcome Letter
- Guidance on appreciative enquiry
- Templates and guidance for obtaining and recording verbal communications
- Patient Safety Response Plan

13.0 Patient Safety Incident Response Reporting Arrangements:

As set out within the Open and Transparent reporting section of this document, our incidents are reported via InPhase. Full Training and Guidance is available to staff on how to use InPhase. Training materials and support available include: -

- Module specific electronic learning sessions on EyeLearn

- The InPhase training library within the system
- InPhase training on report building and question management for system administrators
- Hospital Manager Governance Induction Packs
- Hospital Manager Academy Governance Overview
- Regional workshops provided on an ad hoc basis
- Recorded workshop sessions stored within an InPhase training materials site
- An FAQ's slide show and video recording setting out the basics of SEIPS

Different levels of training are assigned to staff members based on their job role and responsibilities. This is managed by the training team and authorised by the Clinical Governance and Patient Safety Team. Training assigned is mandatory and compliance with training is tracked and managed as part of staff performance reviews and appraisals.

14.0 Patient Safety Incident Response Decision Making:

Hospital Directors and Area Managers are responsible for ensuring that there are local process in place to ensure Hospital Managers are reviewing and escalating key Hospital Site specific themes and trends within their region.

Where a theme or trend arises and this is location specific, the Patient Safety Investigator and Patient Safety Supervisor should ensure that a thematic review of the incidents which sit within a particular trend or category, are investigated, or escalated via SWARM process to the Learning from Patent Safety and Quality Improvement Committee for agreement of next steps.

Support for Local Patient Safety Investigators will be provided through the following meetings:

- Weekly regional huddles
- Bi-weekly patient safety "lunch and learn" sessions.
- Weekly email updates
- HM Update Meetings
- Patient Safety and Quality Improvement Committee (National, Quarterly)
- Regional Clinical Governance Meetings

15.0 Responding to Cross-System Incidents/Issues:

Where a patient safety incident or event occurs and there is a crossover between healthcare organisations, whether that be independent healthcare or an NHS organisation, a Patient Safety Response Plan must be agreed in writing after an open discussion with all parties involved. A standardised tool is available to support this.

A similar approach should be taken where an incident involves multiple departments. An initial incident investigation planning meeting should take place to identify a lead investigator but delegate the relevant points for investigation or actions to the appropriate persons, including subject matter experts and will be guided and supported via the Learning from Patient Safety and Quality Improvement Committee.

16.0 Timeframes for Learning Responses:

SpaMedica is a fast-paced clinical environment, providing day case outpatient treatments and services. It is vital that patient safety responses are completed in a timely manner, to ensure accurate and meaningful data capture which effectively mitigates clinical risk.

NHS England make recommendations for particular types of learning response methods, and SpaMedica will adhere to these:

Learning Response Method:	Timescale for Completion:
Post Incident SWARM/ Specific SWARM	On the same day, or as near to the time the incident occurs as possible.
After Action Reviews (AAR)	Ideally these should take place within 5 days from event occurring or as part of the weekly operational review group meeting.
Patient Safety Incident Investigations (PSII)	These should take a maximum of 6 months regardless of circumstance, but in general should be completed within 3 months of the incident occurring.
Multidisciplinary Team Review (MDT)	This will be completed Monthly via the National LFPSE and Quality Improvement Committee.

17.0 Safety Action Development and Monitoring Improvement:

Safety and Quality Improvement Actions should be developed and agreed for every Patient Safety Incident or Event or aligned to National Quality Improvement Workstreams and closed with supporting narrative.

SpaMedica will use the NHS England 'Safety Action Development Guide' to support their safety action plans. This guide is referenced within the associated documentation section of this policy.

Safety Actions must be SMART:

- Specific
- Measurable
- Achievable
- Realistic
- Timely

Safety Actions should be identified and documented within the final versions of completed learning response tools and templates, and each action should be logged on the associated electronic patient safety record on InPhase within the designated Actions tab.

Quality Improvement and Safety improvement Plans:

Safety Actions across the organisation will be tracked and monitored via the Learning from Patient Safety Events and Quality Improvement Committee and also shared through the Actions Module on InPhase and where applicable will be rolled out nationally via the Clinical Effectiveness Committee.

Within the InPhase 'Actions' Module, all individual actions relating to any one Hospital Site will be available and this complete list of actions, timeframes and progress records will make up the Hospital Site's Safety Improvement Plan.

The Learning from Patient Safety and Quality Improvement Committee who will have one overarching Safety and Quality Improvement Plan which tracks and monitors the progress of national Quality Improvement projects across the organisation. This Plan will be available to all staff members within the organisation via the public 'All Company-Wide' SharePoint site (intranet and will be evidenced and reported via Monthly, Quarterly and Annual Reporting.

18.0 Oversight (Support and Monitoring) Roles and Responsibilities:

Internal Oversight:

SpaMedica's Learning from Patient Safety and Quality Improvement Committee will have overall oversight and management of all learning events, quality improvement, sharing of learning, supporting and setting timescales for investigation and supporting engagement with external stakeholders.

External Oversight:

Following guidance provided by NHS England, SpaMedica adopted an Integrated Care Board (ICB) to work with us to develop and agree our Patient Safety Incident Response Plan and Policy. SpaMedica's ICB Lead is Greater Manchester Integrated Care Board. We will continue to work with our Lead ICB as the development of our PSIRF policy, plan and profile embeds and evolves.

