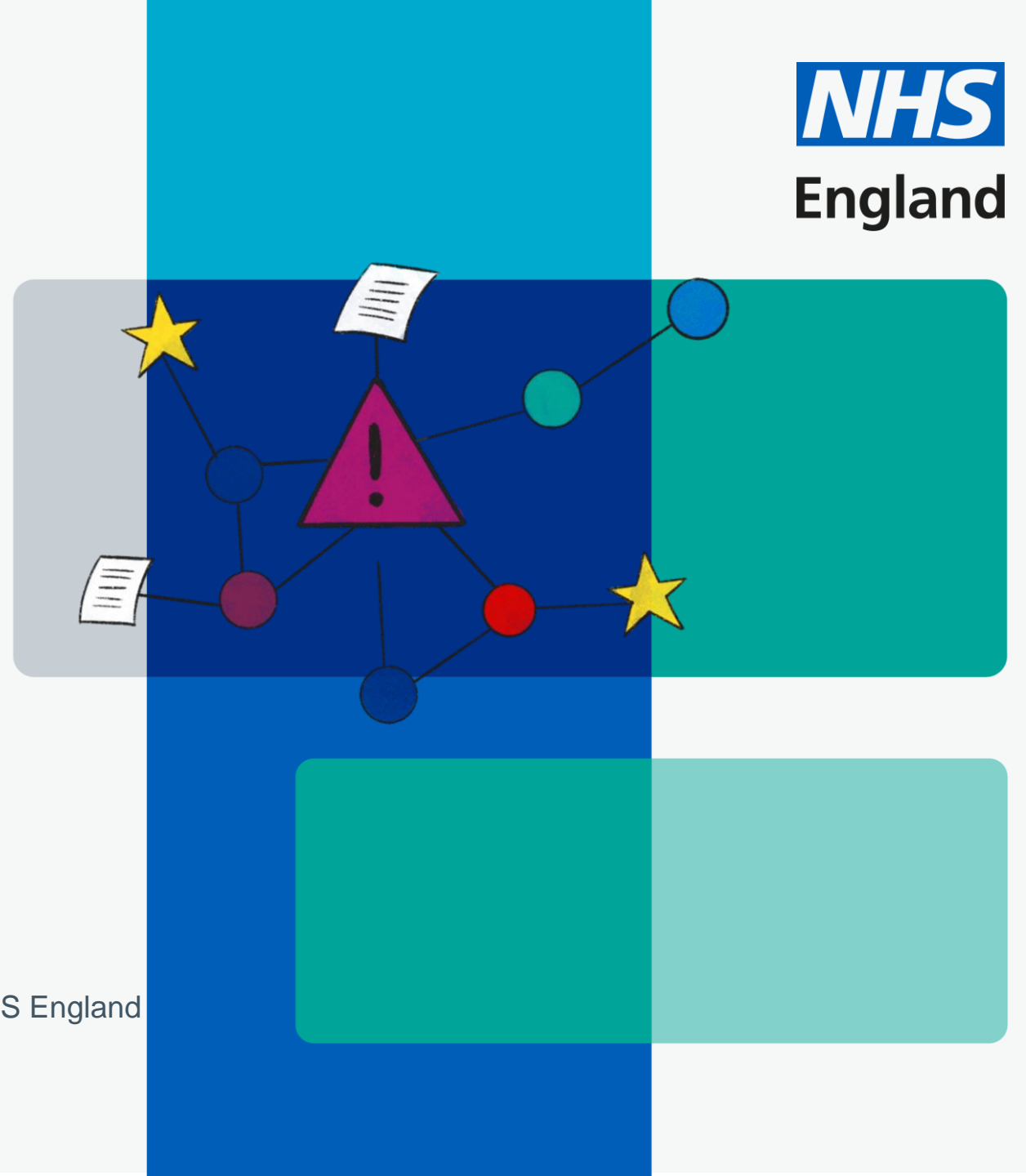


Freedom in a frame

What happens when organisations manage their safety work?

