Patient Safety Incident Response Framework Policy	
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Issue No:	02
Responsible:	Director of Patient Services
Author	Quality Improvement Lead
Consulted:	Director of Patient Services, Medical Director and Clinical Leads
Approved:	Clinical Governance committee
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A.S.P.I.R.E. (created by staff forum on behalf of all staff at Prospect Hospice)
Authentic - **S**pecialist - **P**erson Centred - **I**nclusive - **R**esilient - **E**xcellent
These values and associated behaviours underpin everything we do and the way we work at Prospect Hospice and all employees are expected to abide by them.

Equality Impact Assessment
No one will be disproportionately affected or disadvantaged.

Policy: Patient Safety Incident Response Framework Policy

Version Number	Amendment History	Author of Update	Page/Section Number	Date
V-CG-213 v.01	New policy	Naomi McKenna, Quality Improvement Lead	Throughout	October 2023
V-CG-213 v02		Naomi McKenna, Quality Improvement Lead	Condense sections 1, 2 and 3 as current sections repeat PSIRF principles. Explanatory text placed under one section. Section 3 condensed responsibilities. Section 6 - This removes examples that may change over time and avoids having to update the policy if agencies or reporting requirements change.	October 2026

1.Purpose and Scope

This policy outlines Prospect Hospice's approach to responding to patient safety incidents in line with the Patient Safety Incident Response Framework (PSIRF). The aim is to support learning, improvement, and safer care through a systems-based approach rather than assigning blame. The policy applies to all staff, volunteers, contractors, and bank or agency workers and should be read alongside the Incident Management and Learning Policy and Procedure, Duty of Candour Policy and the Patient Safety Incident Response Plan (PSIRP).

Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident. There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a 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.

1.2 Engaging and Involving Patients, Families and Staff

Patients, families, carers and staff affected by a patient safety incident will be involved in accordance with PSIRF principles and the Duty of Candour. Their perspectives will be sought throughout the response process unless they choose not to participate.

1.3. Involving Colleagues and Partner Agencies

Staff, managers and partner organisations will be involved as appropriate to ensure a transparent, fair and effective response. Prospect Hospice promotes a Just Culture where staff feel supported to report and learn from incidents.

2.Definitions

Patient safety incident response framework (PSIRF) is a national initiative designed to further improve safety through learning from patient safety incidents. The PSIRF outlines how providers should respond to patient safety incidents, and how and when an investigation should be carried out. It includes the requirement for the publication of a local Patient Safety Incident Response Plan (PSIRP) (to note our plan is held on the Prospect Hospice website as a requirement under PSIRF).

Incident and near miss: any event or circumstance arising that could have, or did, lead to unintended or unexpected harm, loss or damage to a person, property, or the organisation. Please refer to the Incident Management and Learning Policy and Procedure.

Harm: Injury (physical or psychological), disease, suffering, disability, or death.

Please refer to the Patient Safety Incident Response Plan for further definitions.

3.Responsibilities

Chief Executive and Director of Patient Services

The overall responsibility for effective risk management in the Hospice, including incident reporting and management, lies with the Chief Executive. At an operational level, the Director of Patient Services is the Director designated with responsibility for governance and risk management.

The Director of Patient Services' key responsibilities in respect of incident reporting and management are:

- Notifying the Trustees Board of incidents reported as Never Events
- Notifying the Board of Directors of incidents considered as meeting the criterion of a PSII
- Presenting reports to the patient service committee of any Patient Safety Incidents Investigations identifying issues of concern, outcome and learning and assurance.

Managers

Managers are responsible for ensuring incidents are reported, reviewed, investigated where required, learning is shared, actions are implemented, and staff are supported throughout the process.

Staff

All staff are responsible for reporting incidents and near misses, taking immediate action to reduce harm, and participating in reviews when required.

4.Patient Safety Incident Response Plan (PSIRP)

Prospect Hospice will maintain a Patient Safety Incident Response Plan (PSIRP) that describes how patient safety incidents are reviewed and responded to. The plan is a living document and will be updated in response to learning, changes in services, emerging risks, or national guidance. It will be published on the Hospice website and formally reviewed every two years.

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.

5.Safety Actions Plan/Safety Improvement Plan and Monitoring

PSIRF moves away from the identification of 'recommendations' which may lead to determining a resolution at an early stage of the safety action development process.

Safety actions arising from learning responses will focus on reducing risk and improving care. Actions will be specific, measurable and monitored through the Hospice governance structure. Progress and effectiveness will be reviewed through the Quality Improvement and Clinical Audit Group and

reported to the Patient Services Committee.

6.External Reporting and Informing Key Stakeholders

Where required, patient safety incidents will be reported to relevant external organisations and stakeholders, including regulators and statutory bodies. Reporting requirements and responsibilities are detailed within the Incident Reporting and Management Procedure.

Depending on the type of incident, it may require reporting to an external agency or key stakeholder, for example, the Care Quality Commission, the Health & Safety Executive, NHS Digital or the Information Commissioner. PP105b (Incident Reporting and Management Procedure) lists the different external agencies/ stakeholders and the types of incidents they need to be notified of.

7.Incident Reporting and Management Training

All staff will receive training appropriate to their role in incident reporting, patient safety and PSIRF principles through induction and mandatory updates.

Staff responsible for overseeing, leading or undertaking patient safety learning responses and investigations will complete training in line with PSIRF standards and organisational requirements.

Relevant staff and Board members will complete the appropriate levels of the NHS Patient Safety Syllabus.