SAINT FRANCIS HOSPICE	Saint Francis Hospice Caring for you

PSIRF (Patient Safety Incident (Event) Response) Policy

Effective date: Anticipated 1st June 2024 following ratification by Board (May 2024).

Estimated refresh date: 6 months review or if any legislative changes (January 2025).

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Purpose

This policy supports the requirements of the Safety Event Response Framework (PSIRF) and sets out Saint Francis Hospice approach to developing and maintaining effective systems and processes for responding to safety events and issues for the purpose of learning and improving safety.

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

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

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

Scope

This policy does not stand alone and must be considered alongside the SFH Concise Safety Response Plan, and the SFH Event Reporting and Analysis including Serious Event procedure.

This policy is specific to safety event responses conducted solely for the purpose of learning and improvement across all services provided by, and within teams and Directorates at Saint Francis Hospice.

Our services:

- Specialist community and crisis support
- The Hospice ward (18 bedded capacity)
- Hospice at Home
- Therapies
- Counselling
- Bereavement services, inclusive of under 18 support
- Support groups.
- Carers, families, and loved ones
- OrangeLine

Responses under this policy follow a systems-based approach. This recognises that 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 event.

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 safety response and are outside the scope of this policy.

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

Response types that are outside the scope of our safety event response plan include, complaints, people and culture investigations, professional standards investigations, coronial inquests, criminal investigations, audits, safeguarding concerns, information governance concerns, and estates and facilities issues.

Other event reporting and response guidance is also held and cross-referenced with the SFH Incident Reporting and Investigation Policy, and the SFH Health and Safety Policy.

Learning response methods are used to support learning and improvement in relation to safety event types through Sentinel, the risk management system and incident management tool which is used to effectively record, manage, and report our organisation's events. These are reported via the Quality Assurance Management Group to the Clinical Governance Committee and Board. Other non-safety is also recorded within the same tool to collate trends and themed analysis to the Corporate Governance Committee and Board.

This safety event response policy links to the following policies in place within our organisation:

1. **Event Reporting and Analysis including Serious Event procedure.**

This policy describes Saint Francis Hospice (SFH) approach to event reporting with a commitment to reducing accidents, events and near misses in the workplace. This policy relates to all events and near misses and clinical events, including unexpected deterioration in the health of a person (H&S).
This policy and procedure apply to all SFH staff, volunteers and contractors working on SHF premises, including staff on honorary contracts. In situations where an event relates to a staffing concern advice is sought from People and Culture Directorate as to the relevant process to be followed.

SFH recognises that an effective event reporting system is one of the key methods for alerting the organisation to issues that, if not addressed, may pose a serious risk to the people in its care, the staff it employs and volunteers working with us. It is also a legal requirement under the Social Security (Claims and Payments). Engaging in pro-active risk management activity, in addition to the process of reactive event management, will enable the early identification of many things that can go wrong as part of a systematic approach to risk assessment. When things do go wrong it is now widely accepted that the response should be one of learning, with an overarching aim to minimise risk for future individuals, people and the workforce who may otherwise suffer as consequence. Learning from an event will take priority over disciplinary analysis except in unusual circumstances.

2. Other documents:

- Risk Assessment Policy
- Working Safely for the Future (Pandemic) Policy.
- Risk Management Strategy Policy
- Risk Register
- Health and Safety Policy and Statement
- Records Management Policy

- Medicines Management Policy
- Freedom to Speak Up (Whistleblower) Policy
- Sickness Absence Policy
- Bullying and Harassment (Dignity at Work) Policy
- Lone Working Policy
- Post Falls and Head Injury Protocol
- Complaints, Comments and Compliments Guide
- Standards of Patient Care Policy
- Duty of Candour Policy
- Safeguarding policy
- On Call Policy
- SFH EDI Strategy

This policy is based on NHS England's Patient Safety Event Response Framework (PSIRF).This

This safety event response policy is published on our website https://www.sfh.org.uk/ .

Our safety culture

Our organisation promotes a climate that fosters a just culture to improve safety culture. In support of open and transparent reporting the development of a just culture is cross-organisational and subject to review and analysis as events are reported and shared within our Governance structure.

We do robustly support individual care and support and do refer to people as people at times rather than using a blanket 'patient' label.

We want and support a positive safety culture. The complete dimensions of safety culture are:

- commitment to overall continuous improvement
- priority given to safety.
- system errors and individual responsibility
- recording and evaluating events and best practice
- learning and effecting change
- communication about safety issues
- personnel management and safety issues
- staff education and training
- team working.

And a generative culture:

- pathological – low priority
- reactive – change once an incident happens.
- bureaucratic – not widely disseminated, individual responsibility.
- proactive – proactive sharing and learning
- generative – everyone's roles and staff actively engage and seek improvement.

With reference to the just culture guide, when analysing events, referral for individual management/ performance review or disciplinary action only occurs for acts of wilful harm or wilful neglect.

Our mission

To provide local people with excellent palliative and end of life care and support, before, during and after death.

Our vision

A world where everyone gets the right palliative and end of life support and care for them and their loved ones.

Our values

Supportive - The ability to listen to and value peoples' experience and use them to give the personal support that is right for everyone.

Compassionate - The ability to be kind and treat everyone we meet with care and compassion. The ability to be friendly and put people at the heart of our actions and words, supporting people's choices and decisions, helping them to feel safe, secure and valued.

Inclusive and Respectful - The ability to be open and transparent and value each person's individuality. To be able to show respect for everyone and value diversity. To be mindful that our different experiences and knowledge make us stronger and together we achieve more.

Professional - The ability to do your best, in providing the appropriate care and expertise to those who need us and support us.

Always Learning - The ability to be open and outward looking, always ready to adapt and change, looking for better ways of doing things, by learning from each other and from the ever-changing world around us.