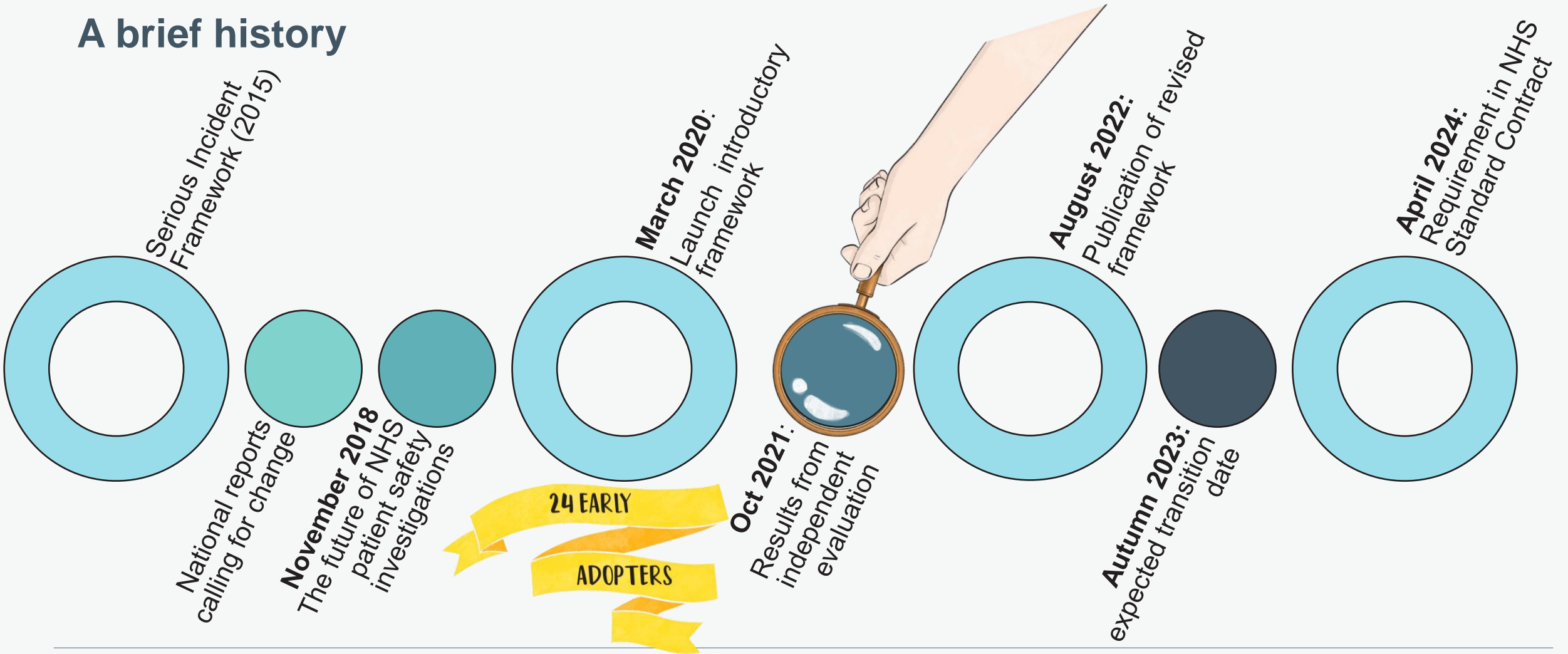
Tracey Herlihey, Head of Patient Safety Incident Response Policy, NHS England

Mark Smith, Patient Safety Partner, NHS England



The Patient safety incident response framework

A brief history



A new approach to learning from safety events

From prescription to principles



Compassionate:

Meaningful, compassionate engagement with those affected by safety events through answering questions, addressing concerns and involvement throughout a learning response **meets both a moral and logical imperative.**



Systems-based:

Focused on understanding how a safety event happened and not who to blame.

Exploring work conditions and processes **enables the creation of a psychologically safe space** for the honest collection of insight.



Proportionate:

Focused on areas where there's the greatest potential for learning and improvement.

Defining local priorities **increases engagement** and investment in organisational improvement. Work becomes more meaningful and source of pride.



Supported:

Focused on enabling improvement and collaboration, moving away from bureaucratic and transactional approach that drains time and deflect resources away from improvement activity.

Boards have **significant influence on values and behaviours across an organisation.**

Supportive relationship with commissioners can **foster greater shared learning.**

What's changed?