NHS England have indicated that they are working with the Care Quality Commission (CQC) to provide guidance to healthcare providers on how their inspections will change with the implementation of PSIRF. This document and associated documents will be updated in accordance with this guidance once received. We intend to use the guidance anticipated from CQC as a standard practice to extend across our other external regulatory bodies for our Hospital Sites in Wales and Northern Ireland (Health Inspectorate Wales (HIW) and regulation and Quality Improvement Authority (RQIA).

19.0 Complaints and Appeals:

Complaints relating to SpaMedica's practice and management of PSIRF, Patient Safety Responses and Patient Safety Learnings should be managed in accordance with our standardised complaints policy and SOP. These documents, along with our Complaints Patient Literature are referenced within the associated documentation section of this policy.

20.0 References and Associated Documentation:

- The National Patient Safety Strategy - Report template - NHSI website (england.nhs.uk)
- Patient Safety Incident Response Framework V1, August 2022- B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk)
- Engaging and Involving Patients, Families and staff following a patient safety Incident V1, August 2022 – B1465-2.-Engaging-and-involving...-V1-FINAL.pdf (england.nhs.uk)
- Guide to responding proportionately to patient safety incidents V 1.1, September 2022 - B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-V1.1.pdf (england.nhs.uk)
- Oversight roles and responsibilities specification V1, August 2022 - B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk)
- Patient Safety Incident response standards V1, August 2022 - B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)
- Patient Safety Incident Response Framework Preparation Guide V1, August 2022 - B1465-6.-PSIRF-Prep-Guide-v1-FINAL.pdf (england.nhs.uk)
- Template Patient Safety Incident Response Policy - B1465-7.-Patient-safety-incident-response-policy-template-v1-FINAL.docx (live.com)
- Template Patient Safety Incident Response Plan - B1465-8.-Patient-safety-incident-response-plan-template-v1-FINAL.docx (live.com)
- NHS England Just Culture Guide - NHS_0932_JC_Guide_A3 (england.nhs.uk)

Related Policies:

Duty of Candour Policy
Risk Management Policy
Safeguarding Adults and Childrens Policies
Policy for the Reporting and Escalation of Clinical Incidents, risks and near misses.

21.0 Monitoring and Effectiveness of the Policy:

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 6 months for the initial 3 years, and then every 12 months thereafter to ensure that 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, and on our standardised documentation library, 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 lead (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, PSII reports, improvement plans, action plans, complaints, claims, peer reviews, staff survey results, inequalities in data, and reporting data) and wider stakeholder engagement.

22.0 Equality and Impact Assessment:

SpaMedica has a statutory responsibility under the Race Relations (Amendment) Act 2000, the Disability Discrimination Act 2005, the Equality Act 2010, and Section 75 of the Northern Ireland Act 1998 to:

- Identify relevant functions, services and policies.
- Set out arrangements, including consultation, to assess the likely impact proposed policies will have on religious belief, political opinion, age, marital status, sexual orientation, gender, race, disability and dependency; and
- Monitor policies for adverse impact.
- Where there is adverse impact, to consider measures which might mitigate the adverse impact.
- SpaMedica also identifies and addresses any adverse impact related to:
- Sexual orientation
- Gender reassignment
- Religion and/or belief

To fulfill this responsibility an Equality Impact Assessment must be completed if screening identifies that a policy has potential to impact on equality of opportunity and good relations, which is designed to:

- identify where certain groups are excluded from any service.
- Help identify direct or indirect discrimination.
- Assess if there may be any adverse impact on groups.
- Assist in considering alternative measures that might address that adverse impact.
- Enable openness, transparency, and early engagement in the policy development process.
- Help mainstream equality in all documents and practices.

The completed Equality Impact Assessment must accompany the procedural document when it is submitted for ratification and once the document is ratified must be forwarded to the relevant Executive Director for publication

Appendices:

Appendix A Equality Impact Assessment Screening Tool.

Equality Impact Assessment Screening Tool

Committee Ratifying	SpaMedica Policy Committee		
Document/Policy Title:	PSIRF Policy and Plan	Version:	1
Author Title:	Daniel Boden, Clinical Governance Lead, Jill Campbell-Ainger, Director of Clinical Services		
Date of Assessment:	April 2024		

	Please complete the following questions:	**Yes/No**	**Comments**
1	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race and ethnic origins	No	
	Gender	No	
	Age	No	
	Religion, Belief or Culture	No	
	Disability	No	
	Sexual orientation	No	
2	**Is there any evidence that some groups are affected differently?**	No	
3	**Is there a need for external or user consultation?**	No	
4	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
5	**Is the impact of the policy/guidance likely to be negative?**	No	
6	**If so, can be impact be justifiable?**	N/A	
7	**What alternatives are there to achieving the policy/guidelines without the impact?**	N/A	
8	**Can SpaMedica reduce the impact by taking different actions?**	N/A	

Recommendation

Full Equality Impact Assessment required: NO ■ YES □

Approval/Endorsed by: Chief Operating Officer

Signed: **Date: 19/06/24**

Name (Printed): Simon Shepherd.