Havens Hospices

Patient Safety Incident Response Framework Policy

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Making every day count

Havens Hospices

Contents

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Audience

Intended Audience: (To be completed / confirmed by the Document Owner (or responsible directorate) to indicate who should see this document)	☒ **Trustees, SLT** ☒ **All care staff**
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Version History

Version Number	Date of Issue	Detail of Changes
Version 1	27/02/2024	New Document

Associated Documents

These documents should be referenced in conjunction with this procedure:

- PSIRF plan
- Complaints policy
- Disciplinary policy
- Medicines Management policies and procedures
- Duty of candour policy
- Safeguarding Children Policy
- Safeguarding Adults Policy
- Information Governance Policy

"Havens Hospices," "The Hospice" refers to Havens Hospice, the Charity, which incorporates the services of Fair Havens and Little Havens.

Havens Hospices is committed to safeguarding and promoting the welfare of children, young people, and adults at risk. Havens expects all staff and post holders to share this commitment. Our approach is laid out in our Safeguarding Policy, and everything we do is guided by this. Therefore, this document should be read in conjunction with our Safeguarding Policy, and any potential safeguarding issues should be given consideration.

1. Definitions

Patient safety response team	The team involved in weekly incident meetings to plan patient safety responses- this will include a member of each care team and the quality team as a minimum
Weekly incident meeting	Weekly meeting of the patient safety response team to discuss incidents and responses
Engagement leads	Managers/Matrons of each service will act as engagement leads where needed
SEIPS framework	System Engineering Initiative for Patient Safety
Swarm huddle	An in the moment analysis of a patient safety incident- see guide in appendix for further information

2. Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Havens Hospices approach to developing and maintaining effective systems and processes for responding to patient safety incidents and concerns for the purpose of learning and improving patient safety and experience.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds the patient safety incident response within a wider system of quality improvement and prompts a 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 concerns
- Supportive oversight focused on strengthening the response system functioning and improvement

This policy should read in conjunction with our current patient safety incident response framework (PSIRF) plan, which is a separate document setting out how this policy will be implemented.

3. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Havens Hospices.

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.

Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes as those listed below and are therefore outside of the scope this policy.

- claims handling
- human resources investigations into employment concerns
- professional standards investigations,
- information governance concerns
- estates and facilities concerns
- financial investigations and audits
- safeguarding concerns
- coronial inquests and criminal investigations
- complaints (except where a significant patient safety concern is highlighted)

For clarity, Havens Hospices consider these processes as separate from any patient safety investigation. 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.

Seven areas are set out for consideration to create the right conditions:

1. Leadership.

2. Training and competencies.

3. Support systems.

4. Ensuring inclusivity

5. Information resources

6. Processes for seeking and acting on feedback

7. Processes for managing dissatisfaction

There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of system learning and improvement.

Patient safety incidents are any unintended or unexpected incidents which could have, or did, lead to harm for one or more patients receiving healthcare. The PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Instead, Havens Hospices are now able to balance effort between learning through responding to incidents or exploring issues and improvement work. This may include information such as the level of risk or safety, number of instances, impact of potential/actual incidents, local instances within other stakeholders.

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.

Criteria on Never events are unchanged and remain in line with legislation NHS England » Never events

Responses covered in this Plan include:

- Patient Safety Incident Investigations (PSIIs)
- Multidisciplinary Team meeting (MDT)
- Incident type specific review meetings

(Falls, Tissue viability, Infection prevention and control, medication incidents)

- Root course analysis (RCA)
- Swarm huddle
- After action review
- Thematic review
- System engineering initiative for patient safety (SEIPS) Framework
- Direct observation

Other types of response exist to manage specific issues or concerns. Examples of such responses include complaints management, human resources investigations into employment concerns, professional standards investigations, coroners' inquests, or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this Plan.

To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

- People team for professional conduct/competence issues and if appropriate, for referral to professional regulators
- Legal services for clinical negligence claims
- Medical Examiners and if appropriate local Coroners for issues related to the cause of a death
- The Police for concerns about criminal activity

4. Our patient safety culture

Havens Hospice has a robust, transparent and reflective incident reporting system using Vantage to record incidents, investigations and action plans. We have a workforce who are encouraged to reflect on learning from incidents to support development. Learning outcomes are shared and discussed at team meetings.