Patient safety partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve safety across healthcare in the UK, including small providers within adult services such as SFH. This is part of the new Patient Safety Incident (Event) Response Framework (PSIRF).

At SFH we are committed to offering safe services , we welcome PSPs to work alongside our people (staff), those using our services, and population to influence and improve safety across our services. PSPs can be people, carers, family members or other lay people (including NHS and Social Care staff from another organisation).

The Individual Experience Management Group (IEMG) membership includes previous and current services users and family members, former trustees with experience of our services and the Havering and Redbridge Healthwatch communities.

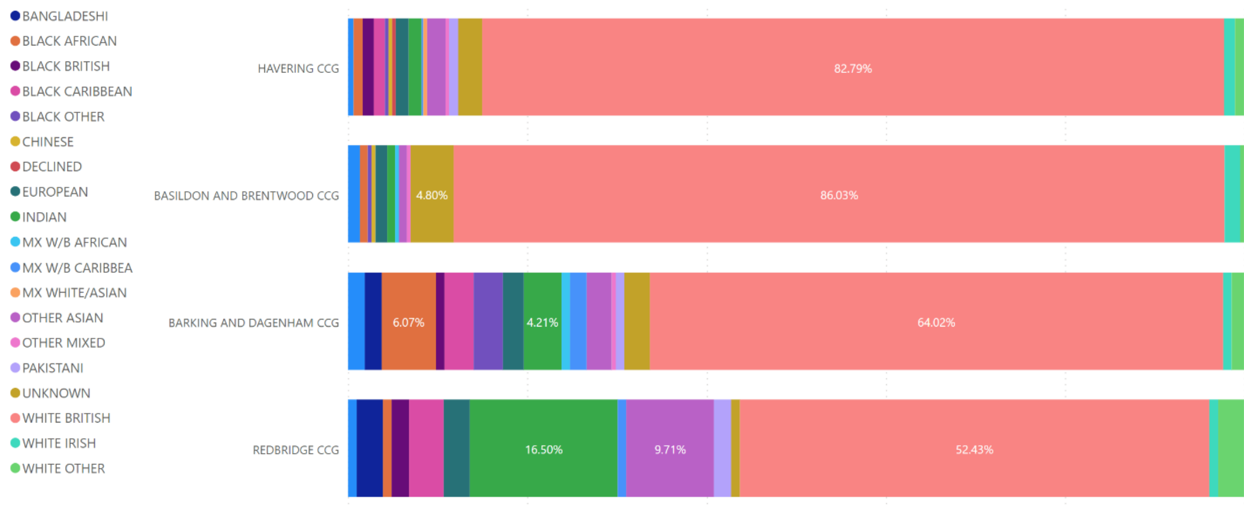
PSPs offer a different perspective on safety, one that is not influenced by organisational bias or historical systems, providing insight from a different perspective on safety.

Further development of joint PSP working within the NEL ICB and other small providers e.g., Hospices is underway.

Alongside the Quality Assurance Management Group, the Clinical Governance Committee has oversight and report to Board as per quarterly process.

Addressing health inequalities

At SFH we have developed service activity reports via iCare (power BI) to provide a full view of ethnic data across all ICBs and help to identify any disproportionate risk to people with specific characteristics.



We explore and respond to issues related to health inequalities as part of the development and maintenance of our safety event response policy and plans. For example, the iWantGreatCare platform reports include the age, ethnicity, gender, and long-standing conditions of those people sharing feedback with us. The tools we use to respond to safety events prompt consideration of inequalities, including when developing safety actions and are highlighted within our Governance and Management structure and reporting processes.

We engage and involve people, families and staff following a safety event with consideration of their different needs (see Duty of Candour). We uphold a system-based approach (not a 'person focused' approach) and ensure staff have the relevant training and skill development to support this approach as detailed in this policy. This supports the development of a just culture and can reduce the ethnicity disparity in rates of disciplinary action across the NHS workforce.

SFH are **Disability Confident** level 1 registered, progressing to level 2, and are committed to and evidencing an action plan for improvement. SFH think differently about disability and take action to improve how we recruit, retain, and develop disabled people.

Equality, Diversity & Inclusion (EDI).

We have a very active activity of Equality, Diversity & Inclusion (EDI) group which gives focus to people who have often encountered discrimination, as known from research and national documents, and are marginalised in the context of palliative and end of life care. It is estimated 1 in 4 people are unable to access the palliative and end of life care services and support needed (Hospice UK, 2021).

Equality impact assessment
This organisation recognises some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership. This organisation is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. We therefore have a standard that all policies are screened for their impact on equality. The Equality, Diversity and Inclusion team provide training, guidance and advice on equality impact assessment.

EDI eLearning mandatory training, provided by IHASCO went live November 2022, and over 85% of the workforce have completed this at year end 2023.

Widening access to all in our offer of palliative care services is essential, irrespective of diagnosis and circumstances. The **SFH EDI Strategy** reflects the work and statement of the group.

Deaf Awareness Training, nationally accredited by British Sign Language commenced in January 2023 for 20 staff from across the organisation.

Learning Disability and Autism Mandatory Training recently implemented the Oliver McGowan Mandatory Training across the organisation (centrally steered by Health Education England (HEE)) as part of the national requirement for CQC registered service providers to ensure employees receive learning disability and autism training, appropriate to their role, to ensure the health and social care workforce have the right skills and knowledge to provide safe, compassionate, and informed care. We have instigated the following module released by HEE November 2023

Inclusivity Statement is on the SFH website https://www.sfh.org.uk/ . This states everyone is welcome and outlines our organisational work to always improve. A public facing guidance document, highlighting the work in EDI, is under consideration.

The **Widening Access Management Group** provides a forum within which specialist leads where they can share progress against their aims and measure success whilst committing to inclusive and accessible working by means of strong internal relationships and wider external reach. The group has a far-reaching remit including identifying opportunities for the work towards appropriate and equitable access to specialist palliative care for people with non-malignant advanced disease, and

those with special vulnerabilities consolidating collective expertise. The group compares the SFH use of services through iCare data with regional (BHRUT) and national cohorts (HUK and the acute sector).

