Cleveland Clinic
London
Safety, Quality, Patient Experience & Governance

Stand Up for Safety-Our Patient Safety Incident Response Plan (PSIRP)

2026

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Contents

Foreword from our Safety, Quality & Patient Experience Director

When questioned about the purpose behind investigating incidents, the common response often centres around the concept of learning. However, this understanding frequently remains confined to grasping the specific details of what transpired, whereas it should embrace a more comprehensive perspective. How often do we encounter the simplistic response of "we investigated it" when addressing an incident? To what degree have concrete changes or improvements been demonstrably achieved through these methodologies over the past two decades?

Since its inception in 2021, Cleveland Clinic London has dedicated itself to establishing robust operational processes that strengthen its approach to patient safety incidents. Over these years, numerous initiatives have exemplified an unwavering commitment to learning and engagement. Most notably, significant strides have been made toward cultivating a restorative just culture where psychological safety is a central priority.

A crucial aspect of this transformative journey involves fostering a patient safety culture that encourages open communication. Initiating conversations and encouraging individuals to speak up within the context of a patient safety incident can be challenging. We are actively exploring ways to empower and support our colleagues in effectively understanding the perspectives of those involved.

It is paramount to acknowledge that investigations serve valuable purposes. Sharing findings, engaging with those directly involved, validating decisions in patient care, and facilitating psychological closure for affected parties are fundamental objectives of any investigation.

Our current challenge lies in developing an investigative approach that generates thematic insights to propel continuous improvement. Unlike previous frameworks, the Cleveland Clinic's "Stand up for Safety" - Patient Safety Incident Response Framework (PSIRF) signifies a comprehensive shift in how we conceptualise and respond to patient safety events to prevent recurrence. PSIRF, unlike its predecessors, is not a mere adjustment or adaptation but rather a systemic transformation focusing on learning and improvement.

In the pursuit of optimal safety outcomes for patients, an exceptional patient safety culture is imperative. Cleveland Clinic London remains steadfast in its commitment to evolving into a high-reliability organization, ready to embark on the next phase of our journey. PSIRF stands as a foundational element in this ongoing journey. Recognising the intricacies of cultural transformation, we are dedicated to embodying an organisation that authentically embraces a safety culture, providing an environment where individuals feel secure to voice their concerns.

Richard

Richard Lloyd-Booth
Director Safety, Quality & Patient Experience

Introduction

Cleveland Clinic London (CCL) is delighted to present the 'Stand Up for Safety' - Patient Safety Incident Response Plan (PSIRP). This comprehensive plan outlines our commitment to responding to and learning from patient safety events reported by both caregivers and patients, aligning with CCL's ongoing efforts to enhance the quality and safety of care. The plan is designed to be adaptable as needed, showcasing CCL's flexibility in addressing specific circumstances surrounding patient safety issues and incidents and catering to the needs of those affected.

CCL has collaborated with major health insurers, the Care Quality Commission, and the Northwest London Integrated Care Board (ICB), with the approval of NHS England (NHSE). This collaboration reflects the spirit of cooperation at the core of PSIRF.

The plan is based on CCL's Quality Assurance Framework, safety reporting policies, Radar (the Quality Management System), and the PSIRF Policy. This policy outlines escalation steps, responses to PSIs, and support for safety actions, improvement plans, and ongoing monitoring.

This revised plan spans a 12-to-18-month period in alignment with the national Patient Safety Strategy for England Patient Safety Incident Response Framework (2019). The PSIRP will continually evolve as CCL learns from its experience within PSIRF. CCL will maintain flexibility, considering the specific circumstances in which patient safety issues and events occurred, as well as the needs of those affected.

The ambition that drives activities within this plan are to:

- Prevent avoidable harm
- Deliver sustainable safety learning insights
- Steer quality and safety improvements in our services
- Reduce the likelihood of patient safety events recurrence

Our plan will help us improve the efficacy of our local patient safety incident responses by:

- Refocusing Patient Safety Incident Investigations (PSIIs) towards a systems approach and the rigorous identification of interconnected causal factors and systems issues
- Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents.
- Transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and caregivers) confidence in the improvement of patient safety through learning from incidents.
- Demonstrating the added value from the above approach

The aim is for this plan to remain dynamic and flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

Strategic aims

Safety is central to Cleveland Clinic's values and guides all operations. Our goal is harm-free, high-quality patient care. The "Stand Up for Safety" initiative empowers Caregivers to speak up without fear, while the Patient Safety Incident Response Plan (PSIRP) supports a reliable, accountable work environment.