PSIRF will enhance this approach by creating much stronger links between a patient safety incident and learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at such learning and improvement within the culture we hope to foster. This will continue to increase transparency and openness amongst our staff in 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.

Our vision, mission and values underpin our culture.

Havens Hospices

Our Vision

Making every day count.

Our Mission

To offer the best possible palliative and supportive care, free from fear and barriers, where the patient and those important to them are always put first.

Our Values

1 **Care and Compassion**

We are driven by our desire to care for and help people with complex or incurable conditions. We focus on their quality of life, offering choice and support in 'Making every day count'.

2 **Commitment**

We are committed to putting other people's needs first. We seek to achieve fairness and equality by making our services inclusive and available to all who need them.

3 **Community**

We work together as a charity and to serve our communities, to ensure everyone feels included, valued and respected for what they contribute.

4 **Courage**

We listen calmly to others and respect different opinions and beliefs. We reflect and think before we act, seek to understand the consequences, overcome fears in making difficult decisions and accept that we can sometimes make mistakes.

5 **Integrity**

Our patients and families are at the heart of every decision we make. We are open, honest and transparent and every action is taken in good faith.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame or liability. We support both the psychological and physical safety of staff through our health and safety group, wellbeing team and provision of clinical supervision through 1:1's appraisal and reflective practice sessions.

To enhance our patient safety culture, all incidents are discussed weekly at our incident review meeting where we consider risks emerging or known and the insight offered from incidents that have occurred and an opportunity to share learning.

We will utilise findings from our staff survey metrics based on specific patient (and staff) safety questions to assess if we are sustaining our ongoing progress in improving our safety culture.

Havens Hospices aims to ensure everyone working within the hospice feels safe and confident to speak up. We encourage our senior leadership team and trustees to listen and take the opportunity to learn and improve from those who speak up.

All staff are encouraged to speak up about anything that affects the safe care of patients or their working life. Staff can contact their line manager in the first instance.

Anonymous "you said, we did" suggestions boxes are available in clinical areas, and we have a "bright ideas" form on the intranet for ideas for improvements.

Havens Hospices also has an appointed Freedom to Speak up Guardian, who can support staff speaking up if they feel unable to do so by other routes.

Our freedom to speak up Guardian can be contacted at

Ftospeak@havenshospices.org.uk

Further information can be found on freedom to speak up posters Freedom to speak up posters and within the Whistleblowing policy.

5. Patient safety partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England / Improvement to help improve patient safety across the NHS in the UK. Patient safety partners will gradually become integrated into organisations to provide a patient voice into committees where patient safety is discussed as well as to support incident reviews where appropriate. Havens Hospices is committed to supporting the role of a patient safety partner within the organisation.

This role across the NHS will evolve over time and at Havens Hospices, the main purpose of the role is to be a voice for the patients and community who utilise our services and ensure that patient safety is at the forefront of all that we do.

People acting as a patient safety partner will communicate rational and objective feedback focused on ensuring that patient safety is maintained and improved, this may include providing reports to Clinical Governance meetings reviewing patient safety, risk and quality and being involved with contributing to

documentation including policies, investigations, and reports. This information may be complex, and the PSPs will provide feedback to ensure that patient safety is our priority. As the role evolves, we may ask our PSPs to participate in the investigation of patient safety events, assist in the implementation of patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support specific to this new role in collaboration with the patient safety team to ensure our PSP has the essential tools and advice they need.

The PSP will be supported in their honorary role by the Head of Quality and professional standards for the hospice who will provide expectations and guidance for the role.

6. Addressing health inequalities

We recognise that we have a core role to play in reducing inequalities by improving access to palliative care services and tailoring those services around the needs of the local population in an inclusive way.

We will collect data on protected characteristics and use this intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. As part of our new incident response framework, protected characteristics will be considered as part of the patient safety review to give insight into any apparent inequalities.

Within our patient safety responses using the NHS patient safety toolkit NHS England » Patient safety learning response toolkit we will directly address if there are any particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

Engagement of patient, families and staff following a patient safety incident is critical to review of patient safety incidents and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

Equality, Diversity and Inclusion (EDI) remain a clear priority for the hospice and through this we endorse a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/service users, carers and families.

7. 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. 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.