Supported and mentored by the Point of Care Foundation, SFH provide the opportunity for all staff and volunteers to attend **Schwartz Rounds**- a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare.

Engaging and involving people, families and staff following a safety event

Engagement principles - nine principles inform the design of our organisation’s systems and processes for engaging and involving those affected by safety events. Due to the range of events that can occur, and the different needs of individuals affected, the principles are be flexibly applied when engaging with or involving those affected by safety events in an investigation

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 compassion:** Everyone involved in a learning response should be treated respectfully. There should be a duty of care to everyone involved in the 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 people, families, and healthcare staff) and the organisation.

5. **Guidance and clarity are provided:** People, families, and healthcare staff can find the processes that follow a safety incident confusing. Those outside the health service, and even some within it, may not know what a safety incident is, why the incident they were involved in is being investigated or what the learning response entails. People, families, and healthcare staff can feel powerless and ill-equipped for the processes following a 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 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, people, 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 people, families, and healthcare staff are all viewed as credible sources of information in response to a safety incident.

9. **Strive for equity**: Organisations may differ from people, families, and healthcare staff in what they consider is the appropriate response to a safety incident. 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 events and be aware of the risk of introducing inequity into the process of safety responses.

SFH consider PSIRF guidance in line with the following guidance.

https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

The PSIRF recognises that learning and improvement following a safety event can only be achieved if supportive systems and processes are in place. It supports the development of an effective safety event response system that prioritises compassionate engagement and involvement of those affected by safety events (including people, families, and staff). This involves working with those affected by safety events to understand and answer any questions they have in relation to the event and signpost them to support as required.

Managers and/or leaders should demonstrate their commitment to compassionate engagement and involvement in their words and actions. Engagement and involvement must be communicated as a genuine priority and not a formality.

Leadership
Managers and leaders should demonstrate their commitment to compassionate engagement and involvement in their words and actions.

Training and competencies
PSIRF sets specific expectations regarding training required for engaging and involving those affected by patient safety incidents.

Support systems
Families and staff may need to be signposted to support at any point during engagement or involvement in a learning response.

Ensuring inclusivity
Engagement and involvement must take into account individual needs. Organisations should consider this in the design and delivery of their service.

Information resources
Those affected by a patient safety incident must have clear information about the purpose of a learning response, and what to expect from the process.

Processes for seeking and acting on feedback
Organisations must assess the progression and outcome of engaging with those affected by a patient safety incident and their involvement in a learning response.

Processes for managing dissatisfaction
When the expectations of those affected are not met, families and staff must be given meaningful, truthful and clear explanations as to why this was not possible.

Just Culture

What do we mean by just culture? A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution. In a just culture we attempt to understand why failings have occurred and how the system led to sub-optimal behaviours. However, a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts. By recognising the consequences of being involved in a safety incident for healthcare staff, we are be ready to provide support for all involved, including people, their family and staff.

Comments

We are always interested to hear views and if people have any comments or suggestions, we encourage them to let us know by using the cut off slip in our leaflet or email us. Completed slips can be handed to a member of staff and at reception.

Compliments (or suggestions)

If people have any views or suggestions, we ask that they email us at registeredmanager@sfh.org.uk, phone us on 01708 753319, or write to us at: Saint Francis Hospice, The Hall, Havering-atte-Bower, Romford, Essex, RM4 1QH.

Individual Experience Management Group

We bring together information from those that use of services, feedback, reviews and Information Leaflets, under one remit to ensure equal sharing of information and provide a forum for this to be communicated, where changes are agreed and taken forward within one meeting group.

Duty of Candour

Saint Francis Hospice (SFH) believes that the organisation and its staff should be open and candid about any and all events involving the health, safety and clinical care of individuals. Being Open is part of a 'no blame' culture, which is striven for at SFH, and this culture is fundamental to learning.

The hospice recognises that as part of Care Quality Commission Regulations, it is a requirement to ensure that people and/or their families are told about safety events that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences. An individual affected by an event should be notified (their nominated significant other if capacity concerns, or at request of the person) at the earliest opportunity.

CQC clearly identifies within Regulation 20:

- The duty of candour is a general duty to be open and transparent with people receiving care from you.
- It applies to every health and social care provider that CQC regulates.
- The duty of candour requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines 'notifiable safety events' and specifies how registered persons must apply the duty of candour if these events occur.

Freedom to speak up

The Board hopes staff feel comfortable raising any concerns about this policy being applied openly and locally. Staff may however wish to refer to the Freedom To Speak Up Policy (Whistleblower). This details routes for raising concerns including via our confidential services.

If a genuine concern is raised, staff will be supported and will not suffer any detriment, reprisal or be at risk.

Responsibility

Ultimate Responsibility – Chief Executive Officer (CEO) – CQC Nominated Individual.

Operational Responsibility - Director of Services, Registered Manager, Medical Director, Accountable Officer and CQC.

First Line Responsibility – all staff have a responsibility for identifying actual or potential hazards, safety events or risks and reporting/escalating issues in accordance with this policy.

