

REPORT TO: TRUST BOARD **PUBLIC SESSION – 25 January 2024**

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SUBJECT: **APPROVAL AND LAUNCH OF THE PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)**

If this report cannot be discussed at a public Board meeting, please explain why.	
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This report is provided for:

Decision ☒ Endorsement ☒ Assurance ☐ Information ☐

The purpose of this report is to

To provide the Board with the necessary information to be able to **ENDORSE** the mandatory change in how patient safety incidents will be dealt with in the future. The Patient Safety Incident Response Framework (PSIRF) is replacing the previous Serious Incident Framework (SIF) in NHS organisations.

Recommendations and decisions required

The Board is asked to **ENDORSE** the implementation of the PSIRF.

Executive summary

NHS organisations in England are changing the way they investigate patient safety incidents. NHS England has introduced this new approach, which is called the Patient Safety Incident Response Framework (PSIRF). PSIRF replaces the previous approach to dealing with patient safety incidents, the Serious Incident Framework (SIF).

There are four key aims:

- 1. Compassionate engagement and involvement of those affected by patient safety incidents.*
- 2. Application of a range of system-based approaches to learning from patient safety incidents.*
- 3. Considered and proportionate responses to patient safety incidents.*
- 4. Supportive oversight focused on strengthening response system functioning and improvement.*

PSIRF introduces and promotes a wider range of investigation approaches than were used under the SIF. Different tools, approaches and formats may be used in different circumstances, and this will be determined by our PSIRP.

The Board is asked to endorse the Patient Safety Incident Response Policy, the Patient Safety Incident Response Plan and the PSIRF oversight and responsibilities framework.

The PSIRF forms part of the standard conditions of the NHS Standard Contract. NHS England sought to support trusts to launch PSIRF in late Autumn of 2023. GHC has elected to launch with system partners in February 2024.

Risks associated with meeting the Trust's values

The PSIRF is an important element in developing and sustaining a just and learning safety culture and engaging staff in safety learning and improvement.

Corporate considerations

Quality Implications	The PSIRF is an essential process in supporting the cultural change that can make care safer.
Resource Implications	The PSIRF may have implications upon Patient Safety Team resourcing
Equality Implications	There are none

Where has this issue been discussed before?

Board Seminar
Senior Leadership Network and Executive Team,
Clinical Policy Group and operational governance processes.

Appendices:

Appendix 1 - Patient safety incident response plan
Appendix 2 - Patient safety incident response policy
Appendix 3 - PSIRF - oversight roles and responsibilities specification

Report authorised by:
Dr Amjad Uppal

Title:
Medical Director

APPROVAL AND LAUNCH OF THE PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)

1.0 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)

Key points

- The Patient Safety Incident Response Framework (PSIRF) – a core element of the NHS Patient Safety Strategy – establishes the NHS's approach to the development and maintenance of mechanisms for responding to patient safety incidents (PSIs) to maximise learning and improvement.
- The PSIRF is a contractual requirement and is mandatory for providers of NHS-funded care. All Trusts will be expected to begin implementing this framework from September 2022.
- The new framework replaces the Serious Incident Framework (SIF). The PSIRF is less prescriptive than its predecessor, encourages learning from PSIs, and no longer differentiates between PSIs and serious incidents.
- Additionally, unlike the SIF, the PSIRF requires a degree of training to ensure that those conducting investigations – as well as those providing oversight of the process – have an adequate level of knowledge and experience to ensure that investigations lead to learning and improvement.

2.0 BACKGROUND

The PSIRF establishes the NHS's approach to the development and maintenance of effective systems and processes for responding to patient safety incidents (PSIs) in a way which facilitates learning and improvements to patient safety. It replaces the existing SIF, with the aim of focusing on learning within and across organisations. The PSIRF aims to introduce a more proportionate approach to investigating PSIs by balancing the resources allocated to learning with those needed to deliver improvement.

It changes how the NHS will respond to PSIs for learning and improvement, including by:

- advocating for a co-ordinated and data-driven response to incidents, prioritising compassionate engagement with those affected;
- embedding patient safety incident response within a wider system of improvement and prompting a cultural shift towards systematic patient safety management.

To comply with the PSIRF, the Trust must develop an understanding of our patient safety incident profile, ongoing safety actions in response to investigation recommendations, as well as established programmes of improvement.

