Farleigh Hospice

Policy Name:
Patient Safety Incident Response

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Policy Owner:
Medical Director

Policy Author:
Head of Nursing and Quality

Approved by: Clinical Governance Committee

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Details of compliance to Legislation/Standards/Regulatory requirements

Legislative/Statutory/Regulatory Body	Applicable Legislation/Standard/Requirement
NHSE	Patient Safety
CQC	Fundamental Standards

The historical record of policy updates/changes and version history are maintained on Sentinel.

Version 1.0 Patient Safety Incident Response Policy

1 Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Farleigh Hospice will approach the development and maintenance of 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 and which we can also align to our existing values:

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

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

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.

Farleigh Hospice are firmly committed to continuously improving 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 also 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.

This aligns with our Mission of leading on the delivery of excellent palliative, end of life and bereavement care, working in partnership with the patient, their family and all others involved in their support.

As well as 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.

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 24 months.

Updated plans will be published on our website, replacing the previous version.

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

Farleigh Hospice also recognises that we have a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Hospice as a public authority is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. The introduction of a new incident management system will allow for the details of patients to be directly drawn from the healthcare record and incidents can then be analysed by protected characteristics to give insight into any apparent inequalities.

Within our patient safety 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.

The Hospice's commitment to transforming organisational culture to that of restorative justice has already been outlined. Further to this, the Hospice has affirmed that it endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/service users, carers and families. As part of this, discrimination of any kind including racism will be dealt with by using a 'Support, Educate, Challenge' approach. With explicit role modelling led by the Hospice Board, we will use these principles to underpin patient safety training and implement the system-based approach to patient safety responses which is at the heart of PSIRF best practice.

2 Definitions

Patient safety incident: unintended or unexpected events (including omissions) in healthcare that could have, or did harm, one or more patients. Under PSIRF there is no longer a distinction between "patient safety incidents" and "serious incidents"

Patient Safety Specialist: individuals within healthcare organisations who have been designated to provide expert support to their organisation, with direct access to their executive team, which facilitates the escalation of patient safety issues or concerns. They play a key role in development of a patient safety culture, safety systems and improvement activity

3 Scope

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

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 concern
- financial investigations and audits
- safeguarding concerns
- coronial inquests and criminal investigations

- complaints (except where a significant patient safety concern is highlighted)

For clarity, the Hospice considers 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.

4 Roles and responsibilities

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

The Hospice follows the 'mindset' principles to underpin the processes we have put in place to allow us to implement PSIRF as set out in the supporting document (NHS England (2022), p 3).

Responsibilities

Alongside our Local ICB structures, the Health and Safety Executive, Charities Commission, Fundraising Regulator and our regulator, the Care Quality Commission, we have specific organisational responsibilities with the Framework.

In order to meet these responsibilities, the Hospice has designated the FH Medical Director to support PSIRF as the Executive lead.

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

The FH Medical Director will oversee the development, review and approval of the Hospice 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 achieve the development of the plan and policy the FH Medical Director will be supported by the Director of Care and Head of Nursing and Clinical Quality.

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 Hospice Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Clinical Governance Committee which receives analysis of patient safety information from the Clinical Quality and Local Risk Groups.

The Clinical Quality Group will provide assurance to the Clinical Governance Committee 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 manage the local response to patient safety incidents at the Local Risk Group and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

The Hospice will source necessary training such as the Health Education England patient safety syllabus and other patient safety 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 as part of regular oversight. A review of this policy will be undertaken at least every 3 years to comply with Hospice guidance on policy development, alongside a review of all safety actions. The associated plan will be reviewed every 12 months.

3. Quality assuring learning response outputs

The Hospice will escalate all PSIIs to executive level for peer review and comment. The Clinical Governance Committee will support the executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed.

5 Our Patient Safety Culture

Farleigh Hospice are committed to establishing an open, restorative, just culture in relation to patient safety incidents

The Hospice senior leadership have strongly embraced this work and will support the organisational transition to a restorative just culture in relation to patient safety incidents.

The main goals of restoration when an incident has happened have been outlined as follows

- Moral engagement
- Emotional healing
- Reintegration of the practitioner
- Organisational learning
- Prevention

PSIRF will enhance these 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.

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, liability or define avoidability or cause of death.

Our safety culture has also progressed in a positive way with reporting of patient safety incidents improving over time and the introduction of a new incident management system database (Sentinel) which has simplified internal reporting for staff and enabled more rigorous review of data gathered.

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.

6 Patient Safety Partners

Farleigh Hospice are committed to developing and continuously reviewing our Patient Safety Incident Response Plan alongside identified Patient Safety Partners. These are new and evolving roles developed by NHS England to help improve patient safety across health care in the UK. They may be involved in patient safety improvement projects to work alongside existing quality and governance meetings. Patient Safety Partners may be service users, carers, family members or other lay people interested in making sure that patient safety is at the forefront of all that we do.

7 Our Patient Safety Incident Response Plan

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.

The Hospice will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our patient safety incident response plan will detail current arrangement and future plans for patient safety investigations, including the benchmarking of Farleigh Hospice data with that of Hospice UK.

8 Responding to Patient Safety Incidents

All staff are responsible for reporting any potential or actual patient safety incidents on the Hospice Sentinel reporting system and will record the level of harm they know has been experienced by the person affected. (see Appendix 1).