We aim to cultivate a climate supporting a just culture and an effective learning response to patient safety incidents. The shift in emphasis from the quantity to the quality of investigations aims to make them more rigorous, identifying causal factors and systemic improvements. Our overarching objective is to optimise current resources, enhance the quality of investigations, and ensure a proportionate response to patient safety incidents, ultimately leading to a safer and more reliable healthcare environment. This approach promotes ownership, rigor, expertise, and efficacy.

Engaging patients, families, carers, and caregivers in investigations and other responses fosters a deeper understanding of issues and causal factors. This approach ultimately facilitates the development and implementation of improvements in a more effective manner. The "Communicate with H.E.A.R.T" service model, an enterprise-wide framework, outlines communication and service excellence behaviours for all caregivers. This empowers caregivers to address patient and colleague concerns and questions with care and responsiveness.

A High Reliability Organisation (HRO) is our aspiration, where all processes, policies, and procedures are consistently adhered to, and potential errors are identified and rectified before causing serious harm to patients or caregivers. To achieve HRO status, we have developed two sets of behaviours: CORE Behaviours for all caregivers and LEAD Behaviours for leaders. If each caregiver incorporates and models these behaviours daily, our goal of achieving Zero Harm is attainable. (Figure 1) All caregivers undergo customized Level 1 & Level 2 face-to-face Patient Safety, high-reliability universal skills & Governance Training during their induction, closely linked to the national PSIRF NHS training and competency program.

Figure 1

Our services

Cleveland Clinic London is part of a global health system that consistently ranks among the top hospitals in the world. We focus on clinical excellence, safety and patient outcomes, all supported by research, medical education, technology and teamwork.

Cleveland Clinic London offers:

- 1,440 caregivers, including 270 medical doctors and 450 nurses.
- 184 inpatient beds.
- 29 ICU beds.
- 8 operating theatres.
- 21 day case rooms for surgery.
- 42-bed neurological suite for rehabilitation.
- Cleveland Clinic Moorgate Outpatient Centre
- Cleveland Clinic Parland Place Outpatient Centre

Through collaboration and learning, Cleveland Clinic London combines the best of Cleveland Clinic with the best of U.K. healthcare. Cleveland Clinic London works alongside the National Health Service (NHS), other private health organisations and leading U.K. clinical research institutes to share knowledge and continually improve the care we deliver.

Cleveland Clinic London Ltd, as a service provider, is registered with the Care Quality Commission to carry out the following Regulated Activities:

- Diagnostic and screening procedures
- Family planning services
- Surgical procedures
- Treatment of disease, disorder, or injury.

Service Types:

- Acute services
- Diagnostic and screening services
- Doctor consultation services
- Doctor treatment services
- Remote clinical advice services

Our mission — caring for life, researching for health, educating those who serve — has driven us to seek continual innovation and improvement over our 100-year history.

Defining our Patient Safety Incident Profile

We have developed our understanding and insights over the past years, including regular discussions and engagement through our PSIRF steering group, as well as discussion at the executive management team meetings (EMT) and Integrated Governance Committee.

Our patient safety issues, and risks have been identified from the following data sources:

- Review and analysis of 4 years of incident reporting data
- Further thematic review of incident reporting data
- Key themes from complaints, claims and inquests
- Key themes and issues from committees and sub-groups with a remit relating to aspects of quality and patient safety (such as medicine safety group, falls steering group etc.)
- Our risk registers
- Themes noted through learning from mortality reviews
- Stakeholder discussions

The insights obtained from analysis of the above data sources were used to inform our local priorities for learning responses within our plan.

We recognise that our plan is not a static document. Our patient safety incident profile will, therefore, be assessed on an on-going basis to ensure we are capturing emerging trends, hotspots, and new patient safety risks; these emerging risk areas will be escalated to our monthly Integrated Governance Committee as appropriate. Both EMT and the Enterprise SQPE executive team will receive and provide challenge to assurance in CCL's response and learning from patient safety incidents.

After reviewing our quality and safety data, we considered existing CCL safety improvement programmes. These programmes will help advance the organisation's PSIRF goals and guide development of safety plans. Sub-groups within Nursing shared governance and the Continuous Improvement Council monitor these plans and report to executive management and the Integrated Governance Committee.