3.0 ABOUT THE PSIRF

The PSIRF's core document brings together the following four main aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents

2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

4.0 WHAT ARE TRUSTS REQUIRED TO DO?

The PSIRF is a contractual requirement under the NHS Standard Contract and is mandatory for the provision of services under this contract, including all acute, mental health, community and ambulance trusts, as well as maternity and specialised services across the NHS. The Trust is required to apply and embed the PSIRF into the development and maintenance of our PSI response policy and plan, via the following:

5.0 PATIENT SAFETY INCIDENT RESPONSE POLICY

This describes our overall approach to responding to and learning from PSIs, as well as identifying the systems and processes in place to integrate the four key aims of PSIRF. It outlines how those affected by an incident will be engaged, what governance processes for oversight are in place and how learning responses are translated into improvement and integrated into wider improvement work across the organisation.

6.0 PATIENT SAFETY INCIDENT RESPONSE PLAN

This specifies how GHC will maximise learning and improvement. It is based on a thorough understanding of our patient safety incident profile, ongoing improvement priorities and available resources.

Plans will need to be updated to incorporate any new learning, the changing risk profile of an organisation, as well as any ongoing improvement initiatives. This will ensure that incident response becomes a key element of our approach to wider safety management.

7.0 PSIRF AND INEQUALITIES

The PSIRF has been developed to provide a mechanism to help address inequalities in patient safety through the following:

- Its flexible approach makes it easier to address concerns specific to health inequalities, and it provides the opportunity to learn from PSIs that did not meet the definition of a 'serious incident';
- It prompts consideration of inequalities in the development and maintenance of patient safety incident response policies and plans, and in the learning response process it describes;
- It gives guidance on engaging those with diverse needs; and
- The framework endorses a system-based approach (instead of a 'person focused' approach). This will support the development of a just culture and aims to reduce gaps in rates of disciplinary action between ethnic groups across the NHS workforce.

8.0 ACCOMPANYING GUIDANCE

Alongside the core PSIRF document, the following pieces of accompanying guidance provide information for trusts to support implementation:

- Oversight roles and responsibilities specification
- Patient safety incident response plan
- Patient safety incident response policy
- PSIRF - oversight roles and responsibilities specification

9.0 OVERSIGHT ROLES AND RESPONSIBILITIES SPECIFICATION

The leadership and management functions of PSIRF oversight are now much broader and multifaceted when compared to its predecessors. When implementing and using the PSIRF, GHC will design oversight systems in a way which evidences improvement rather than compliance. We will not only explore what needs to be improved, but also what we should stop doing.

10.0 OVERSIGHT APPROACH

When designing and maintaining the PSIRF oversight systems and processes, NHSE has outlined principles which GHC has considered. These are:

1. Use a variety of data
2. Reduce the information collection burden
3. Oversight is not 'one size fits all'
4. Capture meaningful insight from patients, families, and staff
5. Metrics require clarity and purpose
6. Beware of perverse incentives

11.0 ORGANISATIONAL RESPONSIBILITIES

NHS England has outlined several organisational responsibilities for an effective governance structure. Trust Boards should be mindful of the following:

- Appointment of a PSIRF executive lead: This may be the individual with an overarching responsibility for quality or patient safety, and they must be a member of the Board or equivalent leadership team.
- PSIRF executive lead responsibilities: The PSIRF executive lead should ensure the organisation meets national patient safety incident response standards, overseeing the development, review and approval of the organisation's policy and plan for patient safety incident response. They should ensure PSIRF is central to overarching safety governance arrangements, and that patient 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).
- Finally, they should quality assure learning response outputs.

A key element of improving the process of learning from PSIs involves external peer review of a sample of learning response reports which have been previously signed off by a Trust Board. GHC has already embarked on entering

a period of peer review and a committing to a national quality process led by the Royal College of Psychiatrists.

12.0 RESPONDING PROPORTIONATELY TO PATIENT SAFETY INCIDENTS

The PSIRF does not mandate investigation as the sole method to produce meaningful learning from PSIs, nor does it prescriptively outline what can and cannot be investigated. Instead, it is a framework which supports the development and maintenance of a patient safety incident response system. The guidance describes what is meant by a system-based approach to learning and taking a proportionate approach to a patient safety incident response, as well as how to achieve these aims through robust patient safety incident response planning.

