Wellspring Recruitment and Care Services Limited
16 Patmore House, Mayville Estate, Mathias Road N16 8LQ

Review Sheet

Last Reviewed 28 Jan 2025

Last Amended 28 Jan 2025

This policy will be reviewed as needs require or at the following interval: Annual

Business Impact:	LOW — Minimal action required. Circulate information amongst relevant parties.
Reason for this Review:	Scheduled review
Changes Made:	Yes
Summary:	This policy will support the arrangements in place at Wellspring Recruitment and Care Services Limited to comply with the NHS Patient Safety Incident Response Framework (PSIRF). It has been reviewed with no significant changes. References have been checked and updated.
Relevant Legislation:	• Care Quality Commission (Registration) Regulations 2009 • Equality Act 2010 • Mental Capacity Act 2005 • Mental Capacity Act Code of Practice • Safeguarding Vulnerable Groups Act 2006
Underpinning Knowledge:	• Author: NHS England, (2024), Patient Safety Incident Response Framework [Online] Available from: https://www.england.nhs.uk/patient-safety/incident-response-framework/ [Accessed: 28/01/2025] • Author: NHS England, (2024), Patient Safety Incident Response Framework and Supporting Guidance [Online] Available from: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/ [Accessed: 28/01/2025] • Author: NHS England, (2021), Never Events [Online] Available from: https://www.england.nhs.uk/publication/never-events/ [Accessed: 28/01/2025] • Author: NHS England, (2021), Framework for Involving Patients in Patient Safety [Online] Available from: https://www.england.nhs.uk/publication/framework-for-involving-patients-in-patient-safety/ [Accessed: 28/01/2025] • Author: NHS England, (2024), Patient Safety Learning Response Toolkit [Online] Available from: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/ [Accessed: 28/01/2025]
Suggested Action:	

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Equality Impact Assessment:	QCS have undertaken an equality analysis during the review of this policy. This statement is a written record that demonstrates that we have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

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1. Purpose

1.1 This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out how Wellspring Recruitment and Care Services Limited will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

1.2 This policy should be read alongside other relevant policies and procedures, to include:

- Serious Incident Notification Policy and Procedure
- Complaints, Suggestions and Compliments Policy and Procedure
- Duty of Candour Policy and Procedure
- Safeguarding Adults Policy and Procedure

1.3

Key Question	Quality Statements
RESPONSIVE	QSR4: Listening to and involving people
SAFE	QSS3: Safeguarding
SAFE	QSS1: Learning culture
WELL-LED	QSW5: Governance, management and sustainability
WELL-LED	QSW7: Learning, improvement and innovation
WELL-LED	QSW6: Partnerships and communities

1.4 Relevant Legislation

- Care Quality Commission (Registration) Regulations 2009
- Equality Act 2010
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice
- Safeguarding Vulnerable Groups Act 2006

2. Objectives

2.1 To ensure that Wellspring Recruitment and Care Services Limited responds to patient safety incidents when they happen, to prevent recurrence, learn, and improve Service User safety.

2.2 To ensure that staff have the relevant knowledge and training as outlined in the PSIRF.

2.3 To ensure PSIRF is central to overarching safety governance arrangements at Wellspring Recruitment and Care Services Limited.

3. Policy

3.1 Wellspring Recruitment and Care Services Limited is firmly committed to continuously improving the care and services it provides, learning from any incident where care does not go as planned or expected for its Service Users and their families to prevent recurrence.

3.2 Patient safety incidents are events where a Service User experienced or could have experienced harm during an encounter with healthcare. This can range from the most minor to the other extreme.

3.3 The 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 (PSIs) for the purpose of learning and improving patient safety to reduce risk.

An effective patient safety incident response system will lead to more compassionate engagement and involvement for those affected by patient safety incidents and give staff space for reflection.

An important factor is to understand how incidents happen. This allows staff to learn and improve, in turn creating a safer care system for Service Users.

3.4 The PSIRF is a contractual requirement under the NHS Standard Contract and, as such, is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers.

3.5 The Patient Safety Incident Response Framework (PSIRF) has replaced the Serious Incident Framework.

This new framework ensures that investigations are strategic, preventative, collaborative, fair and people-focused. It looks at the cause of the incident within the system, rather than seeking someone to blame.

3.6 The Serious Incident Framework (2015) described when and how to investigate a serious incident. The PSIRF focuses on learning and improvement and Wellspring Recruitment and Care Services Limited is responsible for the entire process including what to investigate and how.

Beyond nationally set requirements, Wellspring Recruitment and Care Services Limited can explore patient safety incidents relevant to their context and their Service Users, rather than only those that meet a certain defined threshold.

The PSIRF does not mandate investigation as the sole method to produce meaningful learning from PSIs.

3.7 Wellspring Recruitment and Care Services Limited will develop a thorough understanding of its Service User safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programmes. To do so, information is collected and synthesised from a wide variety of sources, including wide stakeholder engagement.

