St Luke's Hospice Plymouth
Patient Safety Incident Response Plan (PSIRP)

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	NAME	TITLE	DATE
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Please note: This plan uses a CONSCISE version template of a PSIRP created by ICBs to support independent/non-NHS providers adopt a proportionate response to risk profile and number of incidents.

Contents

1 Introduction

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF) as a foundation for change and as such, it challenges us to think and respond differently when a patient safety incident occurs. PSIRF replaced the NHS Serious Incident Framework from Autumn 2023.

Unlike previous frameworks, PSIRF is not a tweak or adaptation of what came before. PSIRF is a whole system change to how we think and respond when an incident happens to prevent or reduce recurrence. Previous frameworks have described when and how to investigate a serious incident, PSIRF focusses on creating a culture of learning and continuous improvement. With PSIRF, each organisation is responsible for the entire process, including what to investigate and how. There are no set timescales or external organisations to approve what we do. There are a set of principles that we will work to but outside of that, it is up to us.

The framework is designed to focus on responding to patient safety incidents and near misses in a more proportionate and collaborative way, where exploration and learning is led by those who are trained in systems-based thinking and investigative approaches. It ensures the involvement of patients, their carers, families, and staff in an embedded system that responds in the right way, appropriate to the type of incidents and associated factors. It recognises the principles of a just and learning culture to provide a safe and supportive environment for those involved in any investigation, with the emphasis on learning and systemic improvement.

Analysis of our current systems and clinical incidents has provided an understanding of our patient safety processes and allowed us to use these insights to develop our Patient Safety Incident Response Plan (PSIRP).

For St Lukes, the PSIRF approach is regarded as an opportunity for us to continue building on and embedding the systems-based approach we have used over the past decade. As a Hospice we were signed up to the Sign Up to Safety campaign in 2008, employ an Ergonomics advisor with a PhD in Human Factors and so have a history of applying systems thinking and human factors system-based design across our whole organisation. We see PSIRF as a way of enhancing rather than changing our current approach to learning and improving to create safer care for patients and staff. We are excited about the opportunity that PSIRF brings to align our wider cultural improvement work specifically focussed on staff wellbeing, developing leadership capability and team working, and embedding Just and Learning culture principles with the more specific patient safety improvement work addressed through this Plan.

2 Scope

This Plan outlines the scope for our systems-based approach to learning from patient safety incidents and concerns. We will identify incidents to review through any nationally and locally defined patient safety priorities.

Patient safety incidents are any unintended or unexpected incidents which could have, or did, lead to harm for one or more patients receiving healthcare. There are many ways to respond to an incident. Our Plan covers responses conducted solely for the purposes of systems-based learning and improvement. 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 types of response exist to deal with specific issues or concerns, and it is outside the scope of PSIRF to review matters to satisfy processes relating to these, examples of which may include complaints, HR matters, legal claims and inquests.

3 Resources

As a small organisation, the infrastructure to support implementation of PSIRF is small but proportionate to our size, clinical activity and risk profile. As per the national PSIRF training standards two staff, one with senior level oversight for patient safety and PSIRF implementation, have completed the HSIB Level 2 *Systems Approach to Learning from Patient Safety Incidents* course, HSIB *Investigative Interview Skills* and Level 1&2 of the *NHS Patient Safety Syllabus*. We will ensure that as a minimum, one member of staff completes Level 3 and 4 of the *NHS Patient Safety Syllabus* once a place can be secured, as places are currently prioritised for NHS based staff.

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3.1 PSIRF Training

In 2022, 12 staff including the current CEO, Director of Clinical Services (CQC Registered Manager) and 3 Clinical Heads of Department (HoDs) completed in-house training in a *Systems Approach to Learning from Patient Safety Incidents.* The programme was delivered by a facilitator who met the PSIRF standards for training delivery.

A group of 4 staff representing a cross section of the Hospice, completed a nationally accredited Restorative and Just Learning training programme in early 2024. Following on from this, our OD team has developed an in-house Just and Learning Culture training session. This training promotes the importance of learning from error and supporting those involved rather than apportioning blame. Negative and blame cultures are recognised as being counter productive to the provision of safe and high quality care.

As of February 2025, St Luke's has added Level 2 of the NHS *Patient Safety Syllabus* as a core role based competency for all clinical staff. The Level 1 and 2 training is also available on our LMS system for any staff who wish to voluntarily complete.

3.2 PSIRF Governance

The Board of Trustees (BOT) are apprised of any patient safety issues, concerns, risks through the Director of Clinical Service's quarterly Quality report. This report shares outcome of any learning and improvement.

The Clinical Review Group (CRG) is a subcommittee of the BOT and chaired by a clinical Trustee. It reviews clinical governance and quality improvement as part of its standing agenda and provides assurance or escalates matters to the BOT.