13.0 WHAT IS A 'SYSTEM-BASED APPROACH' TO LEARNING?

Unlike the Serious Incident Framework (SIF), which had a defined threshold for serious incidents, the PSIRF instead focuses on a system-based approach, which involves an examination of the components of a system - including a person(s), tasks, tools and technology, the environment and the wider organisation – to gain a deeper understanding of how their interdependencies might impact patient safety.

This suggests that patient safety emerges from complex interactions and is not a result of an individual cause, such as one person. As a result, the PSIRF no longer utilises root cause analysis (RCA) and differs from it in the following ways:

- They recognise that outcomes in complex systems result from the interaction of multiple factors – learning should not focus on uncovering a (root) cause, but instead should explore multiple contributory factors
- They do not distinguish between care and service delivery problems. Instead, they explore contributory factors, including 'individual acts' in the context of the whole system
- They use tools to explore multiple interacting contributory factors rather than forcing a single analytical pathway
- A framework based on the well-established SEIPS (Systems Engineering Initiative for Patient Safety) replaces the contributory factors classification framework, a guide for which can be found in the patient safety incident response toolkit

14.0 WHAT DOES 'CONSIDERED AND PROPORTIONATE RESPONSE' MEAN?

The PSIRF supports organisations to respond to PSIs using an approach which will maximise learning and improvement not based on subjective definitions of harm. While some events and issues will arise which will require a special type of response as dictated by policies or regulations (such as the Never Events or learning from deaths criteria), the PSIRF helps organisations conduct investigations relevant to their context and the populations they serve.

There are no new national rules of thresholds to determine what type of response is necessary and organisations can now balance effort between

learning through responding to incidents or exploring issues and improvement work.

15.0 PATIENT SAFETY INCIDENT RESPONSE PLANNING

Under the PSIRF, our patient safety incident response plan will outline how we will respond to PSIs over a period of 12 to 18 months. The four stages of planning response methods are:

1. Examine patient safety incident records and safety data
2. Describe safety issues demonstrated by the data
3. Identify improvement work underway
4. Agree response methods

The plan for patient safety incident response will be approved by local Integrated Care Board after approval by GHC Board.

GHC will review the plans frequently in the early stages of implementation, and NHSE suggest the plan remains a “living document” - which can be amended and improved according to the needs of the organisation.

16.0 PATIENT SAFETY INCIDENT RESPONSE STANDARDS

To ensure that providers meet the minimum expectations of the PSIRF, NHSE has outlined standards for Trusts to uphold on: policy, planning and oversight; competence and capacity; engagement and involvement of those affected by patient safety incidents; and proportionate responses.

17.0 POLICY, PLANNING AND OVERSIGHT

GHC has developed a Patient Safety Incident Response Policy which describes the systems and processes they have established to facilitate learning and improvement following a PSI. This will create the foundations for effective incident response from the outset.

18.0 COMPETENCE AND CAPACITY

Learning response leads, those leading engagement and involvement, as well as those in PSIRF oversight roles, are required to have specific knowledge and experience. Organisations may differ in how they approach engagement and involvement, and this activity may be led by the person leading a learning response, or by a family/staff liaison officer, or someone similar. The Patient Safety Incident Response standards distinguish between the training requirements and competencies for these two roles but recognise they might be fulfilled by the same individual.

The PSIRF calls for significant resourcing and staff time to ensure that the learning responses from PSIs are carried out to standard.

19.0 ENGAGEMENT AND INVOLVEMENT OF THOSE AFFECTED BY PATIENT SAFETY INCIDENTS

The engagement and involvement with those affected by PSIs, as outlined within the relevant guidance, will be led by individuals with a specified level of training. All organisations are required to ensure that the Duty of Candour is upheld.

20.0 PROPORTIONATE RESPONSES

The PSIRF outlines guide timelines for patient safety learning responses and asks for them to begin as soon as possible after the incident is identified. The response methodology outlined in the framework asks that responses are conducted for the sole purpose of learning and identifying improvements that reduce risk and/or prevent or significantly reduce recurrence and that they do not seek to determine liability and blame.

21.0 TRAINING REQUIREMENTS

A key element of the PSIRF is that those conducting investigations – as well as those providing oversight – will now be required to have specific knowledge and experience gained through training, including developing knowledge of systems thinking and system-based approaches to learning from PSIs.

See below the Incident Response Decision Making Flowchart (page 9)

Incident Response Decision Making Flowchart