Refer to:

- The Saint Francis Hospice Duty of Candour Policy.
- Health and Social Care Act 2008 (regulated activities) Regulations 2014: regulation 20
- Freedom to Speak Up (Whistleblower) Policy

https://www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour/read-the-professional-duty-of-candour/

https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/candour---openness-and-honesty-when-things-go-wrong/the-professional-duty-of-candour

https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour

https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

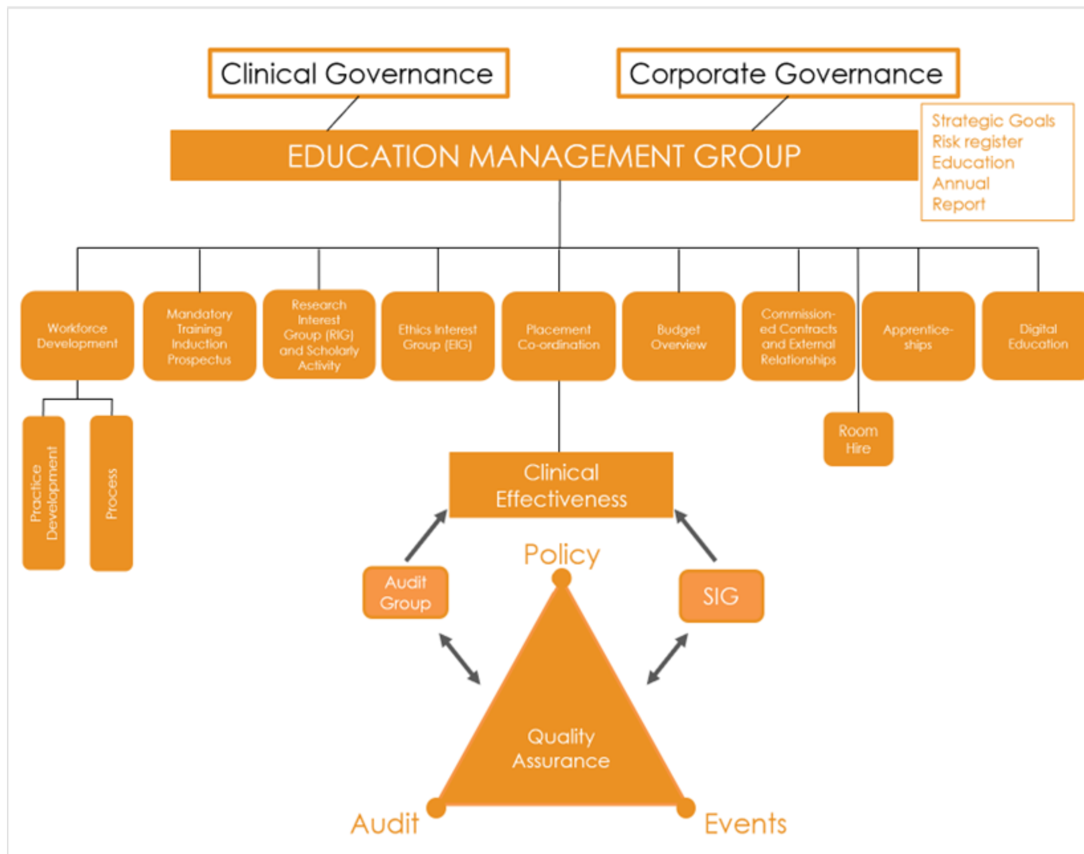
https://www.england.nhs.uk/patient-safety/incident-response-framework/

Responsible for engaging with those affected and responsibility for undertaking learning responses refer to 8 of the plan.

Improvement and transformation work

Saint Francis Hospice has identified the following key individual safety leads:

- PSIRF Executive Lead – Director of Services/ Registered Manager/Caldicott Guardian
- PSIRF Engagement Lead – Ward Manager
- PSIRF Learning Response Lead – Business Manager



Safety event response planning

SFH supports PSIRF in response to events 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, we explore safety events relevant to context and the populations we serve rather than only those that meet a certain defined threshold. We understand the importance of taking a proportionate approach to safety event response.

Planning how to respond to safety events is a collaborative process. We work with a range of stakeholders to create a list of safety event types that are jointly identified as areas of interest in terms of risk and potential learning and improvement e.g., pressure ulcers, falls, medication levels of harm.

Stakeholders that we work with include, but not limited to:

- Patient safety partners (PSPs) and/or patient and public representative groups such as Havering and Redbridge Healthwatch
- NEL ICB safety specialists / PSIRF Provider Forum
- ICB contractors
- CQC – Direct Monitoring Activity, Inspections and scheduled regular engagement.
- BHRUT / acute sector
- Peer reviewers
- Governance Committees with Trustee membership
- Hospice cohorts e.g., St Lukes, St Clares
- Hospice UK (HUK)

Timeframes:

Safety learning responses start as soon as possible after the incident is identified.

Safety learning response timeframes are agreed in discussion with those affected, particularly the person and/or their carer(s), where they wish to be involved in such discussions.

Depending on discussions with those involved, learning responses are completed within one to three months and/or no longer than six months.

Timeframes for learning responses

From sentinel event reports submitted by staff, causative factors are identified by individuals and commentary support strategies and action plans for risk reduction.

- Safety incident investigation (SFH PSIR template) - this analysis offers an in-depth review of a single safety event or cluster of events to understand what happened and how.
- Multidisciplinary team (MDT) review - weekly MDT reviews held by SCCS and the Ward, support learning from safety events that have occurred.
- Swarm huddle is designed to be initiated as soon as possible after an event and involves completed analysis and discussion. Information is gathered about what happened and why it happened as quickly as possible and with insight gathered from other sources, decide what needs to be done to reduce the risk of the same thing happening in future.
- After action review (AAR), is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes and learning as well as events.

Safety Incident Response Methodology:

Responses are conducted for the sole purpose of learning and identifying improvements that reduce risk and/or prevent or significantly reduce recurrence.

Responses are insulated from remits that seek to determine avoidability/ preventability/predictability; legal liability; blame; professional conduct/competence/fitness to practise; criminality; or cause of death.

With reference to the just culture guide, referral for individual management/ performance review or disciplinary action only occurs for acts of wilful harm or wilful neglect.

