

Patient Safety Incident Response Framework (PSIRF)

Board Development Session
February 2024

Background of PSIRF

- PSIRF replaces the current Serious Incident Framework (2015)
 - makes no distinction between ‘patient safety incidents’ and ‘Serious Incidents’
 - no ‘Serious Incidents’ classification and the threshold for it. Never Events remain (for now)
- Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement

The infographic is titled "Think S.U.P.P.O.R.T.I.N.G." and features the NHS logo and "The Tavistock and Portman NHS Foundation Trust" text in the top right corner. The main title is in large blue letters. Below the title are two rows of five icons each, each with a corresponding text label in a blue box. The first row includes: a lightbulb with arrows (Systems Thinking and Supportive Oversight), people at a table (Using the Application of New Tools), an ambulance (Proportionate Response to Incidents), a person with a lightbulb (Psychological Safety), and a person with a lightbulb and the text "Keep Learning" (Opportunities for Learning are Maximised). The second row includes: a person at a computer (Recognising and Analysing Trends), people talking (Thinking & Listening to Patients, Families & Staff), hands holding blocks (Increased Planning & Collaboration), a person with a lightbulb (Notification & Compassionate Engagement), and hands holding a document (Good Application & Expert Investigators). At the bottom, a blue banner reads "Patient Safety Incident Response Framework (PSIRF)".

Think S.U.P.P.O.R.T.I.N.G.

Systems Thinking and Supportive Oversight

Using the Application of New Tools

Proportionate Response to Incidents

Psychological Safety

Opportunities for Learning are Maximised

Recognising and Analysing Trends

Thinking & Listening to Patients, Families & Staff

Increased Planning & Collaboration

Notification & Compassionate Engagement

Good Application & Expert Investigators

Patient Safety Incident Response Framework (PSIRF)

Tavistock and Portman NHS Foundation Trust. Produced: September 2023, Gateway number: PUB23_073

What PSIRF means in practice

- The opportunity to report and review safety incidents in a different way
 - Different format of investigations can be used including After Action Reviews and Safety Huddles
 - Thematic review of incidents where appropriate
 - Near misses can also be investigated
- Links and alignment between patient safety, quality improvement and other related clinical governance systems including complaints
- Promotion and development of a just and fair culture in the incident management process, and the organisation as a whole
- Governance/reporting structures are clear to staff, patients, and the public, and encourage openness and transparency

Key aims of PSIRF

Compassionate engagement and involvement of those affected by patient safety incidents

- In practice;**
- Recruitment of Patient Safety Partners (completed)
 - Involving patients and/or their families in the investigation process
 - Compassionate engagement training
 - Effective Duty of Candour process

Application of a range of system-based approaches to learning from patient safety incidents

- In practice;**
- Different tools and methodologies to review and understand why an incident or number of themed incidents occur
 - Using other data sets to inform improvement cycles (eg complaints, FTSU, claims etc)

Considered and proportionate responses to patient safety incidents

- In practice;**
- Just Culture & support for staff involved in incidents
 - Respond to incidents in a way that maximises learning and improvement
 - Explore patient safety incidents relevant to context and populations

Supportive oversight focused on strengthening response system functioning and improvement

- In practice;**
- Design oversight systems that allows organisations to demonstrate improvement
 - Focus on engagement and empowerment
 - Increased oversight of safety at Boards

What does this mean for the Board?

- Ensure the organisation meets national patient safety incident response standards, supported by the Executive lead for Patient Safety and the Patient Safety Specialist
- Access to relevant information about their organisation's preparation for and response to patient safety incidents, **including the impact of changes following incidents**
- The Board will be briefed as required by the Patient Safety Specialist(s) to be involved in discussions relating to patient safety.
- The Patient Safety Specialist(s) support the Board & SLT to understand the most effective approaches to improving patient safety
- Responsibility for signing off all Patient Safety Incident Investigation (PSII)
- Contract for 24/25 stipulated PSIRF must be 'live' by 1st April 2024

Where we are now & going forward

Actions to date

- Lunch & Learn workshops and focused team sessions
- New Clinical Incident & Safety Group
- New clinical incident process
- Senior clinical and operational staff formally trained in January 2024

Actions to take forward

- Follow up actions from formal training incorporated into implementation plan
- Just Culture development
- Agreement on further training
- Robust processes for sharing learning to be developed
- Review and revise safety priorities, and agreement of our investigation techniques
- Formal closure of open Serious Incidents under governance of current framework
- Confirming timeline for new quality system (Radar)

Appendix – Questions for Assurance

Questions for assurance

Engagement and involvement of those affected by patient safety incidents

- How do we ensure those affected by patient safety incidents are engaged and involved in any learning response?
- Does engagement include prompt and effective communication between those affected by a patient safety incident and our organisation?
- Does engagement and involvement occur respectfully and according to individual needs?
- How do we know how well our processes are working? What are the current barriers?
 - Are patients or staff with protected characteristics represented more often than others in any of our incidents and responses? What are the organisational or cultural reasons behind this?

Policy, planning and governance

- Does our patient safety incident response plan match the risks that feel tangible to us as an organisation?
- Does emerging intelligence match our assumptions about the biggest risks in our plan?
- Can we demonstrate wide collaboration and stakeholder involvement in the development and maintenance of our plan?
- Does our plan demonstrate a thorough analysis of data and provide a clear rationale for the selection of patient safety incidents for further learning?
- Is our ICB assisting cross-organisation working and information sharing?
- How do we choose our response to a patient safety incident?
- How do we support those who bring 'bad news' or surprises about organisational safety?

Competence and capacity

- Are we employing and continuously developing expertise in patient safety science for key roles?
- Are our learning responses adequately resourced (including funding, time, equipment, and training)?
- Are training and competence requirements met for learning response leads?
- Do we have the competence within our teams to feel we can confidently have conversations with patients and families about patient safety incidents?
- Does our ICB have its own continuous development plans in patient safety science training and competence to enable it to participate effectively?
 - Are our teams confident in having conversations with patients and families affected by an incident but where an individual

Questions for assurance

Proportionate responses

- How are we triangulating insight from our responses to patient safety incidents?
- Are we using recognised system-based methodologies for data collection and analysis?
- Is external guidance/information used to inform patient safety responses and findings?
- Do we have collaborative arrangements with our ICB to facilitate cross-system learning responses? This includes processes for recognising when support may be required and raising this with ICB colleagues.
- Are learning responses completed in a timely manner in line with expectations of those affected?

Safety actions and improvement

- How easy is it to make an improvement in our organisation?
 - Is time, priority and expertise given to those who need it?
- Do we have and use processes to share emergent intelligence and receive support from external partners (eg ICSs, regional and national NHS teams, royal colleges, professional associations, patient groups, charities etc)
- How do we assess the sustainability of our safety actions and improvements?