3.8 The PSIRF no longer uses root cause analysis (RCA). It sees patient safety emerging from complex interactions and is not the result of an individual cause, such as one person,

and:

- Recognises that outcomes in complex systems result from the interaction of multiple factors
- Learning should not focus on uncovering a root cause, but instead should explore multiple contributory factors
- Does not distinguish between care and service delivery problems
- Explores contributory factors, including individual acts in the context of the whole system
- Uses tools to explore multiple interacting contributory factors rather than forcing a single, analytical pathway

3.9 The PSIRF supports the development and maintenance of an effective patient safety incident response system with four key aims:

- 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
- Supportive oversight focused on strengthening response system functioning and improvement

3.10 The PSIRF offers:

- Increased Service User Safety by prioritising incident reporting and investigation
- Enhanced Quality of Care - Learning from incidents leads to improved practices and policies, resulting in better quality care for Service Users
- Increased Transparency - Creating trust amongst Service Users and their families
- Continuous Improvement - The culture of learning and improvement at Wellspring Recruitment and Care Services Limited can drive ongoing enhancements in the delivery of social care services
- Empowered Staff - Encouraging incident reporting and providing support to staff nurtures a sense of encouragement and dedication to providing safe care

3.11 Olajumoke Omolola will ensure that any patient safety incident response processes support health equality and reduce inequality for Service Users, families and staff at Wellspring Recruitment and Care Services Limited.

3.12 Wellspring Recruitment and Care Services Limited recognises and acknowledges the significant impact patient safety incidents can have on Service Users and their families.

Getting involvement right with Service Users and families in how Wellspring Recruitment and Care Services Limited responds to incidents is crucial, particularly to support improving the services provided. This involves being open and honest whenever there is a concern about care not being as planned or expected, or when a mistake has been made.

As well as meeting regulatory and professional requirements for Duty of Candour, Wellspring Recruitment and Care Services Limited will be open and transparent with its Service Users and their families as it is the right thing to do. This is regardless of the level of harm caused by an incident.

3.13 Olajumoke Omolola must ensure that those conducting investigations have specific knowledge and experience gained through training.

3.14 The PSIRF is supported by NHS guidance documents which include:

- Guide to responding proportionately to patient safety incidents
- Response tools, templates and guides

- Engaging and involving patients, families and staff following a patient safety incident
- Oversight roles and responsibilities specification
- Patient safety incident response standards
- Patient Safety Incident Response Framework - Preparation guide

Links to the above can be found in the Further Reading Section of this policy.

Olajumoke Omolola will assure that these resources are available to staff.

3.15 All Staff are Required to:

- Report all incidents, patient safety events and near misses via the accident/incident system at Wellspring Recruitment and Care Services Limited
- Ensure the details of any incidents or patient safety events are documented in the Service User's Care Plan
- Raise any concerns with Olajumoke Omolola about situations that led to, or could lead to, an incident, patient safety event, or a near miss
- Actively participate in any subsequent reviews or learning responses, providing a written account, attending multidisciplinary fact-finding and feedback meetings as needed
- Attend a Coroner's inquest if called to do so
- Undertake training in the reporting of incidents/patient safety events
- Understand their responsibilities in relation to the PSIRF and act accordingly
- Know how to access help and support in relation to the patient safety incident response process

3.16 The Registered Manager:

- Ensures that Patient Safety Incident Investigations (PSIIs) are undertaken for all incidents that require this level of response (as directed by the Patient Safety Incident Response Plan (PSIRP) of Wellspring Recruitment and Care Services Limited)
- Has overall responsibility for ensuring there are processes that support an appropriate response to patient safety incidents (including contribution to cross-system/multi-agency reviews and/or investigations where required)
- Has overall responsibility for ensuring the development of the patient safety reporting, learning and improvement system
- Ensures that systems and processes are adequately resourced - funding, management time, equipment and training
- Ensures that the PSIRF, data, findings, improvement plans and progress are discussed at quality meetings
- Ensures compliance with internal and external reporting/notification requirements
- Ensures that Duty of Candour is upheld
- Encourages the reporting of all patient safety incidents and ensures all staff are aware of the reporting system at Wellspring Recruitment and Care Services Limited
- Ensures that incidents are reported and managed in line with internal and external requirements
- Supports and advises staff involved in the patient safety incident response
- Ensures those affected by patient safety incidents have access to the support they need
- Liaises with external bodies and supports Wellspring Recruitment and Care Services Limited as a spokesperson for Wellspring Recruitment and Care Services

Limited as required

- Works with services to address identified areas for improvement in response to patient safety incidents, including gaps in resource, such as skills and/or training
- Develops professional development plans to ensure that staff have the training, skills and experience relevant to their roles in patient safety incident management
- Establishes procedures to monitor and review PSII progress and the delivery of improvements
- Ensures that they and their staff periodically review the PSIRF and the organisation's PSIRP to check that expectations are clearly understood
- Supports the development and delivery of actions in response to patient safety reviews and PSIIs that relate to their area of responsibility

3.17 Providers of NHS Funded Care

Wellspring Recruitment and Care Services Limited is responsible and accountable for effective patient safety incident management in Wellspring Recruitment and Care Services Limited.

This includes supporting and participating in cross system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required.

Oversight under PSIRF will focus on engagement and empowerment at Wellspring Recruitment and Care Services Limited, not command and control.

3.18 Information from a PSII should be shared, if required, with those leading other types of responses.

4. Procedure

4.1 Service User Safety Culture

Olajumoke Omolola will ensure staff feel supported to speak up when things go wrong, rather than fearing blame. This will be achieved through a culture of fairness, openness and learning at Wellspring Recruitment and Care Services Limited.