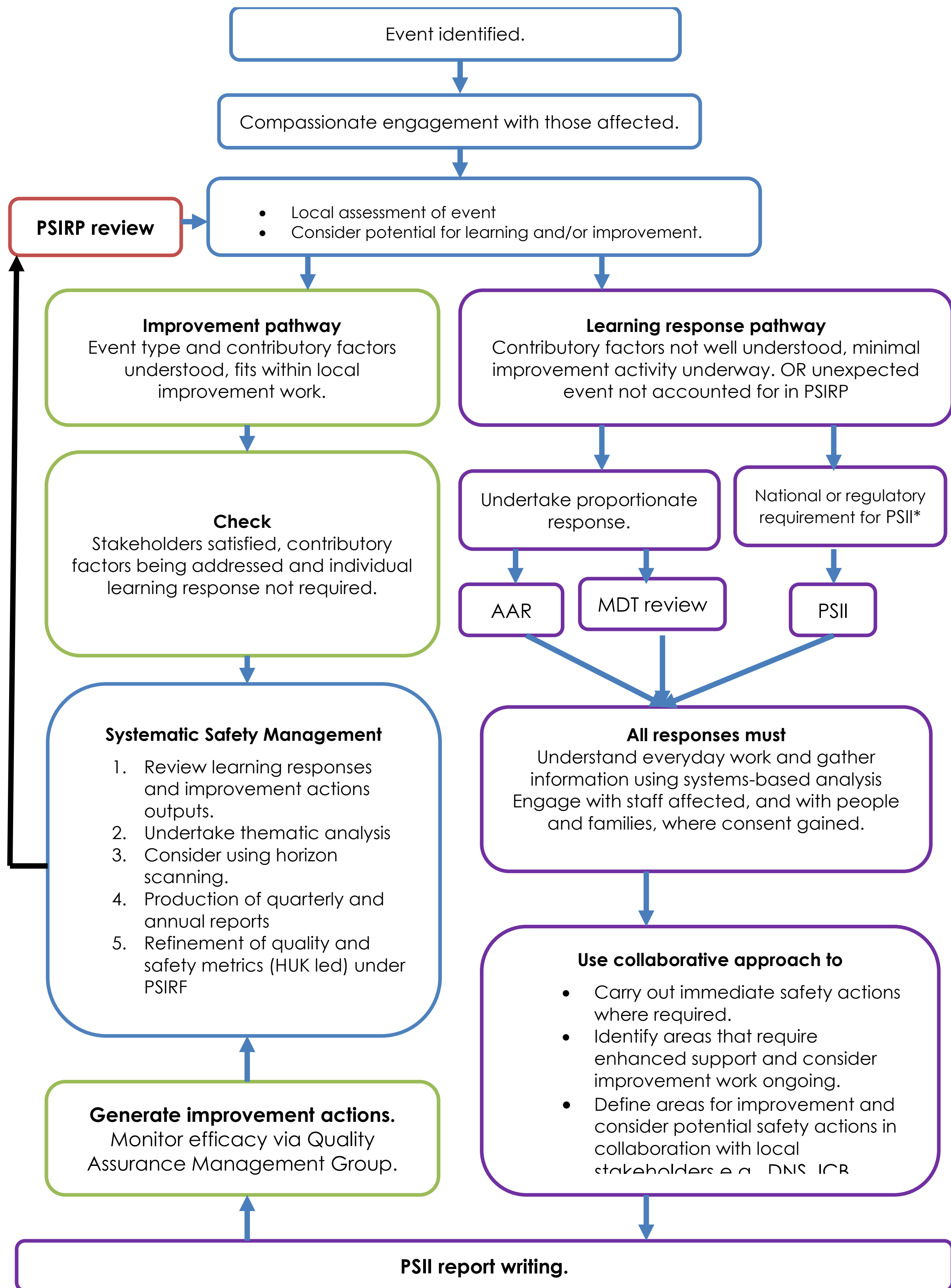
Safety incident investigation reports are produced using the SFH PSII template based on the standardised national PSII template.

Safety incident investigation reports are written in a clear and accessible way.

National tools (or similar system-based tools) are used/guides followed for learning response methods.

Learning and improvement work are balanced, and we do not continue to conduct individual learning responses when sufficient learning exists to inform improvement.

When a cross-system issue is identified, we will contact the ICB and follow the System Response Process. Monthly/quarterly reporting and commissioning engagement provides intermediatory and ongoing communication for full disclosure of anticipated or unplanned events.



Event identified.
Compassionate engagement with those affected.
PSIRP review
Local assessment of event
Consider potential for learning and/or improvement.
Improvement pathway
Event type and contributory factors understood, fits within local improvement work.
Learning response pathway
Contributory factors not well understood, minimal improvement activity underway. OR unexpected event not accounted for in PSIRP
Check
Stakeholders satisfied, contributory factors being addressed and individual learning response not required.
Undertake proportionate response.
National or regulatory requirement for PSII*
AAR
MDT review
PSII
Systematic Safety Management
1. Review learning responses and improvement actions outputs.
2. Undertake thematic analysis
3. Consider using horizon scanning.
4. Production of quarterly and annual reports
5. Refinement of quality and safety metrics (HUK led) under PSIRF
All responses must
Understand everyday work and gather information using systems-based analysis
Engage with staff affected, and with people and families, where consent gained.
Use collaborative approach to
Carry out immediate safety actions where required.
Identify areas that require enhanced support and consider improvement work ongoing.
Define areas for improvement and consider potential safety actions in collaboration with local
Generate improvement actions.
Monitor efficacy via Quality Assurance Management Group.
PSII report writing.

Resources and training to support safety event response.

Staff and others have the confidence to report events and near misses and know what procedure to follow. SFH is aware of events in a timely manner so that appropriate people are informed, and risks can be minimised to people, staff and the organisation itself.

The facts of each event are established, and appropriate actions are taken to satisfactorily remedy any deficiencies. Lessons are learned and communicated in order to prevent, so far as is reasonably practicable, similar events occurring in the future.