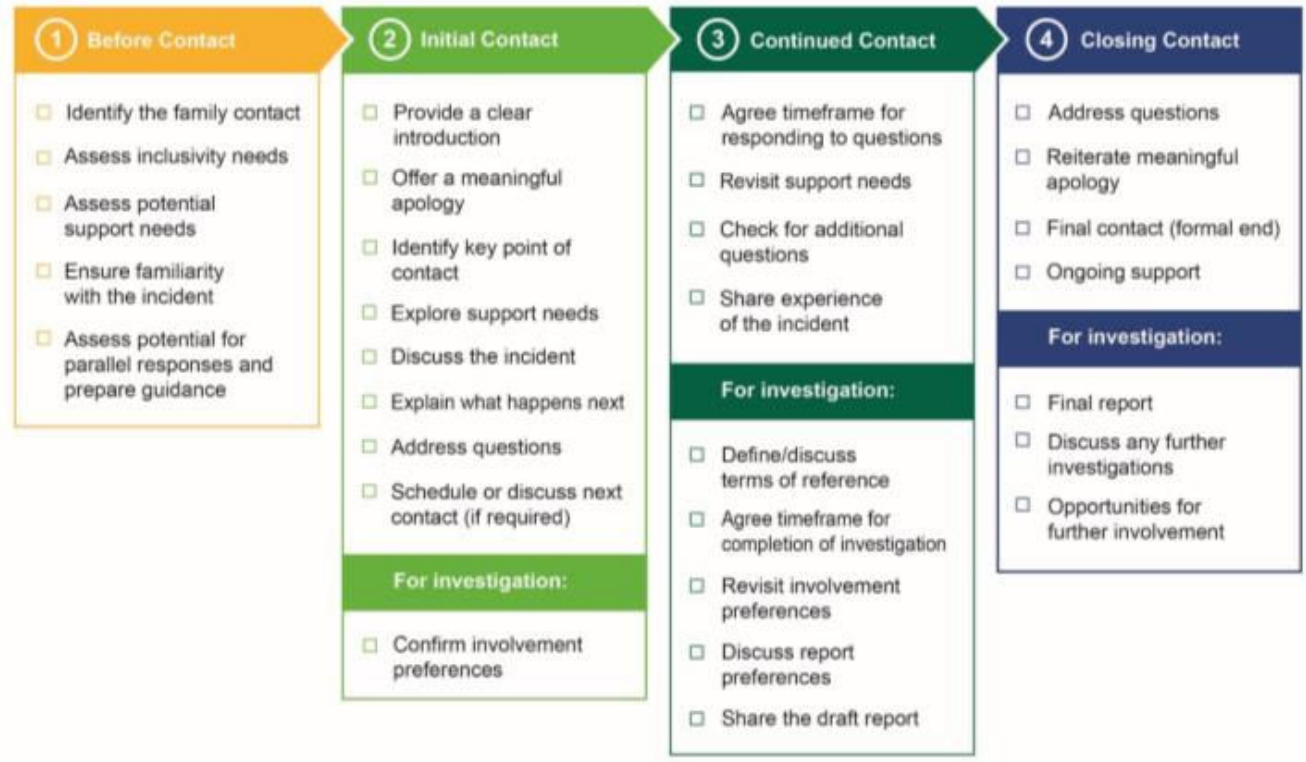
Havens Hospices are committed to continuous quality improvement of the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence. We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide. Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.

In addition to meeting our regulatory and professional requirements for Duty of Candour, we want to be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident. We will do this by creating the right foundations and process and using nine guiding principles. (Please see appendix A)

Our wellbeing team are available to provide counselling and bereavement support to families. Staff can also access support through the Employee Assistance Programme (EAP) or occupational health services.

For those incidents which meet the criteria for a patient safety incident investigation, we will enable the four steps of engagement as outlined in the table below.



If families or staff do not wish to be contacted directly to discuss a patient safety incident, an intermediary can be offered and would be decided on a case-by-case basis, including communicating responses to questions those affected may have, updates on the progress of an investigation, and to request checking of the draft report factual accuracy.

We recognise that there might also be other forms of support that can help those affected by a patient safety incident and will work with patients, families, and carers to signpost to their preferred source for this.

Complaint's advocacy

https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints.