Olajumoke Omolola will ensure they do not undermine just culture by requiring inappropriate automatic suspension of staff involved in patient safety incidents or their removal from business as usual activities

4.2 Patient Safety Partners

Patient safety partners (PSPs) should be involved in safety at Wellspring Recruitment and Care Services Limited by supporting and contributing to the governance and management processes at Wellspring Recruitment and Care Services Limited for Service User safety.

Roles for Patient Safety Partners (PSPs) include:

- Membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- Involvement in patient safety improvement projects
- Working with Wellspring Recruitment and Care Services Limited to consider how to improve safety

- Involvement in staff and Service User safety training
- Participation in investigation oversight groups

4.3 Health Inequalities

Olajumoke Omolola will ensure that any patient safety incident response processes support health equality and reduce inequality by:

- Identifying any disproportionate risk to Service Users with special characteristics, and using this information to inform patient safety incident response
- Exploring and responding to issues relating to health inequalities as part of the development and maintenance of the patient safety incident response of Wellspring Recruitment and Care Services Limited
- Using the tools to respond to patient safety incidents to prompt consideration of inequalities
- Considering inequalities when developing safety actions
- Considering the different needs of Service Users, families and staff when engaging with them
- Upholding a system-based approach and ensuring that staff have the relevant training to support the development of a just culture

4.4 Compassionate Engagement and Involvement of Those Affected by Patient Safety Incidents

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if systems and processes that support compassionate engagement and involvement of those affected by patient safety incidents (patients and service users, families, and staff) are in place.

Compassionate engagement and involvement means 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. When a patient safety incident investigation (PSII) or other learning response is undertaken, Wellspring Recruitment and Care Services Limited should meaningfully involve those affected, where they wish to be involved.

Olajumoke Omolola and Wellspring Recruitment and Care Services Limited will demonstrate their commitment to compassionate engagement and involvement in their words and actions. Engagement and involvement must be communicated as a genuine priority and not a formality at Wellspring Recruitment and Care Services Limited.

When a family or staff member informs an organisation that something has gone wrong, they must be taken seriously from the outset and treated with compassion and understanding.

Engaging with those affected by a patient safety incident and involving them in a learning response has benefits:

- Service Users affected by a patient safety incident may have a range of needs (including clinical needs) as a result and these must be met where possible. This is part of the duty of care at Wellspring Recruitment and Care Services Limited. Meeting a Service User's needs helps alleviate the harm experienced, and helps avoid compounding that harm
- Engaging with those affected by a patient safety incident improves the understanding of what happened, and potentially how to prevent a similar incident in future

- Service Users and their family members may be the only people with insight into what occurred at every stage. Not including those insights could mean an incomplete picture of what happened
- Staff have important contributions to make about their experience of the incident and the working environment at the time, and should be supported to share their account
- Creating much stronger links between a patient safety incident and learning and improvement
- Will continue to increase transparency and openness amongst staff in the reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned

Wellspring Recruitment and Care Services Limited should ensure obligations relevant to the Duty of Candour are upheld.

When a learning response takes place, those affected should be involved in a meaningful way:

- Fully informed about what happened
- Allowed to bring a friend, family member or advocate of their choice with them to any meeting that is part of the learning response process
- Given the opportunity to provide their perspective on what happened
- Communicated with in a way that takes account of their needs
- Given an opportunity to raise questions about what happened and to have these answered openly and honestly
- Given the opportunity to receive information from the outset on whether there will be a specific learning response and what to expect from the process
- Informed in a timely fashion of any delays with the learning response and the reasons for them
- Updated at specific milestones in the learning response should they wish to be
- Offered support and advice throughout a patient safety incident investigation
- Helped to access counselling or therapy where needed
- Signposted to where they can obtain specialist advice and/or advocacy and/or support from independent organisations regarding learning response processes
- Receive a consistent level of timely, meaningful, and compassionate engagement, delivered and assured at every stage, from notification of the incident, through completion of an investigation and during the feeding back of the report, findings and required actions
- Invited to contribute to the development of safety actions resulting from the learning response
- Given the opportunity to feedback on their experience of the learning response and report (e.g. timeliness, fairness, and transparency)

The engagement and involvement with those affected by PSIs should be led by staff with a specified level of training in 'Involving those affected by patient safety incidents in the learning process'. Further information can be found in the NHS Oversight Roles and Responsibilities Specifications - a link can be found in the Further Reading section of this policy.

4.5 Engagement Principles

Nine principles should inform the design of the systems and processes at Wellspring Recruitment and Care Services Limited for engaging and involving those affected by

patient safety incidents. Due to the range of incidents that can occur, and the different needs of Service Users affected, the principles should be flexibly applied when engaging with, or involving, those affected by patient safety incidents in an investigation:

- Apologies are meaningful
- Approach is individualised
- Timing is sensitive
- Those affected are treated with respect and compassion
- Guidance and clarity are provided
- Those affected are 'heard'
- Approach is collaborative and open
- Subjectivity is accepted
- Strive for equity

Further details can be found in the NHS England PSIRF supporting guidance, 'Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident' - a link can be found in the Further Reading section of this policy.

Four Steps of Engagement:

Wellspring Recruitment and Care Services Limited should consider using the NHS framework which can be found in the Forms section, as a guide for building its own systems and processes.

4.6 Duty of Candour and Being Open

Statutory Duty of Candour was brought into law in 2015 for all providers who are registered with Care Quality Commission (CQC).