From SIF to PSIRF



Compassionate:

- New guidance
- Training and competency standards



Proportionate:

- Development of response plan and policy
- Removed mandated SI threshold
- Removed requirement for the application of specific methodology



Systems-based:

- Learning response toolkit replaces outdated investigation methodology
- Embedding safety within wider system of improvement
- Training and competency standards



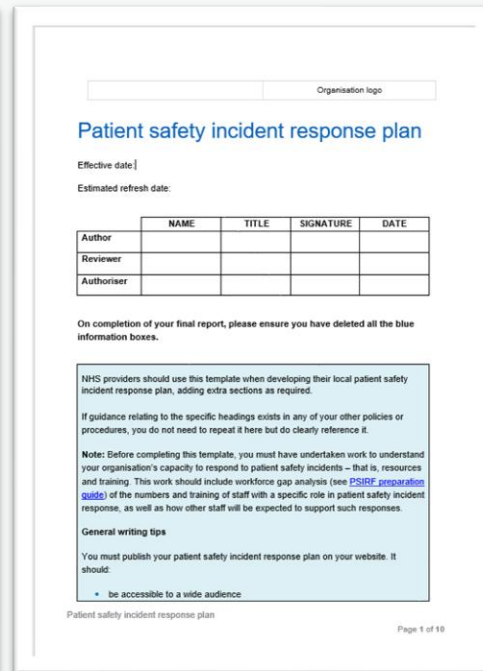
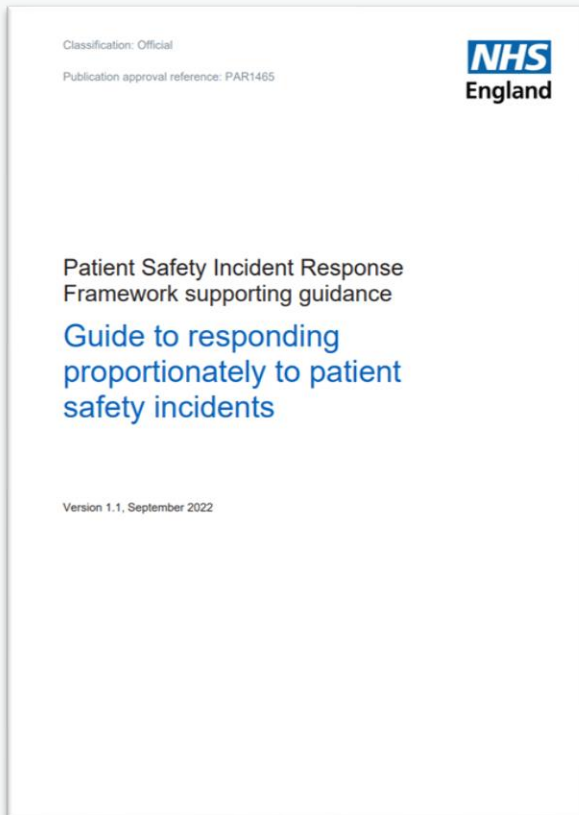
Supported:

- Change in roles and responsibilities of boards and commissioners
- Removal of 60-day timeframe for completion of learning response
- Peer review of learning responses
- Training and competency standards

Proportionate



Patient safety incident response planning



Response **planning** is based on:

- What an organisation already knows about the safety event / issue
- Whether relevant stakeholders are satisfied risks are being appropriately managed
- Improvement work that is ongoing to address known contributory factors in relation to an identified patient safety incident type, and efficacy of safety actions is being monitored

Planning does NOT mean that:

- patients, families and staff are not engaged in a way that helps to answer any questions they have
- organisations ignore incidents that do not have a planned response

[B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf](https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf) (england.nhs.uk)

<https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-8.-Patient-safety-incident-response-plan-template-v1-FINAL.docx>

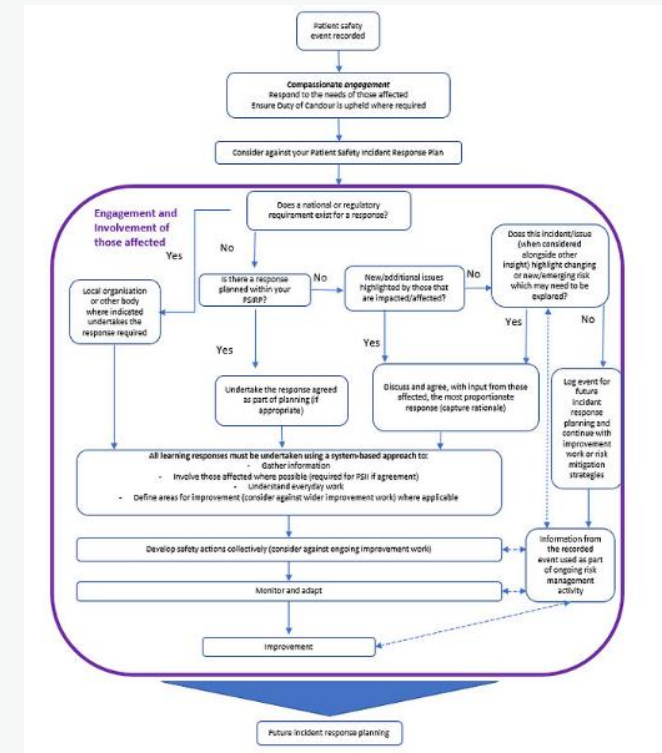
Proportionate



Patient safety incident response decision making

Response **decisions** are based on:

- Specific circumstances of the safety event
- Needs of those affected
- The patient safety incident response plan



[Patient safety incident response decision making flowchart - NHS Patient Safety - FutureNHS Collaboration Platform](#)

Proportionate



Top tips for planning

- Include a diverse group of stakeholders
- Avoid reverting to harm as an indicator for learning
- Don't privilege quantitative data over qualitative and 'softer' intelligence
- Strive for excellence, not perfection – planning will be an iterative process over time, likely years
- Consider policy and regulatory requirements first (e.g., safeguarding, never events)
- Opportunity to consider inequalities
- Should tell a story of how you arrived at your response priorities
- A document to help *inform* incident response decision making

Patient safety incident response plan

Effective date:

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
Author	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Reviewer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Authoriser	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

On completion of your final report, please ensure you have deleted all the blue information boxes.

NHS providers should use this template when developing their local patient safety incident response plan, adding extra sections as required.

If guidance relating to the specific headings exists in any of your other policies or procedures, you do not need to repeat it here but do clearly reference it.

Note: Before completing this template, you must have undertaken work to understand your organisation's capacity to respond to patient safety incidents – that is, resources and training. This work should include workforce gap analysis (see [PSIRF preparation guide](#)) of the numbers and training of staff with a specific role in patient safety incident response, as well as how other staff will be expected to support such responses.

General writing tips

You must publish your patient safety incident response plan on your website. It should:

- be accessible to a wide audience

Patient safety incident response plan Page 1 of 10

Patient safety incident response plan review

What questions did we ask?

Who are organisations involving in plan development?

What data are organisations reviewing?

How are inequalities considered?

What priorities are selected?

How are organisations

Is the learning response clear?

Engagement with public and Local Healthwatch?

Consideration of harm/good catches in learning response decision making

Reflections on priorities

Note: Only PSIRF Plans reviewed. PSIRF Policies were not considered

These may include

- Engagement with public
- Engagement with Local Healthwatch
- Interfaces with other organisations

NHS
Central and North West London
NHS Foundation Trust

Central and North West London NHS Foundation Trust Patient Safety Incident Response Plan 2023-2026

NHS
East Cheshire
NHS Trust

NHS
East Midlands Ambulance Service
NHS Trust

King's College Hospital
NHS Foundation Trust

King's College Hospital NHS Foundation Trust patient safety incident response plan - 2023

Effective date: 1st November 2023
Estimated refresh date: 31st December 2024

Author	NAME	TITLE	DATE
Author	Andy Wilmer	Associate Director of Patient Safety	9 th October 2023
Reviewer	Robin Mulvaney	Director of Quality Governance	30 th October 2023
Reviewer	Suzanne Ayodele	Deputy Chief Medical Officer	30 th October 2023
Authoriser	Leonia Fenna	Chief Medical Officer - Executive Lead for Patient Safety	

Contents

1. Introduction
2. Our services
 - 2.1. Organisational structure

Patient Safety Incident Response Plan (PSIRP)

NHS
Great Ormond Street Hospital
NHS Foundation Trust

Welcome to Great Ormond Street Hospital

NHS
South East London
NHS Foundation Trust

NHS
King's College Hospital
NHS Foundation Trust

King's College Hospital NHS Foundation Trust patient safety incident response plan - 2023

Effective date: 1st November 2023
Estimated refresh date: 31st December 2024

Author	NAME	TITLE	DATE
Author	Andy Wilmer	Associate Director of Patient Safety	9 th October 2023
Reviewer	Robin Mulvaney	Director of Quality Governance	30 th October 2023
Reviewer	Suzanne Ayodele	Deputy Chief Medical Officer	30 th October 2023
Authoriser	Leonia Fenna	Chief Medical Officer - Executive Lead for Patient Safety	

Contents

1. Introduction
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SAFETY DIFFERENTLY
Our opportunities are endless

Our patient safety plan 2023/24:
Our care is safe: we continuously, systematically and consistently prioritise patient safety in everything we do.