Healthwatch

https://www.healthwatch.co.uk/ Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters. You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site https://www.healthwatch.co.uk/your-local-healthwatch/list

Parliamentary and Health Service Ombudsman
https://www.ombudsman.org.uk/ makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau
https://www.citizensadvice.org.uk/ provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

8. 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.

Havens Hospices will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. We will use data from incidents, patient and colleague feedback and complaints to determine areas of risk and where to focus efforts on improvement work.

Our patient safety incident response plan details how this has been achieved as well as how we will meet both national and local focus for patient safety incident responses.

9. Resources and training to support patient safety incident responses.

Havens hospices has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

The hospice will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

The Head of Quality and professional standards will be the Learning Response Lead. The hospice will have governance arrangements in place to ensure that learning responses are undertaken by an appropriate member of the patient safety team as decided at the weekly incident meeting.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All managers will work within our just and restorative culture principles and will have processes in place to ensure psychological safety.

The hospice will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

10. Training

The hospice has implemented a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows

- Level one

National – Health Education England patient safety syllabus module (Essentials for patient safety)

All staff, clinical and non-clinical are expected to undertake these on induction and to repeat each three years.

These modules can be accessed digitally.

National – Health Education England patient safety syllabus module (Essentials of patient safety for boards and senior leadership teams

This module can be accessed digitally.

- Level two

National – Health Education England patient safety syllabus module (Access to Practice) – this is to be undertaken by all clinical staff.

This module is available digitally.

Learning response leads training and competencies

Training

The learning response lead will be the Head of Quality and professional standards but all care heads of service, managers and deputy managers (Band 7 and above) will be expected to be able to lead learning responses leaving the Quality Team able to have oversight. They will have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response. Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.

Those leading learning responses must all also complete Level one and two of the National Patient Safety syllabus.

The learning response lead will undertake appropriate continuous professional development on incident response skills and knowledge.

Learning response leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained through the Patient Safety Group who will also support this.

Competencies

As a hospice we expect that those leading learning responses are able to

a. Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
b. Summarise and present complex information in a clear and logical manner and in report form.
c. Manage conflicting information from different internal and external sources.
d. Communicate highly complex matters and in difficult situations.
e. Support for those new to this role will be offered from the Quality Team and Medical Director as well as other members of the patient safety group.

Engagement leads training and competencies

Training

All care staff of Band 6 and above will potentially act as Engagement Leads and must have completed Level one and two of the National Patient Safety syllabus.

Engagement Leads will undertake appropriate continuous professional development on incident response skills and knowledge.

Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.

Engagement and involvement with those affected by a patient safety incident will be undertaken only by those who have undergone a minimum of six hours training.

Engagement Leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained through the patient safety team meeting.

Competencies

As a hospice we expect that those staff who are engagement leads to be able to

a. Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
b. Listen and hear the distress of others in a measured and supportive way.
c. Maintain clear records of information gathered and contact those affected.
d. Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation.
e. Recognise when those affected by patient safety incidents require onward signposting or referral to support services internally or outside of the organisation.

Oversight roles training and competencies

Training

All patient safety response oversight will be led/conducted by those who have had one day training in oversight of learning from patient safety incidents. Records of such training will be maintained by the Learning and Development team as part of their general education governance processes.

The Head of Quality and professional standards will have the overall oversight role supported when needed by the Medical Director or Director of Clinical Services all of whom must have completed the appropriate module from the National Patient Safety syllabus - Level one - essentials of patient safety and essentials of patient safety for boards and senior leadership teams. Other members of the Quality Team with appropriate training may have delegated responsibilities for oversight.

All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

Competency

As a hospice we expect staff with oversight roles to be able to

a. Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
b. Apply human factors and systems thinking principles.
c. Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
d. Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
e. 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).
f. Summarise and present complex information in a clear and logical manner and in report form.

11. Patient safety incident report plan

Our plan sets out how Havens Hospice intends to respond to patient safety incidents over a period of 12 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.

12. Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan initially after 12 months and then every 24 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 24 months.

Updated plans will be published on our intranet internally and on the Havens Hospices publicly facing website, replacing the previous version.

13. Responding to patient safety incidents

Patient safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incident via our electronic internal reporting system vantage (see Appendix A). Any complaint or feedback received by patients will also be recorded on this system and reviewed weekly by the patient safety group at the incident meeting.

