# Individual Safety Event Response Plan (PSIRP)

**Effective date:** 1st June 2024
**Estimated refresh date:** 1st April 2025

| | NAME | TITLE | DATE |
|---|---|---|---|
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## Introduction

The NHS Individual Safety Strategy was published in 2019 and describes the Individual Safety Event Response Framework (PSIRF) as a foundation for change and as such, it challenges us to think and respond differently when a individual safety event occurs. It is a replacement for the NHS Serious Event Framework. This document is the Individual Safety Event Response Plan (PSIRP) and sets out how Saint Francis Hospice will respond to individual safety events.

PSIRF is designed to promote learning and systemic improvement, moving away from the previous Serious Event Framework which focussed more on process than emphasising a culture of continuous improvement in individual safety.

This framework is designed to focus on doing analysis in a collaborative way, led by those who are trained to conduct them. It ensures the involvement of individuals, their carers, families, and staff in an embedded system that responds in the right way, appropriate to the type of events and associated factors. It recognises the need to provide a safe and supportive environment for those involved in any analysis, with an emphasis on systemic improvement.

Analysis of our current systems has improved our understanding of our individual safety processes and allowed us to use these insights to develop our PSIRP.

## Scope

There are many ways to respond to an event. Our PSIRP covers responses conducted solely for the purposes of systems-based learning and improvement.

Individual safety events are any unintended or unexpected event which could have, or did, lead to harm for one or more individual's receiving healthcare.

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 types of response exist to deal with specific issues or concerns, and it is outside the scope of PSIRF to review matters to satisfy processes relating to these, examples of which may include complaints, HR matters, legal claims and inquests.

This document works alongside the SFH Individual Safety Event Response Policy 2023 and the SFH Event Reporting and Analysis Policy 2023.

## Resources

Our four key aims with regards to safety incidents: compassionate engagement and involvement of those affected; a system-based approach to learning; considered and proportionate responses; supportive oversight focused on strengthening response systems and improvement.

Key PSIRF engagers (Heads of Service, Vantage/Sentinel allocators, team leaders) are led the Director of Services and respond to priority areas that are identified for immediate analysis, action and review.

**Our services**

As an independent charity and one of the largest adult Hospices in the UK, Saint Francis Hospice has a vital role to play in the local community. We have a committed team of specialist consultants, doctors, and nurses who work alongside other health and social care professionals across our catchment area to provide free comprehensive care for all who need it. These qualified and compassionate people provide care and support to individuals with a life-limiting illness, as well as to their carers, families and loved ones. We serve the growing and diverse populations of Havering, Brentwood, Redbridge, West Essex and Barking and Dagenham.

Saint Francis provides free palliative care and support for individuals over the age of 18 who are living with a life limiting illness, such as heart failure, cancer, lung disease or other conditions, as well as their families.

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

**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**

These values underpin all that our charity aspires to do, as well as shaping our external and internal behaviour.

**Supportive:** We listen to people and value peoples' experiences and use them to give the personal support that is right for everyone.

**Compassionate:** We are kind and provide a caring and compassionate environment for everyone. We put people at the heart of our actions and words and support people's choices and decisions, helping them feel safe, secure and valued.

**Inclusive and Respectful:** We are open and transparent and value each person's individuality. We respect everyone and value diversity. We believe our different experiences and knowledge make us stronger. Together we achieve more.

**Professional:** We are experienced in what we do as a Hospice and as a charity. We encourage everyone to give of their best, in providing the appropriate care and expertise to those who need us and support us.

**Always Learning:** We are 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

We run an 18 bedded In Individual Unit (WARD) and our multi-disciplinary team cares for people  with complex palliative care needs.

Our community nursing team (SCCS) are registered clinical nurse specialist (CNS) and paramedics who have specialist training and experience in palliative care. Our Hospice at Home team are registered nurses and health care assistants are here to help people  and loved ones in times of fear, pain or distress. People s receive the same standard of 'You-Centred' palliative care received in the Hospice.