Embedding the new framework and understanding how this will change the lens we use for events/events and safety sits alongside health and safety measures. This is predominantly for those providing services to people. All trustees, directors and heads of service have completed the Patient Safety Syllabus Training programme via an e-LfH account and more recently via the transition of that module to our mandatory training tracker module, so that they are aware of the oversight responsibilities and reporting required.

All staff are required to complete Patient Safety Syllabus Training – Essentials of Patient Safety. All staff must complete Patient Safety Syllabus Training - Level 2 Access to Practice 1. All Senior Leadership Team and Trustee Board members must also complete Patient Safety Syllabus Training – Essentials of patient safety for boards and SLT.

All staff will receive training in accordance with national requirements. Core staff will be trained by 30th September 2023 with remaining relevant staff trained **by 1st April 2024.**

	Level 1 e-learning: Essentials of individual safety for all staff	**Level 2 e-learning Access to practice**	**e-learning Essentials of individual safety for Boards and Senior Leadership Teams**	**Systems approach to learning 2 days/12 hours**	**Involving those affected by individual safety events in the learning process**
All staff	✓				
All clinical staff	✓	✓			
PSIRF learning response lead	✓	✓		✓	
PSIRF Lead	✓	✓		✓	✓
PSIRF Executive Lead			✓		
Trustee Board members			✓		

Our safety event response plan

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

Reviewing our safety event response policy and plan

Our safety event response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to safety events. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our safety event 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, and if appropriate consider peer reviews by external engagers e.g., NHS England.

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, safety event (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to safety events

Safety event reporting arrangements

Following an organisation-wide review of the Event Reporting and Investigation Policy, a number of actions were agreed upon, to separate component parts and provide an investigation pack and template utilising the NHS 'Just Culture' guide - supporting consistent, constructive and fair evaluation of the actions of staff involved in safety events. The Event Reporting and Analysis policy including Serious Incident procedure was reviewed and has been released via NetConsent (a platform to deliver policies across the organisation). A further review will be undertaken in February 2024 – post PSIRF implementation.

Training is key to responsive progress; actions are taken forward for learning by the Practice and Quality Improvement Lead post and shared with the Head of Professional Practice, the Education team and leads of Service

Improvement Groups (SIGs) via the Quality Assurance Management Group and Audit Group (AG).

Reported event data is analysed via Sentinel, SMI/iCare (Power BI), UCP (Universal Care Plan), Summary Care Record (SCR), Views on Care (VoC), Picture Archiving and Communication System(PACS), CyberLab, ePro, System One (St Lukes Hospice), ThankQ (consent checks), OACC and iPlicit (claims).

Saint Francis Hospice continue to comply with the Hospice UK Patient Safety Programme - Clinical Benchmarking for Hospice Care. Data is submitted quarterly via Metrics, Categories and Definitions - as reviewed by HUK in May 2022; the final quarter contain the data reported from all four quarters creating the annual HUK report and historic data which facilitates analysis. Reported data includes but not limited to pressure ulcers, falls and medication levels of harm.

Key Performance Indicator 9 (no of serious untoward events/level 3+drug events) is reported at every Quarterly Report on Clinical Events at the Clinical Governance Committee meeting.

Quarterly Hospice monitoring quality reports detailing notifiable events such as falls, pressure ulcers, for avoidability, levels of harm, inheritance or acquired, are shared with contracted ICB stakeholders. As with HUK, reported data includes but is not limited to pressure ulcers, falls and medication levels of harm.

Whilst reporting events measured by levels of harm, communication is sought and shared with external partners e.g., District Nursing Teams (DNS) to ascertain the completion of Datex for community and ward-based pressure ulcers. The Datex number is noted against our own Sentinel record. SFH actively engage partner organisations that provided care to the people involved where that care may have played a role in the event being examined e.g., care homes and work together and co-operate with any learning response that crosses organisational boundaries.

Safety event response decision-making

Processes are in place locally to decide how to respond to safety events as they arise, including how decisions are take into account in our safety event response plan. This is mapped through Sentinel the Risk Management System which is scrutinised via the Clinical Governance and Corporate Governance Committees. Sentinel requires and prompts analysis depending on the reported event and desired outcome.

Planning supports proactive allocation of safety event response resources, but there will always need to be a reactive element in responding to events. Those events identified as serious are recorded on an adapted SFH PSII/PSIRF template for immediate and proportionate analysis and learning. Responses are always considered for safety events that signify an unexpected level of risk and/or potential for learning and improvement.

Events are identified through the Quality and Assurance reporting process within Sentinel of which the Management Group has oversight. Emergent issues and trends are shared and proportionately actioned (agreed) as appropriate. It may be appropriate to use a combination of methods in response to an issue. Any issues not included in the safety event response plan will be allocated by the designated Executive Team member.

Oversight roles and responsibilities.

Within SFH the Director of Services (Registered Manager), Head of Ward Services and Medical Director have the joint executive responsibility for the implementation of PSIRF. They are responsible for risk management and ensuring appropriate arrangements are in place for safety and the analysis of any events. They are also accountable for ensuring the mechanisms are in place for learning.

The responsibility for oversight of safety within the organisation and the implementation of PSIRF is delegated to the Director of Services, support by the Business Manager and Head of Ward Services. This role will support the responsibilities outlined below, and will provide direct leadership, advice, and support in complex/high profile cases, and liaise with external bodies as required.

PSIRF executive lead responsibilities

Ensure the organisation meets national safety incident response standards. The PSIRF executive lead (Director of Services), supported by the rest of the Board/leadership team and Business Manager, will oversee the development, review and approval of the organisation's policy and plan for safety incident response, ensuring they meet the expectations set out in the safety incident response standards where relevant.

Ensure PSIRF is central to overarching safety governance arrangements.

The board or leadership team must have access to relevant information about their organisation's preparation for and response to safety events, including the impact of changes following events. It is the PSIRF executive lead's responsibility to ensure:

- safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress are discussed at the board or leadership team's relevant sub-committee(s)

- roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to events.