All reported patient safety incidents will be flagged to the group of people predefined in Vantage as needing sight of that incident type. At the time the incident is reported this flagging system is designed to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to teams where Duty of Candour applies. Most incidents will only require local review by the Patient Safety Team, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated through the Risk meeting (see patient safety incident response decision-making Appendix B).

The Patient Safety Team will be supported by the Head of Quality and professional standards, CQC registered managers and CDAO to highlight any incident which appears to meet the requirement for reporting externally. This may be to allow the hospice to work in a transparent and collaborative way with our ICB or CQC if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

The Quality Team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the hospice.

Patient safety incident response decision-making

Havens Hospices will have arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRF plan.

PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. The hospice has developed its own response mechanisms to balance the effort between learning through responding to incidents or exploring issues and improvement work. In the work to create our plan we have considered what our current data shows us about our patient safety profile. We have used this intelligence to build our local priorities for PSII and our toolkit for responding to other patient safety incidents.

We have established a process for our response to incidents which allows for a clear set of mechanisms allowing for oversight of incident management and our PSIRF response.

Staff will have escalation arrangements in place for the monitoring of patient safety incidents and this includes escalation of incidents which appear to meet the need for further exploration as a rapid review due to possibly meeting the criteria as PSII or due to the potential for learning and improvement or an unexpected level of risk.

The Clinical Quality Group will have delegated responsibility for the consideration of incidents for PSII and for oversight of the outcomes of such reviews to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required.

The Clinical Quality Group will have overall oversight of such processes and will challenge decision making of the Patient Safety Team to ensure that the Care Committee can be assured that the true intent of PSIRF is being implemented within our organisation and we are meeting the National Patient Safety Incident Response Standards.

Any incident highlighted will follow the process outlined below which can be seen in diagram form in Appendix B.

Local level incidents – managers of all clinical areas must have arrangements in place to ensure that incidents can be reported and responded to. Incident responses should include immediate actions taken to ensure safety of patients, public and staff, as well as indication of any measures needed to mitigate a problem until further review is possible. This may include for example, withdrawing equipment or monitoring response. Any response to an incident should be fed back to those involved or affected and appropriate support offered. Where Duty of Candour applies this must be carried out according to Havens Duty of Candour Policy.

Incidents with positive or unclear potential for PSII – all staff (directly or through their line manager) must ensure notification of incidents that may require a higher level of response as soon as practicable after the event through internal escalation processes (including out of hours) and this must include their immediate line manager. Duty of Candour disclosure should take place according to Havens Duty of Candour Policy. Where it is clear that a PSII is required (for example, for a Never Event) the responsible clinical person should notify the Registered Manager as soon as practicable so that the incident can be shared to the Medical Director and Director of Clinical Services and then reviewed and monitored at the Clinical Quality Group. A rapid review will be undertaken by an allocated manager determined at the weekly incident meeting to inform decision making at the Patient Safety Group and onward escalation following this. The allocated investigator will not have been directly involved in the incident or be the direct line manager of anyone involved.

Other incidents with unclear potential for PSII, must also be reported to the registered managers. Decision making with regard to escalation to the Risk meeting and or Clinical Quality Group can be considered at the Patient Safety Group. A rapid review will be undertaken by the clinical manager to inform this decision making. Significant incidents which may require consideration for ad-hoc PSII due to an unexpected level of risk and/or potential for learning should be included in this category.

The Hospice Patient Safety Team will discuss at the soonest opportunity the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), any mitigation identified by the rapid review or that is still required to prevent recurrence and whether the Duty of Candour requirement has been met. The team will define terms of reference for a PSII to be undertaken by the response lead. The team will also designate subject matter expert input required for any investigation or highlight any cross system working that may be necessary, as well as indicating how immediate learning is to be shared.

Where an incident does not meet the requirement for PSII, investigations will be undertaken in accordance with patient safety response plan. The Patient Safety team may request a further investigative review or closure of the incident at a local level, with due consideration of any Duty of Candour requirement being met. The Patient Safety team will also determine how any immediate learning is to be shared.

The Patient Safety team will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the CQC according to accepted reporting requirements. Whilst this will include some incidents escalated as PSII, the Patient Safety team will work with clinical managers to have effective processes in place to ensure that any incidents meeting external reporting needs are appropriately escalated.