Pemberton Place provides a broad range of therapies and options to support individuals and those close to them living with serious, long term or life-limiting conditions. The service offers a variety of face-to-face and remote online groups, sessions and courses designed to support people to cope with a long term condition. We are supported by a fully trained team of volunteers.

**Our strategic priorities help to formulate our PSIRF aims:**

| Strategic priorities | PSIRF aims |
|---|---|
| Empower: a dynamic, agile organisation | Develop a climate that supports a just culture and an effective learning response to individual safety events |
| Enable: an outstanding organisation | Improve the safety of the care we provide to our individuals |
| Engage: with our stakeholders and each other | Improve the experience for people, their families and carers wherever a 'individual safety event' is identified |

**Individual Safety Network:**

**Defining our individual/person safety event profile**

In order to determine any priority areas to support the delivery of the new PSIRP, an understanding of the scale of individual related safety activity is required.

Data and information from a variety of sources has been gathered:

- Individual safety events (quarterly)
- Serious Events (quarterly)
- GP Quality Alerts (state period)
- Complaints and compliments (quarterly)
- Legal – Clinical Negligence Claims (quarterly)
- Legal – Inquests (quarterly)
- Freedom to Speak Up

Further data sources to be reviewed:

- Mortality / Learning from deaths
- Feedback and complaints and learning from
- Safeguarding
- Staff survey results
- Risk registers and Board Assurance Framework
- Staff competence breaches and any necessary suspensions
- Quality Improvement projects (QIP)
- CQC inspections and Direct Monitoring Actions and Activity.
- Field safety Notices
- Quality Alerts
- Complaints and compliments (quarterly)
- Legal – Clinical Negligence Claims (quarterly)
- Legal – Inquests (quarterly)
- Freedom to Speak Up

Further data sources to be reviewed:

- Mortality / Learning from deaths
- Safeguarding
- Staff survey results
- Risk registers and Board Assurance Framework
- Staff suspensions
- Quality Improvement projects (QIP)
- Audits

We engage with key internal and external stakeholders to establish the individual safety issues most pertinent to Saint Francis Hospice. These stakeholders were:

- Quality and Assurance Management Group
- Clinical Governance Committee
- SFH Board
- NEL ICB, West Essex ICB and Mid and South Essex ICB (Basildon and Brentwood)
- District Nursing Services

We also introduced a collaborative approach to define our individual safety profile. We engaged other local hospices and our lead ICB (NEL) to share best practice and process to achieving the PSIRF framework.

We have:

- Linked with ICB individual safety leads (NEL ICB).
- Developed our PSIRF hospice policy.
- Identified key stakeholders.
- Identified key lead roles.
- Identified our hospice training needs locally through our own in-house training tracker and externally providers (e-Lfh and HSIB).
- Identified a peer reviewer via EoE.

We examine safety data quarterly and report to the Quality assurance Management Group and the Clinical Governance Committee. Reporting includes safeguarding concerns that are raised in relation to Saint Francis Hospice. Staff recognition of safeguarding concerns are communicated weekly by email for the Safeguarding lead contact rota. Training is undertaken by the Safeguarding Team face to face Year 1 alternating with Training Tracker Year 2. Staff can do the training tracker in addition to the face-to-face year as this may be beneficial to them too.

Pressure ulcers, medication and falls are the three highest reported individual safety events and are currently benchmarked through Hospice UK and reported independently to each relevant ICB (LFPSE is not in use at this time).

**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

**Training**
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 patient safety for all staff | Level 2 e-learning Access to practice | e-learning Essentials of patient 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** | ✓ | ✓ | | ✓ | |

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| **PSIRF Lead** | ✓ | ✓ | | ✓ | ✓ |
| **PSIRF Executive Lead** | | | ✓ | | |
| **Trustee Board members** | | | ✓ | | |

**Governance**

The Quality Assurance Management Group includes key individual safety leads and attendees from across the hospice multi-disciplinary team and will meet quarterly to review the events that have had a completed individual safety review and will make a decision as to whether the event is closed, or further action is required.

