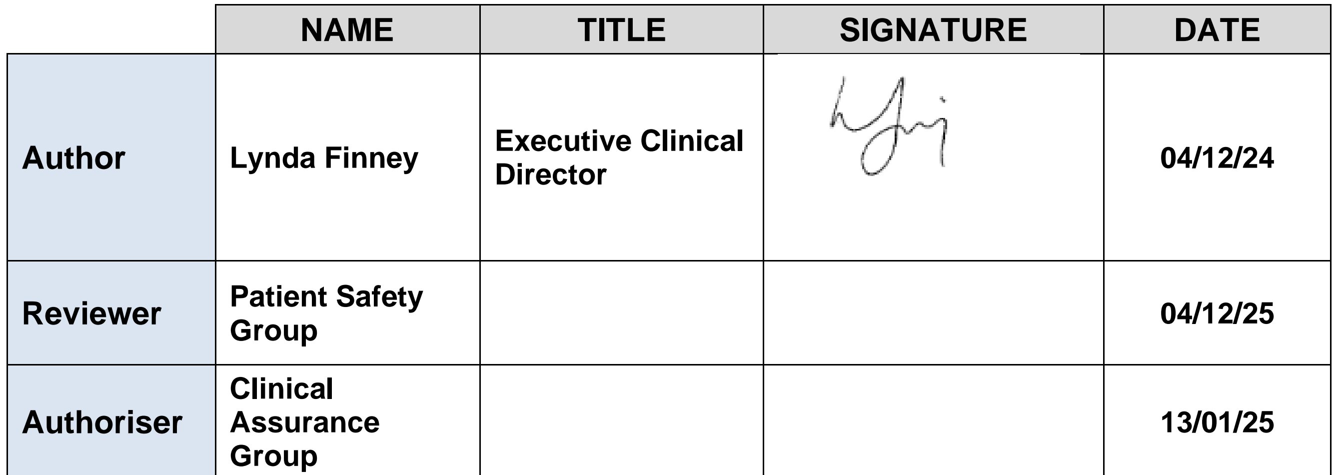
Willowbrook Hospice *Every Contact Count*

Willowbrook Hospice Patient Safety Response Framework Policy

Patient safety incident response policy



	NAME	TITLE	SIGNATURE	DATE
Author	**Lynda Finney**	**Executive Clinical Director**		**04/12/24**
Reviewer	**Patient Safety Group**			**04/12/25**
Authoriser	**Clinical Assurance Group**			**13/01/25**

Contents

Purpose ... 4
Scope ... 5
Our patient safety culture ... 6
Patient safety partners ... 7
Addressing health inequalities ... 8
Engaging and involving patients, families and staff following a patient safety incident ... 9
Patient safety incident response planning ... 11
Resources and training to support patient safety incident response ... 11
Our patient safety incident response plan ... 13
Reviewing our patient safety incident response policy and plan ... 13
Responding to patient safety incidents ... 14
Patient safety incident reporting arrangements ... 14
Patient safety incident response decision-making ... 14
Responding to cross-system incidents/issues ... 16
Timeframes for learning responses ... 16
Safety action development and monitoring improvement ... 17
Safety improvement plans ... 18
Oversight roles and responsibilities ... 19
Complaints and appeals ... 21

Purpose

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

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

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

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

Scope

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

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Our patient safety culture

Willowbrook 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.

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 provision of wellbeing support and provision of clinical supervision through 1:1's appraisal and reflective practice sessions.

To enhance our patient safety culture, all incidents are discussed at our 2 monthly Patient Safety and Quality meeting where we consider risks emerging or known and the insight offered from incidents that have occurred and an opportunity to share learning.

Willowbrook Hospice aims to ensure everyone working within the hospice feels safe and confident to speak up.
We encourage our senior leadership team 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.
Willowbrook Hospices also has Freedom to Speak up Guardians, 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 whftsu@willowbrookhospice.org.uk
Further information can be found on freedom to speak up posters and within the Freedom to speak up policy.

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. Willowbrook Hospice is committed to supporting the role of a patient safety partner within the organisation.

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 assurance 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 Executive Clinical Director and Head of Inpatient Unit Service who will provide expectations and guidance for the role.

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) remains 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.

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 Willowbrook Hospice is 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.

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)

Family liaison support is available to provide bereavement support to families. Staff can also access support through their line manager and/or the Employee Assistance Programme (EAP)

If families or staff do not wish to be contacted directly to discuss a patient safety incident, an intermediary can be offered and this 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 for 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.

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.

Willowbrook Hospice 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.

Resources and training to support patient safety incident response.