Olajumoke Omolola provides support and guidance to staff in adhering to Duty of Candour requirements. Staff should refer to the Duty of Candour Policy and Procedure at Wellspring Recruitment and Care Services Limited

4.7 Patient Safety Incident Investigation (PSII)

It is up to Wellspring Recruitment and Care Services Limited to decide when a Patient Safety Incident Investigation (PSII) should take place, depending on the circumstances and factors. However, there are some categories of incident where carrying out a PSII is mandatory and these include:

- Service User deaths thought more likely than not to be due to problems in care under the 'learning from deaths' criteria
- Deaths of Service Users detained under the Mental Health Act or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care
- Deaths of Service Users with learning disabilities
- Incidents that meet the 'never events' criteria (link can be found in the Further Reading section of this policy) which include:
    - Administration of medication by the wrong route
    - Overdose of insulin due to abbreviations or incorrect device
    - Falls from poorly restricted windows
    - Chest or neck entrapment in bed rails
    - Scalding of Service Users
- Safeguarding Incidents

These are set out in the NHS Guide to Responding Proportionately to Patient Safety Incidents.

If the PSI does not meet these criteria, it still may meet the threshold for Statutory Duty of Candour.

4.8 Patient Safety Priorities

Wellspring Recruitment and Care Services Limited should determine PSIRF priorities to focus on for the year. These should be chosen based on Service User safety insights and thematic analysis.

Wellspring Recruitment and Care Services Limited should work with a range of stakeholders to create a list of patient safety incident types that are jointly identified as areas of interest in terms of risk and potential learning and improvement. Olajumoke Omolola can list as many incident 'types' as deemed appropriate.

The stakeholders that Wellspring Recruitment and Care Services Limited should work with should be diverse and include, but not be limited to:

- Patient safety partners and/or patient and public representative groups such as local Healthwatch
- Integrated Care Board (ICB) patient safety specialists
- CQC and other professional regulators
- Specific and distinct clinical governance teams, clinicians and safety champions

Patient safety incident types should be agreed with the Wellspring Recruitment and Care Services Limited; they could include:

- Pressure ulcers, category 3 and above
- Falls with significant injury including fracture
- Unexpected death after unrecognised physical health deterioration/lack of prompt intervention
- Medication errors
- Violence and distressed behaviour, resulting in significant injury

While planning supports proactive allocation of patient safety incident response resources, there will always need to be a reactive element in responding to incidents.

A response should always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in the organisation's plan.

4.9 Patient Safety Incident Investigation (PSII)

Investigations explore decisions or actions as they relate to the situation. The method is based on the thought that actions or decisions are consequences, not causes, and is guided by the principle that staff are well intentioned and strive to do the best they can.

The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

Patient Safety Incident Investigation Stages:

Planning:

- Identify a team/learning response lead
- Commence engagement with those affected
- Agree terms of reference

Synthesis:

- Gather Information
- Build narrative
- Analysis
- Safety action development
- Report preparation
- Safety improvement

4.10 Patient Safety Incident Investigators

Patient Safety Incident Investigators must have been trained over a minimum of two days in systems based PSII. They will:

- Ensure that they undertake PSIIs in line with the national PSII standards
- Ensure that they are competent to undertake the PSII assigned to them and, if not, request it is reassigned
- Undertake PSIIs and PSII-related duties in line with latest national guidance and training
- Identify those affected by patient safety incidents and their support needs
- Provide those affected by patient safety incidents with timely and accessible information and advice

4.11 Training

The PSIRF requires a degree of training to ensure that those conducting investigations, as well as those providing oversight of the process, have an adequate level of knowledge and experience to ensure that investigations lead to learning and improvement.

Wellspring Recruitment and Care Services Limited is committed to ensuring it fully embeds PSIRF and meets its requirements.

Wellspring Recruitment and Care Services Limited will use the NHS England Patient Safety Response Standards (2022) to frame the resources and training required:

- Learning responses are led by those with at least two days' formal training and skills development in learning from patient safety incidents and experience of patient safety incident response
- Learning response leads have completed level1 (Essentials of Patient Safety) and level 2 (Access to Practice) of the NHS Patient Safety Syllabus (a link can be found in the Further Reading Section of this policy)
- Learning response leads undertake continuous professional development in incident response skills and knowledge, and network with other leads at least annually to build and maintain their expertise
- Learning response leads contribute to a minimum of two learning responses per year

4.12 Support Systems

Olajumoke Omolola will recognise that for staff involved with a PSI, this can be a traumatic experience, and ensure wellbeing support for all staff.

Families and staff may need to be signposted to support at any point during engagement or involvement in a learning response. Wellspring Recruitment and Care Services Limited will ensure it is fair in the support offered to families and staff, and that systems exist for

internal and external support so that those affected can access support in the way they prefer wherever possible.

Sources of support for families may include bereavement and mental health services as well as via independent advocacy services, and for staff, mental health first aid, Second Victim Support and local occupational health services.

Olajumoke Omolola should review, where possible, the support offering of the organisations they signpost to ensure they have the resources to respond.

4.13 Risk Assessment

Olajumoke Omolola must ensure the safety of Service Users, families and staff at Wellspring Recruitment and Care Services Limited.

Risk assessments need to be dynamic throughout the engagement and investigation process.

4.14 Record Keeping

All communications should be documented, even when not successful, and what was discussed recorded. This ensures an accurate audit trail.