The following groups will also meet to support PSIRF:

- The Infection Prevention Service Improvement group – Twice yearly or in response to event review meeting
- The Medicines Management and Drug Events groups – Quarterly or in response to event review meeting
- The Safeguarding Management group – Quarterly or in response to event review meeting
- Clinical Governance Committee - Quarterly or in response to event review meeting
- Health and Safety Committee - Quarterly or in response to event review meeting

Any events that meet the criteria for an individual safety event analysis (PSII) will be managed by the Quality Assurance Management Group team.

Any event that has been categorised as moderate harm or above will have a PSII completed using System Engineering Initiative for Individual Safety (SEIPS) thinking. Once the PSII has been completed, this will be reviewed by the Quality Assurance Management Group team and an ICB quality lead will be invited to attend the review.

**Engaging and involving people, families, and staff**

We will have a compassionate engagement approach to involve individuals, families and healthcare staff in individual safety events. The PSIRF Lead will be notified of all individual safety events which meet the criteria for a PSII. Engagement and level of involvement will be in keeping with the wishes of those affected as far as possible, using the four steps of engagement process.[1]

When the expectations of those affected are not met, families and staff will be given meaningful, truthful, and clear explanations as to why this was not possible. (we have a robust Duty of Candour policy and process) People and families will be

[1] Individual Safety Incident Response Framework supporting guidance - Engaging and involving individuals, families and staff following a individual safety incident https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

offered the opportunity to complain in line with the Saint Francis Hospice complaints procedure. If the complainant is in agreement, the complaint analysis and individual safety event analysis will be combined so that the individual/family get all the answers they are seeking together.

**Supporting families and staff**

Families and staff will be signposted for support during engagement or involvement in a learning response. Sources of support for families will include the hospice Family and Individual Support Services, together with external bereavement and mental health services as well as via independent advocacy services.

In addition to the above, staff can also access support from their manager, the Employee Assistance Programme, and the hospice occupational health service.

**Working with system partners**

The hospice will actively engage partner organisations that provided care to the individual(s) involved where that care may have played a role in the event being examined e.g., District Nursing Services, GPs, acute sector.

We will work together and co-operate with any learning response that crosses organisational boundaries.

**Our individual safety event response plan: national requirements**

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. Events meeting the Never Events criteria (2018) and deaths thought more likely than not due to problems in care (i.e., events meeting the Learning from Deaths criteria for PSII) require a locally led PSII.

Table 1 below sets out the local or national mandated responses.

| | National priority | Response |
|---|---|---|
| **1** | Events that meet the criteria set in the Never Events list 2018 | Locally led PSII |
| **2** | Deaths clinically assessed as more likely than not due to problems in care | Locally led |
| **3** | Death of persons with learning disabilities | Refer for Learning Disability Mortality Review (LeDeR)<br>Locally led PSII (or other response) may be required alongside the LeDeR review |
| **4** | Safeguarding events in which:<br>Babies, children and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence.<br>Adults (over 18 years old) are in receipt of care and support needs by their Local Authority<br>The event relates to FGM, Prevent (radicalisation to terrorism; modern slavery & human trafficking or domestic abuse/violence. | Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards<br><br>**Saint Francis Hospice Safeguarding Management Team and Team leads.**<br><br>**Completion of Safeguarding log by Safeguarding Team.** |
| **5** | Mental health related homicides | Referred to the NHS England and NHS Improvement Regional Independent Analysis team for consideration for an independent PSII. Locally led PSII may be required with mental health provider as lead and STG / ESTH participation |
| **6** | Domestic Homicide | A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria fr |

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| | | a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews. |