The BEESafe is a sub-committee of the BOT. It reviews health and safety matters including infection prevention and control and staff wellbeing and provides assurance to and escalates concerns to the BOT.

The Quality Assurance Group (QAG) meets monthly and reviews all clinical incidents, near misses, concerns and complaints to ensure appropriate action, investigation and learning has been taken and implemented.

The Patient Safety and Quality Improvement Group (PSQIG) is a multi-disciplinary forum which meets quarterly to discuss and share learning and improvement ideas.

4 Defining our Patient Safety Incident Profile

To determine any priority areas to support the delivery of the new PSIRP, an understanding of the scale of patient related safety activity is required. Data and information from a variety of sources has been gathered and considered.

4.1 Our Service

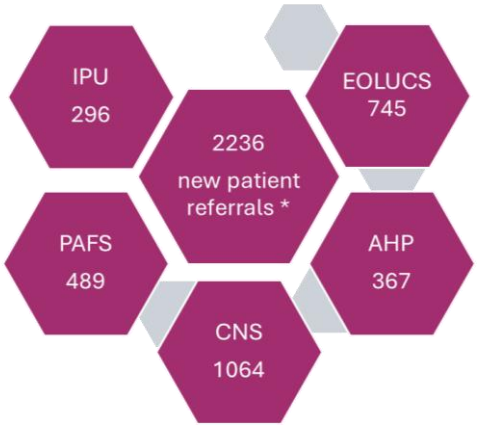
4.1.2 Demand and Capacity

St Luke's provides its clinical care across four core clinical teams:

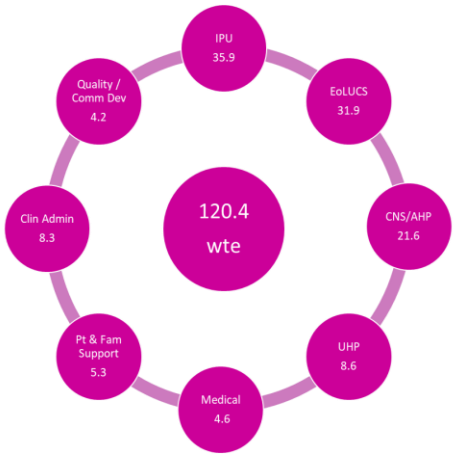
- The Community Clinical Nurse Specialist Team
- The End of Life and Urgent Care Service (EoLUCS)
- The In-Patient Unit (IPU) at Turnchapel
- Input to all services is also provided by our Allied Health Professionals (AHPs) and Patient and Family Support team.

In the year 2023/24 we received the following volume of patient/client referrals, managed by the clinical workforce (wte, as of Nov 2023) shown. St Luke's also provided the Specialist Palliative Care service in Derriford Hospital, up to October 2024 when the team was TUPE'd to UHP.

Patient Referrals 2023/2024



Clinical Workforce – wte (Nov 2023)



(* this figure will include patient referrals made to our UHP based service)

4.2 Patient Safety Events Review

A review of the organisation's risk and incident management system provides the profile and volume of reported clinical incidents, near misses and concerns. The introduction of a new risk and incident management system (Vantage) in March 2023 has enabled the Hospice to improve recording of patient safety incidents, near misses and concerns across all services. Historically, due to participation in the HospiceUK Patient Safety Network we have been stronger at collecting and reporting key patient safety metrics on the IPU (Falls, Pressure Ulcer and Medication incidents). With the introduction of more nuanced categorisation and open, online reporting access for all staff, we are now able to develop a better understanding of some of the key patient safety issues both within St Luke's and across Palliative and End of Life (PEOL) pathways within the geographic community we serve.

IPU Reported Incidents					
Year	20/21	21/22	22/23	23/24	24/25 (to end Q3)
Falls					
No. falls	19	31	25	25	18
No. per 1000/OBD	6.2	9.7	7.6	7.7	7.8
No. graded => moderate harm	1	1	1	3	1
Pressure Ulcers					
No. **New**	x	14	6	20	31
No. per 1000/OBD	x	4.4	1.8	6.7	13.5
No => Cat 3	x	1	0	0	1
No. **POA**	x	23	42	24	41
No. per 1000/OBD	x	7.2	12.5	7.4	17.8
No. =>Cat3	x	1	6	4	0
Medication Incidents					
No. med incidents	4	22	11	6	16
No. per 1000/OBD	1.3	6.9	3.3	3.7	6.9
No. graded =>moderate harm	0	0	1	0	0
Patient Deaths					
No. Deaths on IPU/All Discharges (% deceased)	140	191	216/263 82%	208/251 83%	140/183 77%
Community Reported Clinical incidents					
Partnership concerns	x	x	x	21	30
Medication Incidents	x	x	x	32	20
Equipment failure	x	x	x	1	2
Staff behaviour	x	x	x	2	2
Patient / client behaviour	x	x	x	7	4
Clinical - Service Wide					
Serious Incidents					
No. classified SI	0	0	0	0	1
Inquests/Legal Cases					
No. cases	0	0	0	0	0
Clinical Complaints					
No. by calendar yr 2022 & 2023	7	10	7	7	7
Safeguarding					
No. safeguardiing alerts raised	7	1	23	15	10
Data Protection (clinical specific*)					
No. data protection breaches	6	3	x	6 (1*)	6 (5*)
Freedom to Speak Up (F2SU) (by clinical team*)					
No. concerns raised to F2SUG	x	x	x	8 (4*)	5 (3*)

