Patient Safety Incident Response Policy

Pathways Associates CIC

Effective date: January 2026

Revision date: March 2026

Estimated refresh date: July 2027 (or sooner if significant changes in legislation, guidance, or organisational activities occur)

Reviewed by: Laurence Clark

Responsible Officer: CEO

Approved by: CEO

Main Contact for Queries: info@pathwaysassociates.co.uk

Purpose

This policy supports the requirements of the **Patient Safety Incident Response Framework (PSIRF)** and sets out **Pathways Associates CIC**'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 the 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.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across **Pathways Associates CIC's Expert Hub,** which supplies experts by experience and independent clinicians to Care and Treatment Reviews.

Although Pathways Associates does not provide care and treatment to NHS patients as part of the Expert Hub, their staff, experts by experience and independent clinicians will come into contact with NHS

patients during the course of their work and have a duty to report patient safety incidents.

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

Pathways Associates CIC is a co-production focused, not-for-profit Community Interest Company. We place lived experience at the heart of everything we do. Our culture is built on:

- **Co-production** with Experts by Experience
- **Inclusion** and valuing diverse perspectives
- **Compassionate**, trauma-informed practice
- **Continuous learning** and improvement

Pathways Associates CIC embraces a Just and Learning Culture that enables everyone to contribute to a fair, safe and compassionate environment when things don't go as planned. We want to create an

environment where our staff, experts by experience and independent clinicians feel it is safe to report incidents or near misses, so that the organisation is aware of them providing us with an opportunity to learn. As part of our continuous improvement journey, when incidents happen, we focus on what was responsible rather than who was responsible so that our staff feel supported when things go wrong and empowered to learn, rather than feeling blamed.

Patient Safety Partners

NHS Patient Safety Partners (PSPs) are patients, carers, or laypeople who work within NHS organisations to improve safety, governance, and culture. Introduced in 2022 by NHS England, they assist in safety committees, review incidents, and develop safety resources to provide a patient perspective.

As we are not an NHS organisation, we have not appointed a Patient Safety Partner within Pathways Associates.

Instead, we actively involve **Patient Safety Partners** from NHS organisations who commissioned the services of our Expert Hub.

Addressing Health Inequalities

Pathways Associates CIC recognises the health inequalities faced by population groups/communities and individuals are unfair and that these differences in health across the population, and between different groups within society are avoidable.

Most of our delivery is with by people with learning disabilities, autistic people and people with mental health issues.

Pathways Associates CIC recognises that at both a national and local level we have a role to play in reducing and removing health inequalities, which impact on people's outcomes and experiences, and across all our work (in line with the Equality Act 2010) we ensure that no one is disproportionately impacted on the grounds of their specific characteristic.

Our focus is to work with and include everyone, regardless of their skin colour, culture, ethnicity or faith, gender or sexuality, age or impairment and do not tolerate, under any circumstances, any form of racial abuse or discrimination.

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

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. We prioritise **compassionate engagement** and involvement of those affected (including patients, families, carers, Experts by Experience, and staff). This involves:

- Early, empathetic communication
- Listening to concerns and questions
- Providing clear, accessible information
- Signposting to independent support services (e.g. advocacy, counselling)
- Involving affected individuals in the learning process where appropriate and desired

Our Duty of Candour policy outlines the following aims:

- Be open and transparent when things go wrong, notifying affected people promptly
- Provide sincere apologies and clear explanations without admitting liability
- Offer emotional and practical support to those impacted
- Investigate incidents fairly and learn from them to prevent recurrence. (Since Pathways Associates does not provide care and treatment directly to NHS patients, it will not handle the investigation itself. Instead, it will report the incident to the commissioning ICB / NHS trust and collaborate appropriately in their investigation while maintaining our learning-focused remit.)

- Comply fully with legal requirements and report where necessary
- Foster a no-blame culture that encourages reporting and improvement

We are committed to continuous improvement throughout the service we provide. We want to learn from patient safety incidents.

Patient Safety Incident Response Planning

Our **Patient Safety Incident Response Plan** sets out how Pathways Associates CIC intends to respond to patient safety incidents over a period of **12 to 18 months**. The plan is flexible and considers the specific circumstances of each incident and the needs of those affected.

Resources and Training to Support Patient Safety Incident Response

All staff, independent clinicians and Experts by Experience will receive training in:

- PSIRF principles
- Compassionate engagement
- Trauma-informed practice
- When and how to raise a concern about patient safety.

We provide ongoing support and reflective practice opportunities.

Our patient safety incident response plan

Our plan sets out how Pathways Associates 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 response plan is a **'living document'** and will be reviewed every **12 to 18 months**, or sooner if significant learning emerges or our incident profile changes.

Updated plans will be published on our website (pathwaysassociates.co.uk), replacing the previous version.

A more rigorous planning exercise will be undertaken every **four years** or more frequently if appropriate (as agreed with relevant partners/Integrated Care Board) and well include wider stakeholder engagement with independent clinicians and Experts by Experience

Responding to Patient Safety Incidents

Patient safety incident reporting arrangements

All staff, independent clinicians and experts by experience working for our Expert Hub members are responsible for reporting incidents via our online CTR Review Survey. This survey asks if they want to raise any concerns. They also have the option of reporting an incident directly to the chief executive. Reports are treated confidentially and without blame.

Patient safety incident response

Since Pathways Associates does not provide care and treatment directly to NHS patients, it will not handle the investigation itself. Instead, it will report the incident to the commissioning ICB / NHS trust in a timely manner. We will collaborate appropriately while maintaining our learning-focused remit.

Timeframes for learning responses

We aim to report patient safety incidents to the relevant commissioning ICB / NHS trust within 24 hours of being made aware of the incident.

Safety action development and monitoring improvement

Any actions arising from the commissioning ICB / NHS trust's investigation that concern our practice will be reflected in our PSIRF plan and monitored through our governance structure.

Oversight Roles and Responsibilities

- **Board/Leadership Team** – Overall accountability for PSIRF implementation
- **Expert Hub Lead** – Day-to-day oversight of incident reporting
- **All staff, independent clinicians & Experts by Experience** – Responsibility to report incidents and engage in learning

Complaints and Appeals

Any concerns about our patient safety incident response process should be raised via our complaints procedure. The organisation is committed to deal with any complaints as quickly as possible. Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

This policy will be reviewed annually and updated as required to reflect learning and changes in national guidance.