Records should contain:

- Date and time of all contacts and meetings
- Method of contact (telephone, email)
- Who was present
- Purpose of contact and information exchanged
- Who initiated the contact
- Any contacts unsuccessful or refused/declined

4.15 Other Responses

Other response may take place concurrently with, or following the response of, Wellspring Recruitment and Care Services Limited to a patient safety incident, including:

- Complaint
- Fitness to practise
- Health and Safety Executive
- Coroner's Inquests
- Litigation
- Police investigation
- Social services

Olajumoke Omolola will ensure that Wellspring Recruitment and Care Services Limited assists and complies with other relevant investigations and bodies.

4.16 Report Preparation

When writing a report, the following should be considered:

- Who is going to be reading it – are there language implications?
- Who needs to be involved?
- When is the report required – can this timeline be met?
- How will the needs of the readers be accommodated?
- How should the report be formatted, including how will findings be described?

4.17 Patient Safety Incident Response Planning

A Patient Safety Incident Response Plan (PSIRP) sets out how Wellspring Recruitment and Care Services Limited will respond to patient safety incidents reported by staff, Service Users or their families as part of work to continually improve the quality and safety of the care provided.

Olajumoke Omolola will develop the PSIRP to learn and improve through patient safety incident investigations (PSIIs). It should be based on a thorough understanding of the Service User safety incident profile of Wellspring Recruitment and Care Services Limited, ongoing improvement priorities, available resources and the priorities of stakeholders including Service Users.

A link to the NHS template can be found in the Further Reading section of this policy.

Olajumoke Omolola should ensure the plan:

- Demonstrates a thorough analysis of relevant organisational data
- Demonstrates a collaborative stakeholder engagement process (informed by thorough service and stakeholder mapping activities to ensure all areas are involved and represented appropriately)
- Is a 'living document' that will be appropriately amended and updated as it is used to respond to patient safety incidents
- Is reviewed every 12 to 18 months to ensure the focus remains up to date; with ongoing improvement work, the patient safety incident profile is likely to change. It will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months
- Provides a clear rationale for the response to each identified patient safety incident type
- Is updated as required and in accordance with emerging intelligence and improvement efforts
- Is published on the website of Wellspring Recruitment and Care Services Limited
- Is updated to incorporate any new learning, the changing risk profile of Wellspring Recruitment and Care Services Limited, as well as any ongoing improvement initiatives. This will ensure that incident response becomes a key element of the approach taken by Wellspring Recruitment and Care Services Limited to wider safety management

The patient safety incident response plan of Wellspring Recruitment and Care Services Limited must be agreed by the integrated care board (ICB), other commissioning leads where required, and the board, leadership group or Wellspring Recruitment and Care Services Limited for sign-off.

Under the PSIRF, each organisation's patient safety incident response plan will outline how they will respond to PSIs over a period of 12 to 18 months. The four stages of planning response methods are:

- Examine patient safety incident records and safety data
- Describe safety issues demonstrated by the data
- Identify improvement work underway
- Agree response methods

A rigorous planning exercise that includes a review of data (including PSII reports, improvement plans and reporting data) and wider stakeholder engagement should happen, at a minimum, every four years and more frequently if appropriate (as agreed with the integrated care board (ICB) of Wellspring Recruitment and Care Services Limited) to

ensure efforts continue to be balanced between learning and improvement. Four years is suggested before performing a rigorous planning exercise to allow enough time for safety actions and subsequent improvement to have effect.

4.18 Patient Safety Incident Response Activity

The PSIRF does not mandate investigation as the sole method to produce meaningful learning from PSIs.

PSIRF focuses on a system-based approach, which involves an examination of the components of a system (a person(s), tasks, tools and technology, the environment and the wider organisation) to gain a deeper understanding of how their interdependencies might impact patient safety.

This suggests that patient safety emerges from complex interactions and is not a result of an individual cause, such as one person.

Patient safety incident response activity can be divided into three overarching categories, depending on the key objective:

Learning to Inform Improvement:

Several system-based learning response methods are available for trusts to respond to a PSI:

- Where contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome
- Several system-based learning response methods are available to respond to a patient safety incident or cluster of incidents:
    - (PSII) Patient Safety Incident Investigation
    - MDT Review
    - Swarm Huddle
    - After Action Review (AAR)
- There is the greatest potential for new learning and improvement
- An understanding of everyday work, how work is done and how staff perform routine tasks adjusting to the ever changing conditions and demands can supplement in finding out what happened
- Understanding everyday work is central to any learning response to inform improvement
- Tools to explore everyday work include:
    - Observations guide
    - Walkthrough guide
    - Link Analysis guide
    - Interview guide
- Other tools to gather information include:
    - Timeline mapping
    - Work system scan

Improvement Based on Learning:

- Where an incident type is well understood, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted

at the contributing factors are being implemented and monitored for effectiveness, resources may be better directed at improvement rather than an investigation

- If Wellspring Recruitment and Care Services Limited and its ICB are satisfied risks are being appropriately managed and/or improvement work is ongoing to address known contributory factors in relation to an identified patient safety incident type, and efficacy of safety actions is being monitored, it is acceptable not to undertake an individual learning response to an incident other than recording that it occurred and ensuring those affected are engaged
- A learning response may not be required or may not be the best way to address concerns and questions raised by those affected. If an affected Service User, family or staff member requests a learning response, Wellspring Recruitment and Care Services Limited should carefully consider their request
- If such incidents involve moderate or greater harm, Wellspring Recruitment and Care Services Limited must fulfil its Duty of Candour obligations

Assessment to Determine Required Response

If Wellspring Recruitment and Care Services Limited is unable to easily identify if a learning response is required, it may need to perform an assessment to determine if there were any problems in care that require further exploration and action.