To define our key patient safety risks and planned responses we have taken a collaborative approach that involved the following stakeholders:

- Patient groups through cross-site engagement events
- Caregivers through webinars and away days
- Senior leaders through institute governance boards
- Partner organisations such as NHS partners and Private Medical Insurers

Each of these safety improvement programmes has defined metrics for improvement and overarching plans. The following improvement programmes aligned to the delivery of our PSIRF ambitions have been identified:

- Improving outcomes and reducing the risks related to hospital associated thrombosis
- Reducing harm associated with inpatient falls, with an initial focus on falls risk assessment
- Reducing the risk of harm when undertaking invasive procedures by embedding the National Safety Standards for Invasive Procedures (NatSSIPs2)
- Reducing infection transmission; with an initial focus on improving standards of infection prevention and control practice
- Reducing medication related harm

Additionally, throughout all Cleveland Clinic Hospitals in the UK and worldwide, the Enterprise pinpoints key improvement programs. Each priority is managed by a Senior Responsible Officer (an Institute Vice Chief) and overseen by the Director of Safety, Quality, and Patient Experience.

The following improvement priorities were identified for 2026:

- Reduction in moderate or severe physical harm events
- Reduction in Catheter Associate Urinary Tract Infections
- Reduction of Hospital Acquired Pressure Injuries

Mechanisms to Develop and Support Improvements Following PSIIs:

Our improvement priorities will be directly informed by our patient safety priorities identified from patient safety investigations and identification of themes, as well as by key operational and pathway improvement priorities from across the organisation.

Findings from PSIIs and other learning responses provide key insights and learning opportunities, but they are not the end of the story. Recommendations may be translated into safety actions, which will be detailed on the incident reporting system (Radar) and reviewed and monitored through the continuous improvement council.

If a single response reveals significant risk(s) that require(s) immediate safety actions to improve patient safety, action will be taken as soon as practically possible.

Cleveland Clinic has developed a network across its entire organisation, dedicated to patient safety education and quality improvements in every area it serves. The program brings together caregivers involved in patient safety and enhancement initiatives, fostering collaboration and enabling achievements to be recognised internationally. Cleveland Clinic London also plays a role by contributing insights on patient safety outcomes.

Our patient safety incident response plan: National Requirements

Cleveland Clinic London (CCL) is committed to responding proportionately to patient safety events associated with the key risks identified in our situational analysis. This framework provides flexibility in selecting response methods based on the nature, severity, frequency, and learning objectives associated with each patient safety incident (PSI). Regardless of the chosen response method, the overarching aims remain consistent:

1. Respond to Concerns: Address concerns raised by any patient, their family, or a staff member promptly and comprehensively.
2. Understand Incident Contributors: Conduct thorough investigations to understand the contributing factors that led to the occurrence of the incident in the first place.
3. Identify Areas for Improvement: Identify and analyse areas for improvement, acknowledging the systemic aspects that may have contributed to the incident.
4. Enhance Safety for Future Patients: Implement measures to improve safety, ensuring that lessons learned are applied to prevent similar incidents and enhance overall patient safety for future patients.

Patient safety incident type	Required response	Lead body response
Incidents meeting the Never Events criteria	PSII	CCL
Incident leading to death thought more likely than not due to problems in care	PSII	CCL
Deaths of persons with learning disabilities	PSII	CCL refer to Learning Disability Mortality Review (LeDer)
Safeguarding incidents	These must be reported to CCL Safeguarding Lead and Director Safety Quality & Patient Experience for review and multi-professional investigation. CCL will contribute towards domestic independent inquiries, joint targeted area inspections, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding adults boards	Local designated professionals for child and adult safeguarding

Our Patient Safety Incident Response Plan: Local Focus

Our Stand Up for Safety framework acknowledges that the response method chosen should align with the specific characteristics of each incident. This approach allows for a nuanced response strategy that considers the incident's severity, frequency, and the type of learning needed.

Not all patient safety incidents require a comprehensive investigation (e.g. a PSII) but may instead benefit from different types of learning response to gain insight or address queries from the patient, family, carers or caregivers.

Where this is the case, CCL will consider other learning response techniques such as an after-action review, mortality case review, surgical case review or thematic review. The goal is to foster a culture of continuous improvement, where every patient safety event serves as an opportunity to enhance the quality and safety of care provided by CCL.

CCL has established a robust framework to capture, analyse, and learn from low harm and no harm incidents. A thematic analysis approach will be employed to find recurring patterns across all incidents, regardless of severity, and to develop targeted safety improvements. This will help ensure that all incidents contribute to a comprehensive understanding of patient safety risks and inform proactive measures to prevent harm, even in less severe cases.