**Our individual safety event response plan: local focus**

| Individual safety event type or issue | Planned response | Anticipated improvement route |
|---|---|---|
| Failure to follow up | PSII – SFH template | Quality Assurance Management Group meeting review<br><br>For all of the anticipated improvement routes, responses will be used to inform improvements, e.g. fed into the Quality Assurance Management Group action plan and monitored until resolution/implementation of remedial action is confirmed. |
| Individual falls | After Action Review - AAR | Organisation wide Falls action plan (HUK Falls Toolkit), continue to monitor and update as appropriate.<br><br>For all of the anticipated improvement routes, responses will be used to inform improvements, e.g. fed into the Quality Assurance Management Group action plan and monitored until resolution/implementation of remedial action is confirmed. |
| Pressure ulcers – Grade 3 and Grade 4 (new and inherited) | Quality Assurance Management Group review<br><br>Director of Services, Head of Ward Services and Business Manager review via concise report and submission to CQC (within 1 week).<br><br>* Supported by an immediate SWARM, and an AAR as planned | Organisation wide Pressure Ulcer toolkit and action plan, continue to monitor and update as appropriate.<br><br>Share learning opportunities with the Practice and Quality Improvement Lead.<br><br>Identify training opportunities with the Professional Practice and Education Lead.<br><br>For all of the anticipated improvement routes, |

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| | responses, as indicated in the national example table, given these are the most serious grades of pressure ulcers. | responses will be used to inform improvements, e.g. fed into the Quality Assurance Management Group action plan and monitored until resolution/implementation of remedial action is confirmed. |
| Event resulting in moderate or above harm | Reviewed by ward manager.<br><br>Record on Sentinel.<br><br>Quality Assurance Management group review and PSII - as soon as possible after the individual safety event identified. | Led by PSIRF Learning Response Lead (Quality Improvement Lead).<br><br>Completed within 1 month from start date.<br><br>Reviewed by Quality Assurance Management Group team.<br><br>Involvement of individual/client/relatives and staff in developing safety actions and improvement plans.<br><br>ICB Quality Lead invited to meeting to review.<br><br>For all of the anticipated improvement routes, responses will be used to inform improvements, e.g. fed into the Quality Assurance Management Group action plan and monitored until resolution/implementation of remedial action is confirmed. |
| Event that had potential to result in moderate to severe harm to individual | MDT Review | Analysis of work as planned/work as done, through observational and walkthrough tools.<br><br>Developing Safety Actions,<br><br>Improvement Plans.<br><br>For all of the anticipated improvement routes, responses will be used to |

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| | | inform improvements, e.g. fed into the Quality Assurance Management Group action plan and monitored until resolution/implementation of remedial action is confirmed. |
| New / Deteriorating Pressure Ulcer grade 3 or above, DEEP TISSUE INJURY or multiple grade 2 | After Action Review (AAR) – as soon as possible after event identified * | Led by Head of Ward Services<br><br>Notification to Care Quality Commission (CQC) via concise reporting.<br><br>Reviewed by Director of Services, Quality Improvement Lead, Head of Ward Services and Quality Assurance Management Group.<br><br>For all of the anticipated improvement routes, responses will be used to inform improvements, e.g. fed into the Quality Assurance Management Group action plan and monitored until resolution/implementation of remedial action is confirmed. |
| Medication level 0-2 | After Action Review (AAR) – as soon as possible after event identified | Led by Medical Director (Palliative Consultant).<br><br>Completed within 5 days from start date.<br><br>Reviewed by Medicines Management team.<br><br>Summary reviewed at Clinical Governance Committee meeting.<br><br>All Controlled Drug events submitted to LIN.<br><br>For all of the anticipated improvement routes, responses will be used to |