4.19 Patient Safety Incident Response Methodology

- Responses are conducted for the sole purpose of learning and identifying improvements that reduce risk and/or prevent or significantly reduce recurrence
- Responses are insulated from remits that seek to determine avoidability/preventability/predictability, legal liability, blame, professional conduct/competence/fitness to practise, criminality, or cause of death
- With reference to the just culture guide, referral for individual management/performance review or disciplinary action only occurs for acts of wilful harm or wilful neglect
- Patient safety incident investigation reports are produced using the standardised national template
- Patient safety incident investigation reports are written in a clear and accessible way
- National tools (or similar system-based tools) are used and guides followed for learning response methods
- Learning and improvement work are adequately balanced. Wellspring Recruitment and Care Services Limited does not continue to conduct individual learning responses when sufficient learning exists to inform improvement

4.20 Patient Safety Incident Response Resources

- Learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff
- Learning response leads should have an appropriate level of seniority and influence within Wellspring Recruitment and Care Services Limited; this may depend on the nature and complexity of the incident and response required
- Learning responses are not undertaken by staff working in isolation. A learning response team should be established to support learning responses wherever possible
- Staff affected by patient safety incidents are given time and are supported to participate in learning responses
- Learning response leads have dedicated paid time to conduct learning responses. If necessary, their normal roles are backfilled

- Subject matter experts with relevant knowledge and skills are involved, where necessary, throughout the learning response process to provide expertise (e.g. clinical, or human factors review), advice and proofreading
- There is dedicated staff resource to support the engagement and involvement of those affected

4.21 Competence and Capacity

Learning response leads, those leading engagement and involvement, as well as those in PSIRF oversight roles, are required to have specific knowledge and experience. The patient safety incident response standards distinguish between the training requirements and competencies for these two roles but recognise they might be fulfilled by the same individual.

Staff can refer to the Training Requirements outlined in the NHS England Patient Safety Incident Response Standards (a link can be found in the Further Reading section of this policy).

All staff leading learning responses should be able to:

- Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources
- Summarise and present complex information in a clear and logical manner and in report form
- Manage conflicting information from different internal and external sources
- Communicate highly complex matters and in difficult situations

Competencies and behaviours for engagement leads:

- Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way
- Listen and hear the distress of others in a measured and supportive way
- Maintain clear records of information gathered and contact with those affected
- Identify key risks and issues that may affect the involvement of patients, families, and staff
- Recognise when those affected by patient safety incidents require onward signposting or referral to support services

All staff with oversight roles can:

- Be inquisitive with sensitivity (know how and when to ask the right questions to gain insight about patient safety improvement)
- Apply human factors and systems thinking principles
- Obtain and assess both qualitative and quantitative information from a wide range of sources
- Constructively challenge the strength and feasibility of safety actions to improve underlying system issues
- Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g. inappropriate focus on revising policies without understanding ‘work as done’ or self-reflection instead of reviewing wider system influences)
- Summarise and present complex information in a clear and logical manner and in report form

4.22 Reporting

All patient safety incidents are reported via the accident/incident reporting system at Wellspring Recruitment and Care Services Limited.

Olajumoke Omolola has responsibility for liaising with external bodies and partner providers to ensure effective communication, and for the internal and external notification requirements for the reporting of patient safety related incidents.

Recording incidents allows Wellspring Recruitment and Care Services Limited to spot trends of harm, learn the reasons why these events happen and put measures in place to stop similar incidents happening again in the same environment, or more widely across Wellspring Recruitment and Care Services Limited.

The learning can also be reviewed and used more widely, locally by the Integrated Care System (ICS) and nationally by NHS England.

4.23 Cross-system Incidents

Service Users may receive care from more than one provider. An incident may be reported that involves services provided by another provider. In such cases, these incidents require a cross-system learning response**.**

Where multiple organisations need to be involved in a single learning response:

- The response is led by the organisation best placed to investigate the concerns. This may depend on capability, capacity, or remit
- Organisations work together and co-operate with any learning response that crosses organisational boundaries
- Organisations actively engage partner organisations that provided care to the Service User involved where that care may have played a role in the incident being examined
- Service Users will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents

4.24 Timeframes

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of the start date. No learning response should take longer than six months to complete

The timeframe for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

4.25 Safety Action Development and Improvement

Acting in response to a patient safety incident may take different forms.

Sometimes rapid action is needed to respond to imminent risk (e.g. removing broken/faulty equipment). These actions should be completed as soon as practicable and should be captured as part of a specific incident response.

Developing safety actions that respond to underlying system issues starts with identifying and understanding aspects of the work system that need to change to reduce risk and potential for harm (i.e. areas for improvement or system issues). Actions to reduce risk (i.e. safety actions) are then generated in relation to each defined area for improvement.