The Board or leadership team will monitor the balance of resources going into safety incident response versus improvement. Repeat responses should be avoided when sufficient learning is available to enable the development and implementation of a safety improvement plan.

The SFH PSIRF Policy and Plan will be reviewed and updated within two years of initial transition to PSIRF as part of regular oversight processes. An overall review of the PSIRF Safety Incident Response Policy and Plan will be undertaken at least every four years alongside a review of all safety actions.

Responding to cross-system events/issues

At SFH we use a variety of data methods to improve based on learning from safety events. It is important to triangulate a mixture of qualitative and quantitative measures to get a clear understanding of the effectiveness of our safety incident response systems and processes in place. Data is outcome or process based and we use both. Examples of outcomes data which provided information after something has occurred would be complaint from a bereaved family member. The engagement and acknowledgement process would be undertaken by email, letter, and face to face meetings if appropriate.

We strive to reduce the information collection burden on our analysts and ICT and digital services. We have stream-lined data collection after reviewing the capability of our systems within SMI using iCare data through PowerBI. This meaningful information is pulled from existing data streams and is available real-time to Governance Committee members and team leaders. Oversight is more of a focus at meetings in support of the capacity to deliver safe services.

Meaningful insight is a priority and is captured from people, families, and staff via staff surveys, iWantGreatCare, our compliments and complaints procedures, social media platforms, amongst others. Learning is shared via the IEMG (including Havering and Redbridge Healthwatch), the MMG, QAMG and Audit Group.

Hospice UK (HUK)

By definition, a safety event is an unintended or unexpected event which could have or did lead to harm for one or more person receiving care.

Safety events are not a synonym for error, but do include harm unrelated to errors (for example, adverse reactions to mediation that could not have been anticipated or prevented) and situations with potential for causing harm that staff recognise and report before they can result in an error. Reflective of the NHS Patient Safety Strategy, safer care is nurtured on the foundations of a safety culture and a safety system.

SFH follow the document which lays out the metric definitions as agreed with the Patient Safety Network members enrolled in the safety programme. The Metric, Category and Definition are given for each area of monitoring. The programme enables clinical benchmarking within hospices across the UK by the regular collection of data relating to safety events within their services. These metrics are of particular significance due to the vulnerability of palliative people and their increased risk of harm from safety events involving pressure ulcers, medication events and falls.

Data is submitted monthly or quarterly, reports distributed contain historic data to facilitate analysis.

Peer reviews

The East of England Palliative and End of Life Care Strategic Clinical Network Review undertook a review in March 2022. A comprehensive 13-page action plan was formulated and updated whilst implemented across all service areas.

More recently (November 2023) the ICS lead (NHSE - NHS England), agreed to conduct a peer review for two initial PSIRF event analysis based on the PSII template. We have received good feedback.

Annual peer reviews will be planned and scheduled, or in cases where an event is considered appropriate for external review.

Safety action development and monitoring improvement

Learning from event responses to inform improvements are agreed and shared with individual and team members via email, team minutes and action logs.

Safety actions are monitored via the Quality and Assurance Management group, the Medicines Management Group (MMG), the Ward Manager, Sentinel, the Clinical Governance Committee (CGC), the Audit Group (AG) , the Service Improvement Groups (SIGs), scheduled policy reviews via

NetConsent, Short Observational Framework Investigations (SOFIs) and safe systems of working implementation.

Quality Improvement Projects (QIP) identify a deficit in quality of care and aim to improve, by making small cumulative changes and measuring their effects. These differ from our ‘clinical’ audits in that audits test practice against more formal standards and there is a longer interval between the two data collection points. These are presented at Audit Group.

The responsibilities of the Head of Professional Practice and Education broaden the scope to include all professions, as well as nursing. Contribution to the People Strategy and organisational development (OD) and collaboration with People and Culture continues the working relationship between Education and ICT.

Mandatory training in terms of content, volume, monitoring, and reporting as a unified approach, is discussed in conjunction with People & Culture Management Group, considering identified risk in a quarterly meeting for Project management of all mandatory training and delivery.

Safety improvement plans

Organisational safety improvement plans take different forms. For example, we may create an organisation-wide safety improvement plan summarising improvement work or create individual safety improvement plans that focus on a specific service, pathway, or location e.g., on site or in the community. However, we collectively review output from learning responses to single events when it is felt that there is sufficient understanding of underlying, interlinked issues. Using available data, stakeholder views, improvement priorities, and insight from safety event responses we analyse events which are embedded in an improvement (action) plan.

Learning is supported by bespoke and mandatory training provision across the organisation. This is driven locally and nationally. Audits and observations align the improvement efforts of service groups across the organisation e.g., Service Improvement Groups (SIGs) and task and finish groups.

Oversight roles and responsibilities.

Roles and Responsibilities:
The Chief Executive Officer/Executive Team will, within their area(s) of responsibility ensure that:

- this policy and its associated procedures are implemented.
- a positive reporting culture is maintained.
- any improvement recommendations are suitably progressed.
- all events are appropriately investigated.
- at least two Directors and the CEO are aware of serious events with moderate or higher harm.

The Senior Leadership Team will ensure that:

- this policy is fully implemented within their area of responsibility.
- all events and near misses are reported on Sentinel (Online Risk Management reporting system).
- relevant Director(s) and CEO are notified of all adverse events with a moderate to higher risk profile this is done automatically via Sentinel.
- adequate time is afforded to staff to complete Sentinel to report events and near misses.
- Notes (iCare) will refer to the Sentinel report (for future reference by clinical team)
- all events are initially reviewed before an event owner and investigator are nominated and requested to gather all relevant information and evidence as required.
- information is completed on Category No and Low Harm - within 5 working days of event.
- information is completed on Category Moderate and Higher harm events within 24hrs of event (including root cause analysis)
- staff are treated fairly and equitably during any analysis.
- all Sentinel events are maintained securely and fully compliant with General Data Protection Regulation 2016 (GDPR) and the Data Protection Act 1998 and 2018.
- If appropriate, once analysis have been completed events are reviewed with lessons learnt detailed on the IRF and shared with appropriate teams.