(OBD = Occupied bed day)

4.3 Partnership Concerns

The key themes emerging from 'partnership concerns' relate to delays and accuracy in prescribing, administering or obtaining medications, seeking GP input - particularly out of hours, and issues around ambulance transport. We have also seen an increase around concerns raised about other care providers who our EOLUCs team work alongside in providing CHC funded care.

4.4 Learning from Patient Safety Episodes (LFPSE) system

The Community team have historically reported any wider partnership concerns through the Devon ICB PITCH reporting system. The Hospice is registered with LFPSE so staff can report system-wide incidents, and we can hear, learn and act on any concerns or incidents system partners report about our services.

4.5 Mortality Reviews

All our clinical teams conduct weekly mortality reviews, with an aim to review every patient death. Since 2022 the Hospice has been participating in a pilot project with the Plymouth Medical Examiner's (ME) office regards reporting deaths which occur in community settings. As of April 2024, the national change was implemented, and all deaths are now reviewed by the ME Office (unless referred to the Coroner). To date, the ME's office has not raised any issues or concerns. In 2025 we launched our new in-depth all team mortality review based on a model developed by St Helena's Hospice, Liverpool. Cases are picked randomly each month (1 case from each team), reviewed and discussed by a multi-disciplinary team. In the spirit of encouraging true system learning the intent is to invite any partners to join us for reviews, e.g. – UHP, Livewell, Primary Care, Marie Curie team.

4.6 Patient Complaints

The key themes which emerge from a review of patient complaints surround continuity of care, particularly highlighting confusion with the roles, responsibilities and number of different agencies involved in care provision, referral delays and access to care (particularly out of hours) issues around medication and attitude of staff.

4.7 Our People

Every 2 years we undertake a survey of staff and volunteers across the whole organisation. These results highlight how respondents replied to a selection of questions - chosen as they have relevance when considering our workplace culture, sense of staff belonging, value, purpose and wellbeing. We need to create conditions where staff feel they can bring their authentic self to work and feel psychologically safe and so able to raise any concerns or ideas they may have.

Whilst we listen and talk to staff to understand the experiences beneath the results to continuously improve staff and volunteer experience, it is good to see that most respondents report a positive experience of working at St Luke's. Positive staff experience sets the foundation for safer care, based on the published evidence demonstrating an inextricable link between staff experience and patient experience/outcomes.

Respondents' cumulative results to selected questions.
97% would be happy with the standard of care if a friend or relative needed treatment
93% are proud to work for this charity
93% enjoy the work they do job
83% are comfortable being themselves at work
88% feel they are making a difference
83% would be able to raise a personal /wellbeing issue
77% receive clear feedback from their immediate manager on their work
77% would recommend the charity as an employer
74% have not experienced bullying or harassment at work
71% feel appreciated
65% feel their morale at work is high
61% feel their workload is manageable
57% feel views are listened to and valued

5 Involving Patients, Families and Carers

One of the fundamental standards identified by the NHS and CQC (Regulation 20) is the Duty of Candour. As a provider of outstanding care, we work to ensure that staff at all levels understand and operate within a culture of openness and transparency. Whenever any type of untoward event involving a patient occurs, irrespective of harm level, we will inform and apologise to the patient and/or their advocate (unless the patient specifically requests that we do not discuss with the advocate). Recording of 'duty of candour' conversations is included on SystmOne, our patient information record system and electronic incident reporting system. Where there is further investigation and learning to share we will ensure the patient and/or advocate is kept informed and involved to the extent that they want.

We welcome and encourage all types of feedback, including; concerns, complaints, learning and improvement suggestions, and positive feedback. By listening to the concerns and experiences of patients and families, we gain valuable insights into their needs, expectations, and preferences. Learning from lived experience also helps us develop a real understanding of how 'work is done' rather than 'work as imagined' – a key factor in strengthening and building safer care. In 2025 we will establish a *Hospice User Group* which will ensure we have another avenue to hear the voices of patients, families and our wider community to learn and improve together.