Our local priorities outlined in the table below provide a list of key patient safety risks and themes which have been identified for pre-defined learning responses. This list has been developed based on the following criteria:

Potential for harm / future harms:

- People: physical, psychological, loss of trust (including impact on patients, family & caregivers)
- Service delivery: impact on the quality and delivery of healthcare services; impacts on service capacity

Potential for learning and improvement Likelihood of occurrence:

- Persistence of the risk
- Frequency
- Potential to escalate

These pre-defined responses DO NOT mean these are the only events CCL will be responding to; we will continue to review and respond to every incident report, ensuring the most appropriate learning response is being initiated. No harm and low harm incidents, not defined as a local priority within our plan, will follow our local incident management policy for local review and learning will be used to inform ongoing areas of improvement at Institute, Cleveland Clinic London or Enterprise-wide level.

A review of safety learning across each department and Institute will be undertaken on an annual basis via Safety, Quality and Patient Experience Department to ensure trends and themes are robustly identified and used to inform our existing local priorities and approach to PSIRF.

Patient Safety Event	Description	CCL Proportionate Response Type
Surgical Site Infection/ Blood Stream Infection	Infection post-surgery	Post Infection Review and Thematic Analysis
Return to Theatre	All return to theatre within 30 days	Case Note Review and Audit
Cardiac Tamponade	All Cardiac Tamponades	Observation & Thematic Review
Falls with Fracture or Haemorrhage	Inpatient falls leading to injury or haemorrhage	Post Fall protocol and PSII
Hospital Acquired Pressure Ulcers	HAPU Grade PU2 and above	After Action Review
Good Catch	Retained foreign body	After Action Review
Patient Safety & Quality Improvement Projects* **CCL Continuous Improvement plan 2024-2026*	Analysis of recurring patient safety incidents within Radar such as medication events, Falls. Allows for pattern analysis and continues to analyse newly occurring events	Thematic Review
Hospital Acquired Thrombosis (HAT)	Avoidable HAT, mortality associated with HAT, based on the level of harm from the thematic review	Full PSII investigation
Deterioration of a patient	Failure to recognise and treat early deterioration	Full PSII investigation
Mortality Review	Expected and Unexpected Deaths	Structured Judgement Review Tool PSII if following completion of Structured Judgement Tool, cases where the overall care score is 3 or less, or the overall avoidability score is 4 or less, escalation is required and PSII investigation is triggered
All other patient safety Incidents	All other patient safety Incidents that do not meet the requirement of a PSII	Managers review - STAR SWARM huddle, local action and shared learning

Local reporting of patient safety incident Investigations (PSIIs)

The full details of the reporting arrangements are detailed within the CCL's Incident Management Policy. The policy provides the reporting structure for reporting incidents at CCL including regulatory reporting to External Agencies. Our new Patient Safety Incident Response Policy will describe how the insight from our learning responses feeds into driving future safety improvement plans.

Tiered huddles are conducted daily to facilitate the escalation of Patient Safety Events. All reported events are reviewed during the daily Tier 1 Safety, Quality, and Patient Experience (SQPE) Safety Event meeting to assess the need for additional information and to determine the appropriate type of investigation. Subsequently, these patient safety events are further discussed with senior managers and leaders during the Tier 3 huddle.

Types of incident response

The Patient Safety Incident Response Framework (PSIRF) does not mandate a single model of incident response (with the exception of national priorities and Never Events); instead, it is for CCL to determine the most appropriate response type. CCL will utilise a range of potential responses including comprehensive Patient Safety Incident Investigations (PSIIs), thematic review into previous learning, After Action Reviews (AARs) with those involved; or we may determine that no individualised response is needed.

By carefully determining when an individualised response is needed (or not needed) the Trust will be able to make the best use of its resources to focus safety improvement efforts in areas where they will have the most benefit. Types of incident response include (but are not limited to):

Department Review (DR)

The Department review is a process used to gather additional information about an event, which includes consideration of:

- Compassionate engagement with people involved with / affected by an incident
- Proportionate decision making and events alongside the Patient Safety Incident Response Plan (appendix 1)
- Systems-based review and learning from an incident
- Identifying and providing assurance of immediate improvement actions being taken

The DR can be used as a stand-alone learning response where actions can feed into existing improvement programmes of work.

Patient Safety Incident Investigation (PSII)

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.

