HOMEWISE
REPAIRS, IMPROVEMENTS & ADAPTATIONS

Patient safety incident response policy

Effective date: 30 June 2025

Estimated refresh date: June 2026

Contents

Purpose

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

Homewise is a small, registered charity that has been offering Home Improvement Agency services in parts of East Lancashire for over 30 years.

We help older, disabled and vulnerable people to repair, improve and adapt their homes so that they can remain in relative comfort and security.

Our services include:

- Advice and Information
- Handyperson and Small Repairs Service
- Minor Aids and Adaptations
- Memory Matters Service

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 Homewise's services.

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

At Homewise, we aim to promote a just culture for the safety of all our clients. This approach enables everyone to contribute to a fair and safe environment when things go wrong. We want to create an environment where staff feel it is safe to report incidents or near misses, so that the organisation is aware of them, this provides an opportunity to learn and improve our services. As part of the continuous journey of improvement we concentrate on what was responsible, rather than who was responsible. This approach supports staff and enables the organisation to focus on learning.

Patient safety partners

All our work is dependent on strong collaborations and partnerships. We will continue to work closely with referral partners, including Occupational Therapists, GPs, Social Prescribers and the ICB patient safety team and other relevant agencies to support patient safety. All safety incidents are reported to our service manager and reviewed by our Chief Officer and appointed Board Trustee.

The Patient Safety Partner (PSP) is a new and evolving role developed by the NHS England Improvement to help improve patient safety across the NHS in the UK. We are not expected to have our own PSP.

Addressing Health Inequalities

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

Most of our delivery is with people living in areas of high deprivation, and facing these inequities - for example those from Black, Asian and minority ethnic communities, the homeless population in urban areas, LGBTQ population, etc

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

Our focus is to provide (ourselves and via our delivery partners) the best care for our service users, regardless of, their skin colour, culture, ethnicity or faith, gender or sexuality, age or if they have a disability and do not tolerate, under any circumstances, any form of racial abuse or discrimination. As part of the patient safety incident response framework (PSIRF) our delivery partners will utilise the available protected characteristic datasets held to allow for incidents and intelligence to be analysed by protected characteristics, providing insight into any apparent inequalities.

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.

As an organisation we are committed to continually improving our services. We want to learn from any incidents that occur that which are unexpected or unplanned. We are committed to being open and transparent in everything we do.

Alongside our professional and statutory requirements for Duty of Candour, we commit to being open and transparent regardless of the level of harm caused by an incident.

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.

Homewise will take a proportionate approach to its response to patient safety events to ensure that the focus is on maximising improvement.

Resources and training to support patient safety incident response

Homewise has committed to ensuring that we fully embed the 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 organisation has introduced patient safety training to ensure that all staff are aware of their responsibilities in reporting and responding o patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows.

All staff are expected to undertake level 1 Patient Safety training outlined below. Level 2 training will also be undertaken by key practitioners.

Patient safety syllabus level 1: Essentials for patient safety. probably with the view to have all your staff trained to L1)

Patient safety syllabus level 2: Access to practice.

NHS Patient Safety Syllabus training - elearning for healthcare (e-lfh.org.uk)

The team will also have access to NHS England Patient Safety Learning Response Toolkit where you will find an introduction to SEIPS and other useful documents. NHS England » Patient safety learning response toolkit

All incidents will be reported through LFPSE regardless of level of investigation required.

NHS England » Learn from patient safety events (LFPSE) service

Our Patient safety incident response plan

Our plan sets out how **Homewise** 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.

The aim of our plan is to:

- To ensure staff are aware of what they need to report significant events
- To create an open and transparent environment where staff feel supported in reporting
- To facilitate learning and improvement from reported events
- To ensure patients, friends and families feel listened to, supported and incidents are always dealt with robustly.

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.

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 incidents to the Service Manager within 24 hours of the incident occurring. The document below outlines our process.

Patient safety incidents will be responded to proportionately and in a timely manner. This should include consideration of the Duty of Candour. If there is an incident these could only require local 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 ICB for support where cross system working can support with a collaborative response.

The chief officer will act as liaison with external bodies and partner organisations to ensure effective communication and point of contact for the organisation.

Patient safety incident response decision-making

All reported patient safety events will be reviewed by the chief officer and service manager, who will also agree appropriate learning responses and share with external agencies. Incidents will also be reported to Board of Trustees.

Learning responses available include:

Patient Safety Incident Investigation (PSII)

A Patient Safety Incident Investigation (PSII) is a comprehensive investigation which will utilise the System Engineering Initiative for Patient Safety (SEIPS) framework. These investigations may be initiated where it is felt a patient safety event meets the criteria to be defined as a national or local priority

Duty of Candour disclosure should take place accordingly.

After-Action Review

An After-Action Review is a method of evaluation that is used when there is an unexpected outcome of an activity or event. It aims to capture learning from these tasks to avoid failure and promote success for the future. Everyone should feel they are able to contribute without fear or retribution. After-Actions reviews are not about accountability but learning.

Responding to cross-system incidents/issues

Homewise will work with partner organisations and the ICB to establish and maintain robust processes and procedures to facilitate a free flow of information and to minimise delays in joint working on cross-system incidents.

Timeframes for learning responses

The enquiry must start as soon as possible after the incident is identified and should ordinarily be completed within one to three months of the start date. No learning response should take longer than six months to complete.

Safety action development and monitoring improvement

Following the patient safety event, we will agree and generate safety actions in relation to defined areas for improvement. Following this, the organisation will have measures to monitor any safety action and set out review steps. These actions will be overseen by the Board of Trustees.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. Homewise patient safety incident response plan has outlined the local priorities for focus of investigation under the PSIRF to help to focus our improvement work.

Monitoring of progress regarding safety improvement plans will be overseen by reporting Chief Officer to the Trustees.

Oversight roles and responsibilities

Chair of Trustees	The Chair of Trustees has the ultimate responsibility for all aspects of patient safety which includes the management of incidents. This includes ensuring that appropriate structures are in place to enable full investigation, analysis and learning and ensuring resources are available to comply with this policy.
Board and stakeholders	Board/ stakeholders will receive assurance regarding the implementation of the PSIRF and associated standards to ensure that the Board understands organisational safety actions and improvement.
Chief officer	The chief officer has responsibility for patient safety with Homewise and is accountable for ensuring an adequate system is in place to enable appropriate responses to safety incidents that occur.
All other staff / volunteers	All staff and volunteers across the organisation are responsible for ensuring any patient safety events are reported within 24 hours of occurrence to this policy.

This policy and plan will be adopted at a meeting of the Trustees on 20 May 2025. Implementation and staff training will take place in June 2025. The policy and plan will be reviewed in 12 -18 months time.

The Board of Trustees	Have responsibility for policy setting in respect of Patient Safety.
Chief Officer and Service Manager	Have responsibility for implementation, embedding policy and reporting mechanisms

Complaints and appeals

Homewise recognises that there will be occasion when the patients, families or carers are dissatisfied with aspects of the care and support they receive.

The organisation is committed to dealing with any complaints as quickly as possible. Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.