AccEPT Patient safety incident response policy

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	NAME	TITLE	SIGNATURE	DATE
Author	**Kim Wright**	**Prof**	**KWright**	**29.1.26**
Authoriser	**Kim Wright**	**Prof**	**KWright**	**29.1.26**

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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the Accept Service's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

This policy is based on NHS England's Patient Safety Incident Response Framework (PSIRF).

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement within the AccEPT Service.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. 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.

Our patient safety culture

In addition to our formal incident reporting process, whereby incidents are reported to the clinic lead by email, Tthe AccEPT Service creates opportunities for people to raise concerns through general staff meetings, regular supervision and staff meetings focussed upon particular clinical topics. Highlighting actual or potential safety issues is actively encouraged. Where instances relevant to patient safety are reported the service aims to take a systemic approach to the matter, speaking to members of staff involved and attempting to understand the factors leading to the incident. A report and action plan is produced and the members of staff concerned are informed of the outcomes. Staff confidence in the patient safety incident process is monitored through the annual staff survey.

The AccEPT Service has in place a policy on freedom to speak up that all staff are reminded of on an annual basis. In terms of points of contact for whistleblowing / freedom to speak up outside of the Service staff are able to make use of the University of Exeter formal, informal and anonymous reporting procedures: Exeter Speaks Out | Exeter Speaks Out | University of Exeter and also an independent speak-up service: The Guardian Service: katy.s@theguardianservice.co.uk or wayne.w@theguardianservice.co.uk or call 0333 001 5124.

The policy gives details of who staff can speak to outside of the organisation and in the local NHS structures.

Patient safety partners

The AccEPT Service works with a panel of individuals with lived experience of mental health difficulties, many of whom are previous patients of the service (Friends of AccEPT: FoA). This panel supports the work of the service. FoA members have been consulted on the design of the incident response process over 2025-2026.

Addressing health inequalities

The numbers of patient safety incidents reported in the AccEPT service are extremely small, making it difficult to identify patterns or trends in the data pertaining to health inequalities. The response tool requires consideration of equality issues when exploring incidents, and as is standard practice in our service, patients and families are communicated with giving careful consideration to their individual needs.

Engaging and involving patients, families and staff following a patient safety incident

The AccEPT Service recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Patient safety incidents meeting the PSIRF threshold (the DPT identified priorities) for a full Patient Safety Incident investigation (PSII) will be investigated by Devon Partnership NHS Trust in partnership with the clinic leads. The clinic co-lead most independent from the event will investigate incidents not meeting the threshold i.e. a local learning response. They will apply duty of candour as appropriate (notifiable safety incident: Duty of candour - GOV.UK).

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

Resources and training to support patient safety incident response

The operational clinic lead will receive training in patient safety incident responding.

Our patient safety incident response plan

Our plan sets out how the AccEPT Service intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

Updated plans will be published on our website (AccEPT Clinic | AccEPT Clinic | University of Exeter), replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement

Responding to patient safety incidents

Patient safety incident reporting arrangements

Patient safety incidents will be notified internally to the clinic co-leads and externally via LFPSE. Data breaches will be reported through LFPSE and to the Information Commissioner's Office (ICO) if there's a risk to people's rights and freedoms, within 72 hours of becoming aware of the breach.

We will review CAS alerts as they arise and locally document our response to these.

Patient safety incident response decision-making

Patient safety incidents meeting the PSIRF threshold (the DPT identified priorities) for a full Patient Safety Incident investigation (PSII) will be investigated by Devon Partnership NHS Trust in partnership with the clinic leads.

The clinic leads will make the initial decision as to whether the incident meets the PSIRF threshold (with advice from DPT if required).

The lead will ensure actions for AccEPT from any PSII are attributed and completed.

The lead will direct any local learning response for incidents not meeting the PSII threshold.

Responding to cross-system incidents/issues

The AccEPT service lead will work with others in the local system to respond effectively to cross-system incidents. It is likely that in such instances leadership will reside within the larger organisations involved.

LFPSE will be monitored by AccEPT for information about patient safety incidents relevant to our service.

Timeframes for learning responses

Timescales must be set where possible for all response methods. A response must start as soon as possible after an incident is identified, and usually completed within one to three months. The timeframe for completing a PSII should be agreed with those affected by the incident, as part of setting the terms of reference for the PSII,

provided they are willing and able to be involved in that decision. PSIIs (and other local response) should take no longer than six months, but this must not become a new default target. If an organisation's local responses are often taking more than 6 months, or exceeding timeframes set with those affected, then processes should be reviewed to understand how timeliness can be improved. In exceptional circumstances (eg when a partner organisation requests an investigation is paused), a longer timeframe may be needed to respond to an incident. In this case, any extension to timescales should be agreed with those affected (including the patient, family, carer, and staff).

The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the incident, and the risk that for as long as findings are not described, action may not be taken to improve safety or further checks will be required to ensure the recommended actions remain relevant. Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the local response leads should work with all the information they have to complete the response to the best of their ability; it may be revisited later, should new information indicate the need for further investigative activity.

Safety action development and monitoring improvement

The safety action development and improvement monitoring process will be proportionate to the incident. For more minor incidents this may involve cascading information to the staff team and scheduling of a future monitoring check, for example. For more serious incidents this may involve production of an incident report and safety action plan, involvement of an independent individual to consult on the report and plan, and institution of a regular monitoring process.
Relevant tools can be found here:

https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/#heading-5

https://www.hssib.org.uk/education/resources/

Safety improvement plans

Given the small size of the AccEPT service (currently around 3fte clinicians) safety improvement plans will focus on the service specifically.

Oversight roles and responsibilities

The clinic co-leads are responsible and accountable for PSIRF in AccEPT. This includes supporting and participating in cross-system / multi-agency responses and / or independent patient safety incident investigations (PSIIs) where required.

The clinic operational lead will take on the responsibilities of the PSIRF executive lead including overseeing the development, review and approval of the relevant policies and plans and ensuring they meet the responsibilities in the PSIRF where relevant.

Patient safety incidents will be reviewed annually by the senior leadership team of the AccEPT service. This will involve scrutiny of any incidents over the past year in terms of learning and actions taken as a result as well we consideration of whether or not the current policy and plan is fit for purpose.

will work in partnership with Devon Partnership NHS Trust both in terms of reviewing higher level incidents, and in terms of accessing appropriate training and engaging in system-wide reviews and process improvement.The clinic operational lead is responsible for reviewing PSII reports in line with the patient safety incident response standards and signing them off as finalised. They may be supported in this by relevant colleagues as appropriate. While a full report for submission to the leadership team may not be produced for learning response methods other than PSII, the clinic operational lead will monitor the quality of all response methods. For general guidance see: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf

Complaints and appeals

Information about the complaints process is publicly available here: Our policies | AccEPT Clinic | University of Exeter