Key to continuous quality development at Wellspring Recruitment and Care Services Limited:

- Agree areas for improvement. Specify where improvement is needed, without defining how this improvement is to be achieved
- Define context. Agree approach to developing safety actions by developing context
- Define safety actions to address areas for improvement. Continue to involve the team - make this a collaborative experience
- Prioritise safety actions. Avoid prioritising actions based on intuition/opinion alone
- Define safety measures. Identify what can be measured to determine whether the safety action is influencing what is intended. Prioritise safety measures. Document who is responsible for collecting, analysing, reporting and acting on the data collected
- Write safety actions. Document in a learning response report or safety improvement plan, including details of measurement and monitoring
- Monitor and review. Continue to be curious and monitor if safety actions are impactful and sustainable
- Document, record and review safety action progress and impact through governance groups and links to quality improvement

4.26 Safety Improvement Plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. They can take different forms, for example, Wellspring Recruitment and Care Services Limited might consider:

- Creating an organisation-wide safety improvement plan summarising improvement work
- Creating individual safety improvement plans, each focusing on a specific service, pathway, or location
- Reviewing output from learning responses undertaken in relation to single incidents collectively, when it is felt that there is sufficient understanding of the underlying, interlinked system issues
- Creating a safety improvement plan to tackle broad areas for improvement (overarching system issues)

Wellspring Recruitment and Care Services Limited should consider which approach is best suited to the data it has, and insight gained. The key is to demonstrate why a specific safety improvement plan approach is the right one for Wellspring Recruitment and Care Services Limited based on available data, stakeholder views, improvement priorities, the patient safety incident profile and insight from patient safety incident responses.

There are no thresholds for when a safety improvement plan should be developed, for example, after completing a certain number of learning responses. The decision to do so must be based on knowledge gained through the learning response process and other relevant data.

4.27 Oversight Roles and Responsibilities

Wellspring Recruitment and Care Services Limited should identify a PSIRF executive lead to support the responsibilities of the PSIRF. The lead must also provide direct leadership,

advice, and support in complex/high profile cases, and liaise with external bodies as required.

The PSIRF executive lead may be the person with overarching responsibility for quality or, more specifically, Service User safety. They should be a member of the leadership team at Wellspring Recruitment and Care Services Limited and equipped (through training and professional development) with up-to-date safety skills, knowledge and experience as described in the patient safety incident response standards.

PSIRF Executive Lead Responsibilities:

- Ensure Wellspring Recruitment and Care Services Limited meets national safety incident response standards
- Ensure PSIRF is central to overarching safety governance arrangements
- Quality assure learning response outputs

4.28 Complaints and Appeals

Any complaints or appeals relating to a patient safety incident response by Wellspring Recruitment and Care Services Limited will be dealt with in line with the Complaints, Suggestions and Compliments Policy and Procedure at Wellspring Recruitment and Care Services Limited.

5. Definitions

5.1 Never Events

- Never Events are defined as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers
- A Never Event has the potential to cause serious harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event

5.2 Route Cause Analysis (RCA)

- Process of uncovering the core causes of problems and eliminating them through continuous improvement

5.3 System-based Approach

- The focus is examining the components of a system (e.g. person, tasks, tools and technology, the environment, the wider organisation), understanding their interdependencies and how those interdependencies may contribute to patient safety

5.4 Multidisciplinary Team Review

- Supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events due to the passage of time or availability
- Through open discussion to agree the key contributory factors and system gaps that impact on safe patient care

5.5 Swarm Huddle

- Designed to be initiated as soon after an event and involves an MDT discussion

- Staff 'swarm' to the site to gather information about what happened and why, as quickly as possible, and decide what needs to be done to reduce the risk of the same thing happening again

5.6 After Action Review (AAR)

- A structured, facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement

5.7 Observation Guide

- Helps understand how work is actually performed, rather than what is documented in training, procedures or operating manuals, how we imagine work is conducted or how staff tell us work is performed

5.8 Walkthrough Guide

- A structured approach to collecting and analysing information about a task or process, to understand how work is performed

5.9 Link Analysis Guide

- Creates a visualisation of the frequency of interactions observed in a specific location or environment

5.10 Interview Guide

- Contains questions that help plan an interview with staff involved in a patient safety incident, or with Service Users and families

5.11 Timeline Mapping

- A working document to help create a narrative understanding of a patient safety incident
- Useful for understanding any gaps in information

5.12 Work System Scan

- A checklist and documentation tool to ensure the full breadth of the work system is considered

5.13 Patient Safety Partner (PSP)

- Service Users, families or lay people who work in partnership with staff to influence and improve governance and leadership within an organisation

5.14 Second Victim

- Refers to a healthcare employee who has experienced a significant personal or professional impact due to a patient safety incident

6. Key Facts - Professionals

Professionals providing this service should be aware of the following:

- The Patient Safety Incident Response Framework (PSIRF) has replaced the Serious Incident Framework
- The PSIRF is a contractual requirement under the NHS Standard Contract and, as such, is mandatory for services provided under that contract
- Wellspring Recruitment and Care Services Limited is committed to continuously improving the care and services it provides, learning from any incident where care does not go as planned or expected by Service Users and their families to prevent recurrence

- An effective patient safety incident response system will lead to more compassionate engagement and involvement for those affected by patient safety incidents and give staff space for reflection
- Beyond nationally set requirements, Wellspring Recruitment and Care Services Limited can explore patient safety incidents relevant to their context and their Service Users
- Wellspring Recruitment and Care Services Limited recognises and acknowledges the significant impact patient safety incidents can have on Service Users and their families

7. Key Facts - People Affected by The Service

People affected by this service should be aware of the following:

- You can be assured that all near misses, accident and incidents are reviewed to ensure that measures are introduced to reduce risks of events happening again
- Wellspring Recruitment and Care Services Limited supports compassionate engagement and the involvement of those affected by patient safety incidents (patients and Service Users, families, and staff)
- Patient safety partners (PSPs) support and contribute to the governance and management processes for Service User safety at Wellspring Recruitment and Care Services Limited
- Staff conducting investigations have knowledge and experience gained through training
- You can be signposted to support at any point during engagement or involvement in a learning response

Further Reading

NHS England - Patient Safety Incident Response Plan:

https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2022%2F08%2FB1465-8.-Patient-safety-incident-response-plan-template-v1-FINAL.docx&wdOrigin=BROWSELINK

NHS Improvement - Never Events List:

https://www.england.nhs.uk/wp-content/uploads/2020/11/2018-Never-Events-List-updated-February-2021.pdf

NHS England - Patient Safety Incident Response Framework - Preparation Guide:

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-6.-PSIRF-Prep-Guide-v1-FINAL.pdf

NHS England - Patient Safety Incident Response Framework Supporting Guidance - Oversight Roles and Responsibilities Specification:

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf

NHS England - Patient Safety Incident Response Framework Supporting Guidance - Guide to Responding Proportionately to Patient Safety Incidents:

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1-FINAL.pdf

NHS England - Patient Safety Incident Response Standards:

https://www.england.nhs.uk/long-read/patient-safety-incident-response-standards/

NHS England - Patient Safety Incident Response Framework Supporting Guidance - Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident:

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

NHS England - NHS Patient Safety Syllabus:

https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/

Outstanding Practice

To be "outstanding" in this policy area you could provide evidence that:

- The wide understanding of the policy is enabled by proactive use of the QCS App
- Wellspring Recruitment and Care Services Limited has a thorough understanding of its Service User safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programmes
- Olajumoke Omolola ensures that any patient safety incident response processes support health equality and reduce inequality for Service Users, families and staff
- Wellspring Recruitment and Care Services Limited supports and participates in cross system/multi-agency responses where required
- Wellspring Recruitment and Care Services Limited has a culture of fairness, openness and learning

Forms

The following forms are included as part of this policy:

Wellspring Recruitment and Care Services Limited
16 Patmore House, Mayville Estate, Mathias Road N16 8LQ

Title of form	When would the form be used?	Created by
Levels Of Harm - CC200	To understand the levels of harm	QCS
Four Steps Of Engagement - CC200	Engagement with families	QCS

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Levels Of Harm - CC200

Levels of Harm

Physical Harm:

No physical harm: No physical harm occurred.

Low physical harm: Low physical harm is when all of the following apply:

- Minimal harm occurred - patient(s) required extra observation or minor treatment
- Did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit
- Did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication
- Did not or is unlikely to affect that patient's independence
- Did not or is unlikely to affect the success of treatment for existing health conditions

Moderate physical harm: Moderate harm is when at least one of the following applies:

- Has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment and did not need immediate lifesaving intervention
- Has limited or is likely to limit the patient's independence, but for less than 6 months
- Has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm

Severe physical harm: Severe harm is when at least one of the following applies:

- Permanent harm/permanent alteration of the physiology
- Needed immediate lifesaving clinical intervention
- Is likely to have reduced the patient's life expectancy
- Needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
- Has, or is likely to have, exacerbated or hastened permanent or long-term (greater than 6 months) disability of their existing health conditions
- Has limited, or is likely to limit, the patient's independence for 6 months or more

Fatal (previously documented as 'Death' in NRLS):

- Staff should select this option if, at the time of reporting, the patient has died and the incident may have contributed to the death, including stillbirth or pregnancy loss. Staff will have the option later to estimate to what extent it is considered that a patient safety incident contributed to the death

Psychological Harm:

No psychological harm: Being involved in any patient safety incident is not pleasant. Staff should only select 'no harm' if they are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse.

Low psychological harm: Low psychological harm is when at least one of the following applies:

- Distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit

- Distress that did not or is unlikely to affect the patient's normal activities for more than a few days
- Distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

Moderate psychological harm: Moderate psychological harm is when at least one of the following applies:

- Distress that did or is likely to need a course of treatment that extends for less than six months
- Distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months
- Distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months

Severe psychological harm: Severe psychological harm is when at least one of the following applies:

- Distress that did or is likely to need a course of treatment that continues for more than six months
- Distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months
- Distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

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Four Steps Of Engagement - CC200

Four Steps Of Engagement

Before Contact:

- Identify the family contact
- Assess inclusivity needs
- Assess potential support needs
- Ensure familiarity with the incident
- Assess potential for parallel responses and prepare guidance

Initial Contact:

- Provide a clear introduction
- Offer a meaningful apology
- Identify key point of contact
- Explore support needs
- Discuss the incident
- Explain what happens next
- Address questions
- Schedule or discuss next contact (if required)
- **For Investigation:**
    - Confirm involvement preferences

Continued Contact:

- Agree timeframe for responding to questions
- Revisit support needs
- Check for additional questions
- Share experience of the incident
- **For Investigation:**
    - Define/discuss terms of reference
    - Agree timeframe for completion of investigation
    - Revisit involvement preferences
    - Discuss report preferences
    - Share the draft report

Closing Contact:

- Address questions
- Reiterate meaningful apology
- Final contact (formal end)
- Ongoing support
- **For investigation:**
    - Final report
    - Discuss any further investigations
    - Opportunities for further involvement