All members of staff:

- report all events and near misses using the sentinel reporting system as soon as reasonably possible.
- supply as much supporting information at the time of making the report to prevent vital information becoming lost
- contribute to discussions with management regarding possible solutions to prevent a recurrence of the event via case review as necessary.

The Quality Assurance Management Group and Health and Safety Management Group will:

- receive reports on significant trends and obtain relevant assurances that appropriate action plans are in place.
- monitor progress of recommendations following the outcome of an analysis into an event
- ensure that lessons learned from events are appropriately communicated to those who may benefit from the information.
- report quarterly to the both the Corporate Governance Committee for all events and Clinical Governance Committee for clinical events

The Director of Services (Registered Manager) will ensure that:

- all notifiable serious events are reported to the Care Quality Commission via relevant statutory notification form, within 24 hours as per regulations (Regulation 18 Care Quality Commission (Registration) Regulations 2009 (Part 4)) and to the relevant ICB.
- the Care Quality Commission is provided with regular updates during and at the end of the analysis, or as and when appropriate.
- a record of the serious event is created, and update details provided during/post analysis.
- all relevant serious events are reported to the relevant statutory/regulatory bodies.

Health & Safety Officer will ensure that:

- All Events reportable to the HSE under the RIDDOR regulations are reported within the stated timescales – see Appendix 1
- All other events are adequately investigated, and the correct procedure is followed.
- Will collaborate with the (Safety Officer) and the Practice and Quality Improvement Lead (PQiL).

Complaints and appeals

Complaints are administered centrally by the Complaints Co-ordinator, in accordance with the Complaints, Comments & Compliments Policy. A complaints log is maintained by the Complaints Co-ordinator and the Executive Team reviews the Complaints log regularly to ensure complaints are being administered, progressed, and resolved appropriately.

The Complaints, Comments & Compliments Policy was last reviewed and updated in August 2021, with an Appendix added in February 2023 to cover Complaints received for Brite Vox. The Policy is due for full review in January 2024.

The Corporate Governance Committee continues to receive quarterly update reports and summaries on complaints so that the Committee may consider trends, if any, that may be developing.

https://www.sfh.org.uk/compliments-and-complaints

Saint Francis Hospice aims to provide the highest standards of care to people, families, and carers. We hope you will be happy with all aspects of

our care and services, and we welcome your views, comments, and suggestions.

Sometimes situations occur that cause concern and when they do, we would like to know. If any aspect of our service gives cause for dissatisfaction, we encourage people to please speak to us. All complaints are taken seriously and will be dealt with promptly, sympathetically and in complete confidence.

What to do first? Ask to talk with the nurse/manager in charge who will try to deal with concerns straight away.

After speaking to somebody, what can a person do if they are still unhappy with the response to their complaint?

Write to or email one of the service directors or Chief Executive Officer to discuss your concerns further. The email address is registeredmanager@sfh.org.uk.

Receipt of a complaint will be acknowledged within three working days. Every endeavour will be made to investigate a complaint and provide a full response within 28 days of receipt of the complaint, or a timescale agreed with the person. In cases where a lengthier investigation is required, a revised timescale will be agreed with the person.

What can a person do if they are not happy with the outcome? They can write to the Chief Executive Officer or the hospice's Corporate Services Manager. If they are still unhappy you can contact the Care Quality Commission. If they are unhappy with the investigation and outcome, they can seek independent advice from VoiceAbility, NHS Complaint Advocacy Service.

If they remain concerned, they can contact the Parliamentary and Health Service Ombudsman. If a person has a complaint about any aspect of our service, they can email us.

National guidance

- NHS England and NHS Improvement Patient Safety Strategy, accessible via: Report template - NHSI website (england.nhs.uk)
- NHS England » Patient Safety Incident Response Framework
- NHS England » Primary care information on the new national learn from patient safety events service
- NHS England » Patient Safety Specialists
- NHS England » Framework for involving patients in patient safety
- NHS England Patient Safety Incident Response Framework, accessible via: B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk)
- NHS England Engaging and involving patients, families and staff following a patient safety incident, accessible via: B1465-2.-Engaging-and-involving...-v1-FINAL.pdf (england.nhs.uk)
- NHS England Guide to responding proportionately to patient safety events, accessible via: B1465-3.-Guide-to-responding-proportionately-to-patient-safety-events-v1.1.pdf (england.nhs.uk)
- NHS England Oversight roles and responsibilities specification, accessible via: B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk)
- NHS England Patient safety incident response standards, accessible via: B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)
- NHS England Patient Safety Incident Response Framework – Preparation guide, accessible via: B1465-6.-PSIRF-Prep-Guide-v1-FINAL.pdf (england.nhs.uk)
- NHS England Safety action development guide, accessible via: B1465-Safety-action-development-v1.1.pdf (england.nhs.uk)
- NHS England SHARE debrief tool, accessible via: B1465-SHARE-Debrief-v1-FINAL.pdf (england.nhs.uk)
- NHS Resolution: Being fair 2

Local guidance

- Equality, Diversity and Inclusion Policy (including Just Culture)
- Duty of Candour
- Freedom To Speak Up (Whistleblower) Policy
- Bullying and Harassment (Dignity at Work)
- Reasonable adjustments (Health and well Being and Sickness Absence) policies.
- Leave policy.
- Complaints, comments and compliments policy and guide
- Health and Safety Policy
- Event Reporting and Analysis Policy
- Medicines Management Policy
- Risk Management Framework
- Care Strategy