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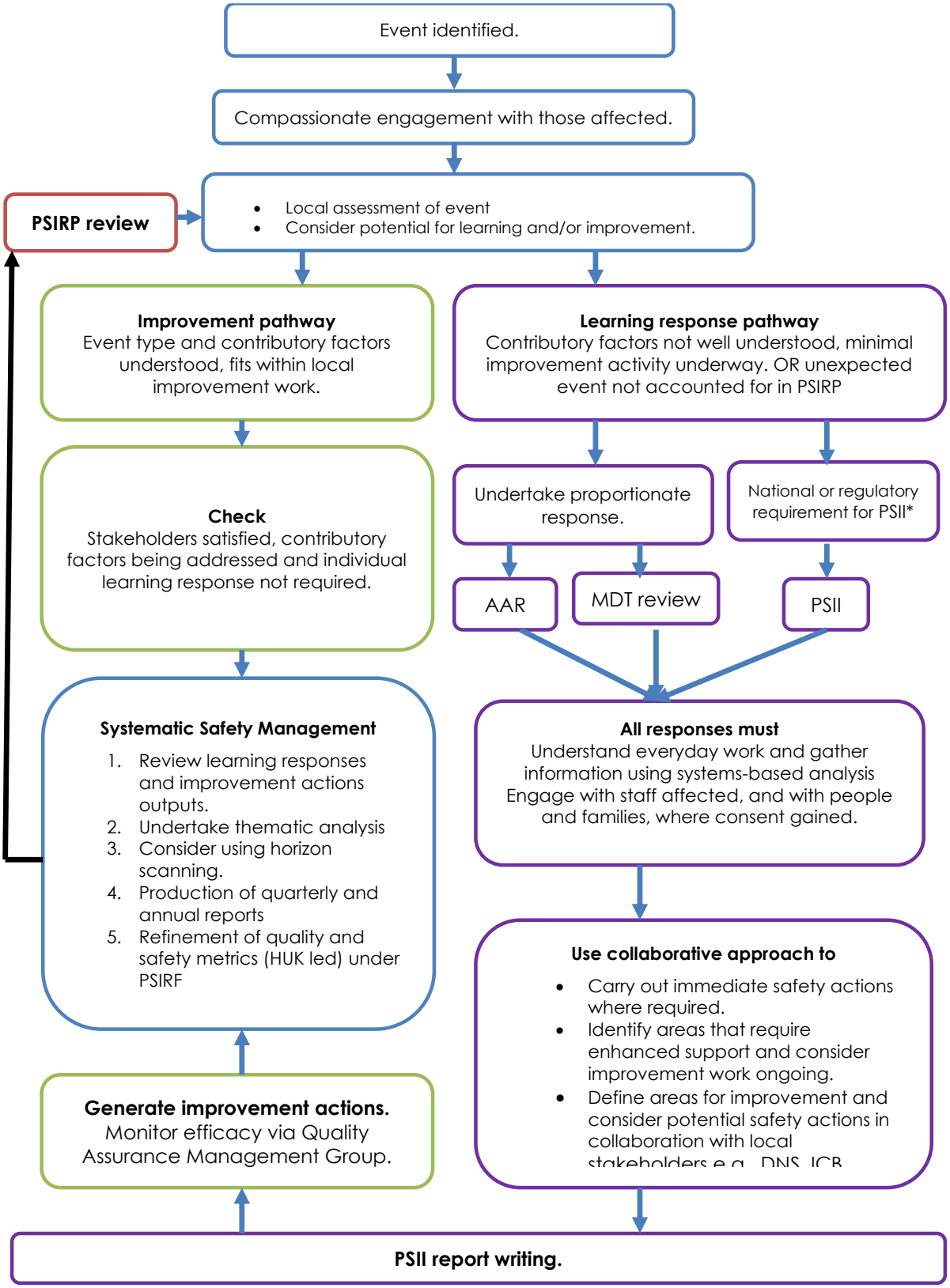
| | | inform improvements, e.g. fed into the Quality Assurance Management Group action plan and monitored until resolution/implementation of remedial action is confirmed. |
| Slip trip, falls no and low harm | After Action Review (AAR) – as soon as possible after event identified | Led by Head of Ward Services<br><br>Reported on Sentinel and reviewed at quarterly Quality Assurance Management Group meeting.<br><br>Completed within 5 days from start date.<br><br>Summary reviewed at Clinical Governance Committee meeting.<br><br>For all of the anticipated improvement routes, responses will be used to inform improvements, e.g. fed into the Quality Assurance Management Group action plan and monitored until resolution/implementation of remedial action is confirmed. |
| Increase or multiple theme events identified as need for further analysis | MDT Review and SEIPS | Led by PSIRF Learning Response Lead.<br><br>Completed within 1 month from start date.<br><br>Reviewed by individual safety review team.<br><br>May involve multiple stakeholders including individual representatives.<br><br>For all of the anticipated improvement routes, responses will be used to inform improvements, e.g. |