The Hospice has review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This includes consideration and prompting to teams where Duty of Candour applies (See Hospice policy, Being Open and Duty of Candour). Most incidents will only require rapid review within the service, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated to the Clinical Manager.

Clinical Managers will highlight to the Medical Director, as Patient Safety Specialist, or Executive Team, any incident which appears to meet the requirement for reporting externally. Timeframes for learning responses for such incidents should not exceed 3 months unless through exceptional agreement at Executive Team level.

The Hospice will also work in a transparent and collaborative way with our ICB and regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

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

Where the nature of an incident is cross system or multi-organisational the Farleigh Hospice will identity the lead organisation to coordinate investigation and involve relevant system partners, including patient representatives or family members. Where required Farleigh Hospice will participate in, and contribute to whole system reviews.

9 Training

All patient safety response oversight will be led/conducted by those who have had relevant training and hold skills in learning from patient safety incidents. Records of such training will be maintained on the Learn Portal as part of the general education governance processes.

Those with an oversight role on our Hospice Board and leadership team (i.e., executive leads) must complete the appropriate modules from the national patient safety syllabus - Level one - essentials of patient safety and essentials of patient safety for boards and senior leadership teams.

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.

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.

The Hospice 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.

Farleigh Hospice works closely with the ICB safety team for external oversight of incidents, including contract compliance and safeguarding.
Responsibility to designate leadership of any learning response sits at Executive Director level to one of the Clinical Managers.

The Hospice has governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. Incidents are discussed at Local Risk, Clinical Quality and Clinical Governance Committee, depending upon their severity.

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 work within our just and restorative culture principles and utilise other support methods such as Clinical Supervision, Employee Assist Program, Occupational Health Referral and internal support mechanisms such as 1:1's and appraisals. Processes are in place to ensure that managers work within this framework 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 Monitoring / Audit

Safety actions are monitored within the Clinical Directorate's risk structure to ensure that any actions put in place remain impactful and sustainable. Reporting on the progress with safety actions including the outcomes of action plans will be made to the Clinical Quality Group and escalated to Clinical Governance as required.

11 Complaints & Concerns

Complaints and concerns are reviewed at each stage of the governance structure where learning is identified through incident review, thematic analysis and individual service user feedback. Engagement is encouraged from the individual reporting a concern and process followed through the Complaints Policy.

12 References

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.

National guidance for NHS trusts engaging with bereaved families

https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-families-v2.pdf

Learning from deaths – Information for families

https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/ explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

Help is at Hand – for those bereaved by suicide

https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf specifically for those bereaved by suicide this booklet offers practical support and guidance who have suffered loss in this way.

Mental Health Homicide support

https://www.england.nhs.uk/london/our-work/mental-health-support/homicide-support/ for staff and families. This information has been developed by the London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.

Child death support

https://www.childbereavementuk.org/grieving-for-a-child-of-any-age

https://www.lullabytrust.org.uk/bereavement-support/

Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

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

13 Farleigh Hospice Policies related to and/or referenced in this document

Zero Tolerance Policy
Complaints and Concerns Policy
Being Open and Duty of Candour
Capability Policy
Incident Policy

Appendix 1:

Learning from Patient Safety Events (LFPSE) Levels of Harm

Physical Harm:

Level of harm	What does this mean?
No physical harm	No physical harm
Low physical harm	Low physical harm is when all of the following apply: • did not or is unlikely to affect that patient's independence • did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit • did not or is unlikely to need further treatment beyond simple dressing changes or short courses of oral medication • did not or is unlikely to affect the success of treatment for existing health conditions
Moderate physical harm	Moderate harm is when at least one of the following apply: • has limited or is likely to limit the patient\s independence, but for less than 6 months • has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond simple dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention • has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life

	expectancy or accelerated disability described under severe harm
Severe physical harm	Severe harm is when at least one of the following apply: • needed or likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment • is likely to have reduced the patient's life expectancy • needed immediate live-saving clinical intervention • has, or is likely to have, reduced the chances of preventing or delaying disability from their existing healthcare conditions • has limited or is likely to limit the patient's independence for 6 months or more
Fatal	You should select this option if the patient has died and there is at least a slight possibility the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent a patient safety incident contributed to this fatal outcome.

Psychological Harm:

Level of harm	What does this mean?
No psychological harm	Distress is inherent in being involved in any patient safety incident, but please select this option if there is no specific psychological harm over and above this
Low psychological harm	Low psychological harm is when at least one of the following apply:

	• distress that did not or is unlikely to affect the patient's normal activities for more than a few days • distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit • distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition
Moderate psychological harm	Moderate psychological harm is when at least one of the following apply: • distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months • distress that did or is likely to need a course of treatment or therapy sessions that extends for less than six months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months
Severe psychological harm	Severe psychological harm is when at least one of the following apply: • distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months • distress that did or is likely to need a course of treatment or therapy

	sessions that continues for more than six months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

Equality Impact Assessment

During the development of this policy the hospice has carried out a full Equality Impact Assessment to consider the impact on each of the protected characteristics as outlined in the Equality Act (2010) with the aim of minimising and where possible removing any disproportionate impact on staff/volunteers/service users (delete as applicable). No detriment was identified.