6 Our Plan: National Requirements

NOTE: This section is standard from the national guidance (and recommended that it is included as it outlines the mandated requirements)

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Incidents meeting the Never Events criteria (2018), and deaths thought more likely than not due to problems in care (i.e., incidents meeting the Learning from Deaths criteria for PSII) require a locally led Patient Safety Incident Investigation (PSII).

The table below sets out the local or national mandated responses to events which could be relevant within our Hospice sector.

	National priority	Response
1	Incidents that meet the criteria set in the Never Events list 2018	Locally led PSII
2	Deaths clinically assessed as more likely than not due to problems in care	Locally led PSII
3	Death of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally led PSII (or other response) may be required alongside the LeDeR review
4	Safeguarding incidents in which: Babies, children and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism; modern slavery & human trafficking or domestic abuse/violence.	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards
5	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation team for consideration for an independent PSII. Locally led PSII may be required with mental health provider as lead and STG / ESTH participation
6	Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the

		criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.

7 Our Plan: Local Focus

Based on a review of the data currently available we have determined what our priorities will be and what approaches we will normally take to explore, learn and improve. We will need to seek agreement from our health and care partners on how best we all use the PSIRF to support collaborative and systems-based thinking to address some of the 'wicked problems' which face patients, families and staff working across our wider community. We believe this is the opportunity that PSIRF enables, freeing us all to identify and investigate less volume but more effectively and collaboratively. Our plan below shows how we as an organisation would propose to use different tools to address the issues we see most commonly.

St Luke's is currently working closely with the Quality and Safety team at our local community provider, Livewell South West, to develop greater collaboration in strengthening safer care and promoting a systems-based thinking approach to improvement.

Patient Safety Issue	Planned Response	Anticipated Improvement Route
Patient falls	PSR - SEIPS, Huddle & thematic review	Learning and improvement activity identified, developed, and shared through IPU Leadership group
Pressure ulcers – (Grade 3 and Grade 4*)	Thematic review *PSII (as per national)	Learning and improvement activity identified, developed, and shared through IPU Leadership group & EOLUCS
Smooth discharge from IPU, particularly communication re TTOs	PSR – SEIPS, Huddle & AAR	Learning and improvement activity identified, developed, and shared through IPU Leadership group & PSQIG
Medication errors	PSR – SEIPS, Huddle, Thematic review	Learning and improvement activity identified, developed, and shared through PSQIG
Partnership working – medicines optimisation	Thematic review, multi-agency reflect & learn	Learning and improvement activity identified, developed, and shared through Primary Care Network & End of Life Area group
Partnership working – transport issues	Thematic review, multi-agency reflect & learn	Learning and improvement activity identified, developed,

		and shared through End-of-Life Area group

This PSIRP will have the flexibility to manage emergent risks or new incidents that signify extreme levels of risk or incidents that do not fall into the outlines national or local categories. We will take a pragmatic approach and a proportionate response to maximise learning.

8 Review of the Plan

We will review this plan every 18 months in line with national guidance. If there is a change to the plan, we will notify our Board of Trustees through the Clinical Review Group and where relevant, system partners and or the ICB to apprise them of the changes.

Annex 1 - Glossary

PSII - Patient Safety Incident Investigation

PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

PSIRP - Patient Safety Incident Response plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through discussion and analysis of local data.

PSIRF - Patient Safety Incident Response Framework

Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSR – Patient Safety Review

The term Patient Safety Review refers to a lightly hybridised version of AARs & swarm. It refers to the action of bringing staff together to reflect on an event whilst its still fresh in their mind. Depending on the event it might be appropriate to follow a more structured model like AAR, a hot debrief / SWARM huddle (as close to the event as possible and focussed on ensuring patient and staff wellbeing/ closure immediate actions), or a more in-depth facilitated reflect and learn session.

AAR – After action review

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 to identify the opportunities to improve and increase to occasions where success occurs.

Never Event

Patient safety incidents that are considered to be preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Deaths thought more likely than not due to problems in care.

Incidents that meet the 'Learning from Deaths' (LfD) criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

The Four PSIRF Learning Response Tools

The PDF attached is for reference. It gives some useful guidance on what different methods are available to support learning and includes an assessment of their strengths and weaknesses.

The-Four-PSIRF-Learning-Response-Tools·

PSIRP Consultation

As a courtesy and in line with the principle of system-wide learning our draft PSIRP was shared with external partners for feedback, including

- Devon ICB
- Livewell Southwest

Internally the plan was developed with and reviewed by

- Clinical HoDs
- Patient Safety & Quality Improvement Group (PSQIG)
- Clinical Review Group (CRG) (March 2024 and February 2025)
- Senior Management Team (SMT)