| | | |
|---|---|---|
| | | fed into the Quality Assurance Management Group action plan and monitored until resolution/implementation of remedial action is confirmed. |
| Delayed or failed admission, discharge or transfer into community | After Action Review (AAR) – as soon as possible after event identified | Led by Head of Ward Services or Medical Director.<br><br>Completed within 5 days from start date.<br><br>Reviewed by MDT.<br><br>For all of the anticipated improvement routes, responses will be used to inform improvements, e.g. fed into the Quality Assurance Management Group action plan and monitored until resolution/implementation of remedial action is confirmed. |
| IT/Information Governance (IG) event resulting in data breach | After Action Review (AAR) – as soon as possible after event identified | For all of the anticipated improvement routes, responses will be used to inform improvements, e.g. fed into the Quality Assurance Management Group action plan and monitored until resolution/implementation of remedial action is confirmed. |

It should be noted that levels of harm are used in the above table – at this time we are not planning to use LFPSE harm level definitions. Further consultation with our Event Reporting tool, Vantage, is ongoing in pursuit of a test module, should the ICB and NHSE mandate its use.

This PSIRP will have the flexibility to manage emergent risks or new events that signify extreme levels of risk or events that don't fall into the outlines national or local categories. Saint Francis Hospice will take a pragmatic approach and a proportionate response to maximise learning.


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.

**Review of the Plan**

Saint Francis Hospice will review this plan every 12-18 months in line with national guidance. If there is a change to the plan, Saint Francis Hospice will notify the ICB to agree sign off the change.

Where there is a cluster or unexpected significant number of events, ICB may ask for an earlier review of the plan as appropriate.

## Annex 1 - Glossary

### After Action Review (AAR)

An After-Action Review (AAR) is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.

### Deaths thought more likely than not due to problems in care.

Events that meet the 'Learning from Deaths' criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the individual's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

### Multidisciplinary Team (MDT) review

The multidisciplinary team (MDT) review supports health and social care teams to: identify learning from multiple individual safety events; agree the key contributory factors and system gaps in individual safety events; explore a safety theme, pathway, or process; and gain insight into 'work as done' in a health and social care system.

### Never Event

Individual safety events that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

### PSII -Individual Safety Event Analysis

PSIIs are conducted to identify underlying system factors that contributed to an event. These findings are then used to identify effective, sustainable improvements by combining learning across multiple individual safety event analysiss and other responses into a similar event type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our individuals.

**PSIRP** - Individual Safety Event Response plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

**PSIRF** - Individual Safety Event Response Framework

Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to individual safety events, prioritising support for those affected, effectively analysing events, and sustainably reducing future risk.

### SEIPS

SEIPS (System Engineering Initiative for Individual Safety (SEIPS) is a framework for understanding outcomes within complex socio-technical systems. SEIPS can be used as a general problem-solving tool (eg to guide how we learn and improve following a individual safety event, to conduct a horizon scan, and to inform system design).

**Swarm/Huddle**

Swarm-based huddles are used to identify learning from individual safety events. Immediately after an event, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.

**Thematic Review**

A thematic review can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews can use qualitative (e.g. open text survey responses, field sketches, event reports and information sourced through conversations and interviews) as well as quantitative data to identify safety themes and issues.