Clinical Quality group

The Clinical Quality Group meeting will support the final sign off process for all PSIIs. The occurrence of and outcomes from all PSIIs will be shared at Care Committee along with all incident data. Through this mechanism the Board of Trustees will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety and improvement profile within the hospice.

14. Responding to cross – system incidents/issues

The Quality Team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

The hospice 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. The Governance Team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

The hospice will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

15. Timeframes for learning responses

Timescales for patient safety PSII

Where a PSII for learning is indicated, the investigation 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 their start date. No local PSII should take longer than six months.

The time frame 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.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) Havens can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the Patient Safety team.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the hospice and those affected.

Timescales for other forms of learning response

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

Safety action development and monitoring improvement

Havens Hospices acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, safety actions are needed.

The hospice will have systems and processes in place to design, implement and monitor safety actions from incidents to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the hospice's working systems where change could reduce risk and potential for harm – areas for improvement. The hospice will generate safety actions within action plans in relation to each of these defined areas for improvement. Following this, the hospice will have measures to monitor any safety action. Safety actions related to medicines management, falls, infection control or tissue viability will be held by the relevant subgroups. Other action plans from incidents will be monitored through the risk

meeting.

Learning response should not describe recommendations as this can lead to premature attempts to devise a solution - actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement action development will be completed in a collaborative way with a flexible approach from clinical managers and the support of the Quality team with their improvement expertise, this will usually happen through discussion at the patient safety team but may be added to at relevant subgroups or risk meeting if this is felt necessary on review there.

Safety Action development

The hospice will use the process for development of Safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows

1. Agree areas for improvement – specify where improvement is needed, without defining solutions

2. Define the context – this will allow agreement on the approach to be taken to safety action plan development

3. Define actions to address areas of improvement – focussed on the system and in collaboration with teams involved

4. Prioritise actions to decide on testing for implementation

5. Define measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics

6. Safety actions will be clearly written and follow SMART principles and have a designated owner

7.Safety actions should be recorded with the relevant incident in vantage and highlighted as a safety action - the incident should not be closed until all safety actions are completed or transferred to a relevant group action plan.

8.Ongoing monitoring of any significant changes should be decided on as part of the action plan but passed to the relevant group which maybe a specific subgroup for actions around falls, tissue viability, medicines management or infection control or otherwise the risk meeting.

Action Plan Monitoring

Actions to reduce risks must continue to be monitored within governance arrangements to ensure that any actions put in place remain impactful and sustainable. Reporting on the progress with actions including the outcomes of any measurements will be made to the Risk Group either directly or by report from the relevant subgroup using the monthly “update to risk” template.

For some actions with wider significance, this may require oversight by members of Clinical Quality Group which reports to the Care Committee.

16. Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues.

The hospice patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

The hospice will use the outcomes from patient safety incident reviews where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work. The clinical managers will work collaboratively with the Risk group and others to ensure there is an aligned approach to development of plans and resultant improvement efforts.

Where overarching systems issues are identified by learning responses outside of the hospice local priorities, a safety improvement plan will be developed. These will be identified through Risk meeting and reported to the Clinical Quality Group. Again, clinical managers will work collaboratively with the Patient Safety Group and others to ensure there is an aligned approach to development of the plan and resultant improvement efforts.

Monitoring of progress with regard to safety improvement plans will be overseen by reporting to the Risk meeting on a monthly basis.

17. Oversight roles and responsibilities

Principles of oversight

Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.

Responsibilities

Alongside our NHS regional and local ICB structures and our regulator, the Care Quality Commission, we have specific organisational responsibilities within the Framework.

In order to meet these responsibilities, the hospice has designated the Medical Director to support PSIRF as the executive lead.

1. Ensuring that the organisation meets the national patient safety standards

The Medical director will oversee the development, review and approval of the hospice's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote the restorative just working culture that the hospice aspires to.

To define its patient safety and safety improvement profile, the hospice will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders.

2. Ensuring that PSIRF is central to overarching safety governance arrangements.

The Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Care Committee. The Committee quarterly quality report will include all incident data as well as specific outcomes and learning from any PSII.

The Patient Safety Group will provide assurance through Risk and Clinical Quality Group that PSIRF and related workstreams have been implemented to the highest standards. Clinical managers will be expected to report on their patient safety incident learning responses and outcomes. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.