Willowbrook 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 and liaised with Cheshire and Merseyside Integrated Care Board, patient safety leads.

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.

Willowbrook Hospice patient safety team will support the investigating managers be the Learning Response Lead. The hospice will have governance arrangements in place to ensure that learning responses are not undertaken solely by the clinical heads of departments working in isolation and that the patient safety team and quality assurance group will further support learning responses.

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.

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.

Topic	All Hospice Staff	Staff undertaking incident investigations	Patient Safety Specialist & Engagement Lead	PSIRF Oversight Role	Exec Leadership Team / Board	Trustees
Patient safety syllabus level 1: Essentials of patient safety for all staff	✓	✓	✓	✓	✓	✓
Patient safety syllabus level 1: Essentials of patient safety for boards and senior leadership teams				✓	✓	✓
Patient safety syllabus level 2: Access to practice		✓	✓	✓		
Oversight of learning from patient safety Incidents (HSSIB)				✓		
Systems Approach to Learning (HSSIB)		✓				
Involving those affected by Patient Safety Incidents in the Learning Process (HSSIB)			✓			
Continuing professional development (CPD)		✓	✓	✓		

Our patient safety incident response plan

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

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 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 reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

Patient safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incident via our electronic internal reporting system vantage and on the Learning from Patient Safety Event Service (LFPSE) Any complaint or feedback received by patients will also be recorded on this system and reviewed monthly by the patient safety group at the risk 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 relevant Head of department, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated through the patient safety team.

The Patient Safety Team will be supported by the Executive clinical director, who is also the CQC registered manager and CDAO to highlight any incident which appears to meet the requirement for reporting externally.

The Head of relevant department 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

Willowbrook Hospice 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.

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 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 Willowbrook Hospice 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 must take place according to hospice guidance. Where it is clear that a PSII is required, the clinical manager allocated to investigate from the raised incident should notify the Exec Clinical Director who is also the registered manager as soon as possible so that the incident can be reported on STEIS, (Strategic Executive Information System) this may also be done via PLACE. The incident will also be shared with the Executive leadership team and then escalated to the Board of trustees if necessary. A rapid review will be undertaken by an allocated manager 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 manager. Decision making regarding escalation to the Executive Leadership team 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. The Trustee led Clinical Assurance Group meeting will support the final sign off process for all PSIIs. The occurrence of and outcomes from all PSIIs will also be shared at Trustee led Clinical Assurance Group 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 sfety and improvement profile within the hospice.

Responding to cross-system incidents/issues

The Patient Safety 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.

Any incidents that involve more than one organisation will be worked on collaboratively, producing one response. The ICB will support if there are difficulties working collaboratively. Willowbrook hospice will ensure robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The head of INPU/ORS will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

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) Willowbrook Hospice 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

Willowbrook Hospice 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 monthly risk meeting and Quality Assurance meeting.

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 Quality Assurance 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 monthly and discussed at the Quality assurance group.

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.

To meet these responsibilities, the hospice has designated the Exec Clinical Director to support PSIRF as the executive lead.

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

The Exec Clinical 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 Trustee led Clinical Assurance group. The Clinical assurance group 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 Quality assurance 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.

Willowbrook Hospice 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. Willowbrook Hospice 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.

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 The Executive Clinical Director, Willowbrook Hospice Complaint' in the subject line.

For advice and guidance on any aspect of this policy/procedure document please contact: Executive Clinical Director, Lynda Finney. Lyndaf@willowbrookhospice.org.uk

References

NHS England » Patient safety learning response toolkit **Accessed 30/11/2024.**

20. Appendix A

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 (e.g. birthdays, funeral dates, anniversaries), particularly where someone has lost a loved one.

4. Those affected are treated with respect and dignity

Everyone involved in a learning response should be treated with respect and 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.

Equality impact Assessment Template

		Yes/No	If yes, in what way?	Action required/undertaken
Does the document/guidance affect one group less or more favourably than another on the basis of:				
1	• Race	**No**		
2	• Ethnic Origin (including gypsies and travellers)	**No**		
3	• Nationality	**No**		
4	• Gender	**No**		
5	• Culture	**No**		
6	• Religion or belief	**No**		
7	• Sexual orientation	**No**		
8	• Disability	**No**		
9	• Age	**No**		
Is there any evidence that some groups are affected differently?		**No**		
If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?		**n/a**		
Is the impact of the document/guidance likely to be negative?		**n/a**		
If so, can the impact be avoided?		**n/a**		
What alternatives are there to achieving the document/guidance without impact?		**n/a**		
Can we reduce the impact by taking different action?		**n/a**		