After Action Review (AAR)

AAR is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It is a structured, professional discussion involving caregivers who may be directly involved. It aims to capture learning from such events to avoid failure and promote success for the future. The AAR objectives are:

- To ensure the AAR focuses not on accountability but on learning
- To set out the responsibilities of staff participating in AAR
- To explain how AAR works and the requirements to carry out a successful review to provide assurance of the governance around shared learning from AAR

Thematic review

A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use a combination of qualitative (e.g. incident reports, open text survey responses, and information sourced through conversations and interviews) and quantitative data (e.g. operational metrics, closed survey responses, audit, and other numerical information sources) to identify safety themes and issues.

Thematic review will be undertaken in the following ways:

- Collating data from different datasets (for example incidents, complaints, claims, and operational performance) to inform the on-going development of CCL's patient safety incident response plan.
- Analysing a patient safety theme to identify issues and trends using qualitative and, sometimes, quantitative data.
- Triangulating and synthesising data to inform or assess the impact of patient safety improvement plans.

Thematic reviews will be scheduled across the year to ensure there is sufficient time for participation, understanding and cascade of learning via our safety groups and committees.

Star Swarm Debrief

A Star Swarm debrief is a structured process whereby a team comes together when needed so they can continue to work safely and effectively. It is intended to be brief, and most importantly supportive and encouraging. Star Swarm can be led by any senior manager who will act as the CCL's safety culture champion.

The aims of the Star Swarm are:

- To provide a safe, supportive, inclusive and collaborative environment
- To allow everyone to share (but sharing is not compulsory) without providing space for arguments, accusations or criticism
- To ensure kindness and encouragement are at the centre of the process
- To empower everyone to share their experiences of the event without judgement, regardless of their role

Procedures to support patients, families and carers affected by PSIIs

To build transparency and trust, Cleveland Clinic London will implement formal communication protocols to involve patients, families, and caregivers in post-incident investigations. This approach ensures affected individuals are kept informed throughout the investigation process, including updates on findings and any actions taken as a result. A Patient and Family Liaison within the SQPE team now supports this effort by facilitating compassionate and timely communication, actively involving families and caregivers, and using their feedback to guide ongoing improvements in patient safety.

When any patient safety event occurs, Caregivers are expected to engage in an open and honest discussion with those affected, explaining what has happened. The formal Duty of Candour applies when a patient safety incident reaches a certain level of severity. In such cases, the regulation establishes specific legal responsibilities for providers, detailing how and when to notify patients or their representatives about the incident. Regulation 20 also outlines the circumstances under which the Care Quality Commission (CQC) must be informed of a safety incident (CQC, 2014). At Cleveland Clinic London, this notification will be coordinated by the SQPE team in partnership with the responsible medical consultant and forms an integral part of the first stages of a Patient Safety Incident Investigation.

Cleveland Clinic London is dedicated to upholding Just Culture principles, which promote fair, open, and transparent treatment of caregivers following patient safety incidents. These values are integrated into our procedures when reviewing such events, and we understand the considerable effects these incidents can have. SQPE Team will advise and signpost Caregivers to the following support resources:

- Mental Health First Aid (MHFA) Provides: workplace guidance for employers and employees, information on mental health first aid training
- Occupational Health Service
- Freedom to Speak Up Guardian: A confidential service for Caregivers if they have concerns about the organisational response to a patient safety incident.
- Second Victim Support -A website resource for healthcare staff and managers involved in patient safety incidents.

Appendix 1

Method	Description
Patient safety incident investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.
MDT review	An MDT 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 either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care
STAR Swarm Debrief	The STAR Swarm huddle/debrief is designed to be initiated as soon as possible after an event and involves an MDT discussion. Stop, Think Act review is HRO skill that all Caregivers are taught. Caregivers 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
After Action review	AAR is 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. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: • What was the expected outcome/expected to happen? • What was the actual outcome/what actually happened? • What was the difference between the expected outcome and the event? • What is the learning?
Thematic Review	A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews typically use qualitative (e.g. open text survey responses, field sketches, incident reports and information sourced through conversations and interviews) rather than quantitative data to identify safety themes and issues. Thematic reviews can sometimes use a combination of qualitative data with quantitative data. Quantitative data may come from closed survey responses or audit, for example.
Case Review	A case review (surgical or mortality) in healthcare refers to the process of examining and evaluating patient records to assess the quality of care provided. The process involves several key steps: Selection of case notes, Examination of records, Assessment of care quality, Identification of issues or trends, Recommendations for improvement, Follow up and monitoring.

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