Clinical managers will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

All staff will be responsible for the reporting of incidents with detail as needed and playing a part in initial investigations into those incidents to ascertain what has happened and allow the patient safety group to make an informed decision about what action is needed. All staff are responsible for selecting the correct incident types on Vantage in order that appropriate people are informed.

Havens will source necessary training across the organisation as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every 3 years to comply with hospice guidance on policy development, alongside a review of all safety actions.

Havens Hospices recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided.

It is important to understand that there is a distinction made between complaints and feedback as the use of the word complaint should not automatically mean that someone expressing feedback enters the complaints process.

18. Complaints and appeals

Complaints are defined as expressions of dissatisfaction from a patient, service user, their family or carer, a person acting as their representative, or any person who is affected or likely to be affected by the action, omission or decision of the hospice and requires a formal review.

Complaints should be raised and handled in accordance with the Complaints policy.

Specifically, complaints can be raised by writing directly to Chief Executive Officer, Havens Hospices, 226 Priory Crescent, Southend on Sea, Essex SS2 6PR or email info@havenshospices.org.uk marking 'Complaint' in the subject line.

For advice and guidance on any aspect of this policy/procedure document please contact:

Medical Director - rmarchant@havenshospices.org.uk

19. References

NHS England » Patient safety learning response toolkit Accessed 30/1/2024

20. Appendix A

9 Guiding principles for involving patients, families, carers and staff in patient safety incident responses

- **1. Apologies are meaningful**
- Apologies need to demonstrate understanding of the potential impact of the incident on those involved, and a commitment to address their questions and concerns. Ideally, an apology communicates a sense of accountability for the harm experienced, but not responsibility for it ahead of investigation. Getting an apology right is important – it sets the tone for everything that follows. Apologising is also a crucial part of the Duty of Candour.

- **2. Approach is individualised**
- Engagement and involvement should be flexible and adapt to individual and changing needs. These needs could be practical, physical, or emotional. Engagement Leads should recognise that every response might need to be different, based on an understanding of the different needs and circumstances of those affected by an incident.

- **3. Timing is sensitive**
- Some people can feel they are being engaged and involved too slowly or too quickly, or at insensitive times. Engagement Leads need to talk to those affected about the timing and structure of engagement and

involvement, and any key dates to avoid (eg birthdays, funeral dates, anniversaries), particularly where someone has lost a loved one.

- **4. Those affected are treated with respect and compassion**
- Everyone involved in a learning response should be treated respectfully. There should be a duty of care to everyone involved in the patient safety incident and subsequent response, and opportunities provided for open communication and support through the process. Overlooking the relational elements of a learning response can lead to a breakdown of trust between those involved (including patients, families, and healthcare staff) and the organisation.

- **5. Guidance and clarity are provided**
- Patients, families, and healthcare staff can find the processes that follow a patient safety incident confusing. Those outside the health service, and even some within it, may not know what a patient safety incident is, why the incident they were involved in is being investigated or what the learning response entails. Patients, families, and healthcare staff can feel powerless and ill-equipped for the processes following a patient safety incident. Therefore, all communications and materials need to clearly describe the process and its purpose, and not assume any prior understanding.

- **6. Those affected are 'heard'**
- Everyone affected by a patient safety incident should have the opportunity to be listened to and share their experience. They will all have their individual perspective on what happened, and each one is valid in building a comprehensive picture to support learning. Importantly, the opportunity to be listened to is also part of restoring trust and repairing relationships between organisations and staff, patients, and families.

- **7. Approach is collaborative and open**
- An investigation process that is collaborative and open with information, and provides answers, can reduce the chance litigation will be used as a route for being heard. The decision to litigate is a difficult one. Organisations must not assume that litigation is always about establishing blame – some feel it is the only way to get answers to their questions.

- **8. Subjectivity is accepted**
- Everyone will experience the same incident in different ways. No one truth should be prioritised over others. Engagement Leads should ensure that patients, families, and healthcare staff are all viewed as credible sources of information in response to a patient

- **9. Strive for equity**
- The opportunity for learning should be weighed against the needs of those affected by the incident. Engagement Leads need to understand and seek information on the impact of how they choose response types on those affected by incidents and be aware of the risk of introducing inequity into the process of safety responses.