NHS
Southern Health
NHS Foundation Trust

Patient Safety Incident Response Plan; 2023/24

Proposed transition date: 16 October 2023
Estimated review date: 31 December 2023

Author	NAME	TITLE	DATE
Author	Georgia Walker Liz Hall		
Reviewer	Suzanne van Hook		
Executive Lead	Paula Hull		
Authorisers	Quality and Trust Board Integrated Care Board		

NHS
North West Ambulance Service
NHS Trust

PATIENT SAFETY INCIDENT RESPONSE PLAN (PSIRP)

NHS
Hampshire Hospitals
NHS Foundation Trust

PATIENT SAFETY INCIDENT RESPONSE PLAN 2023

NHS
Humber Teaching
NHS Foundation Trust

Patient Safety Incident Response Plan 2023-2025

Effective date: 4th December 2023
Refresh date: Initial 12 month review by 31st January 2025

Author	NAME	TITLE	DATE
Author	Jane Kershaw	Head of Patient Safety, OHFT	29/11/23
Reviewer	Marie Crofts Karl Marlowe	Chief Nurse Officer, OHFT Chief Medical Officer, OHFT	29/11/23
Authoriser	Rachael Corser (on behalf of the BOB/ICS System Quality Group)	Chief Nurse Officer, BOB Integrated Care Board	29/11/23

Working together to deliver the best for our communities, our people & the environment

MISSION | **VALUES** | **VISION** | Outstanding care by an outstanding team

Patient safety incident response plan (OHFT) Page 1 of 10

NHS
University Hospitals Sussex
NHS Foundation Trust

Patient Safety Incident Response Plan (PSIRP)

Effective date: September 2023
Estimated refresh date: September 2025

NHS
Essex Partnership University
NHS Foundation Trust

PATIENT SAFETY INCIDENT RESPONSE PLAN

2023
2025

Estimated refresh date: 28 February 2025

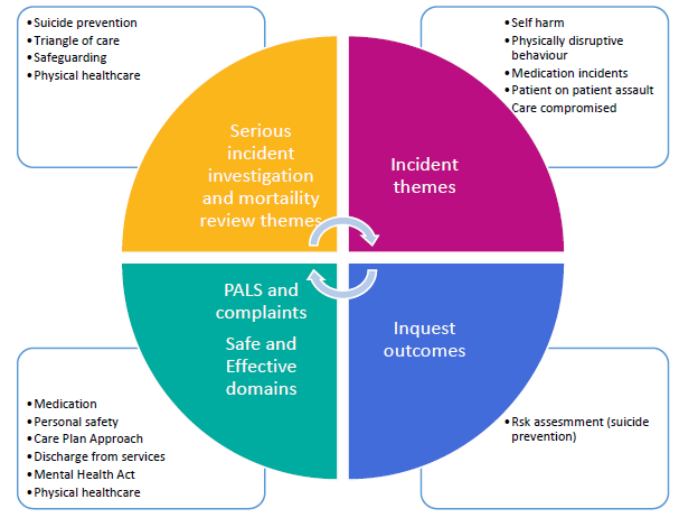
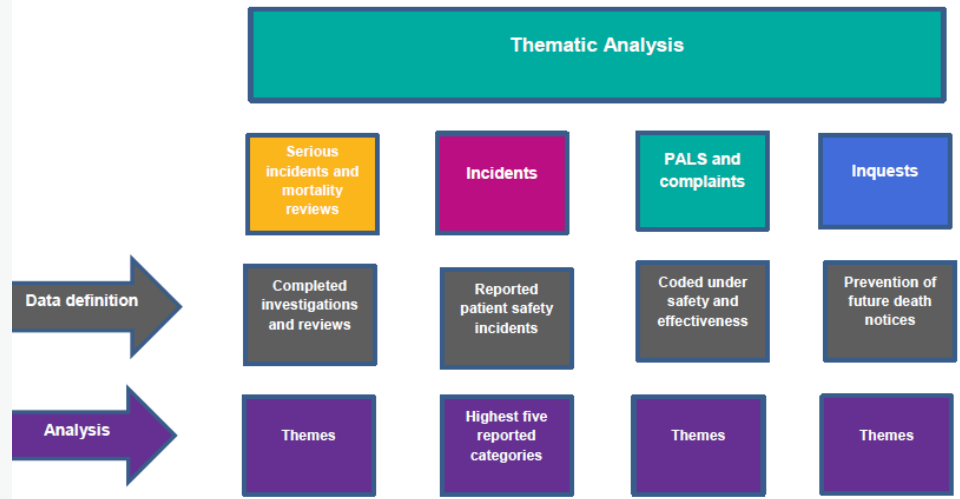
Who are organisations involving in plan development?

Stakeholder engagement

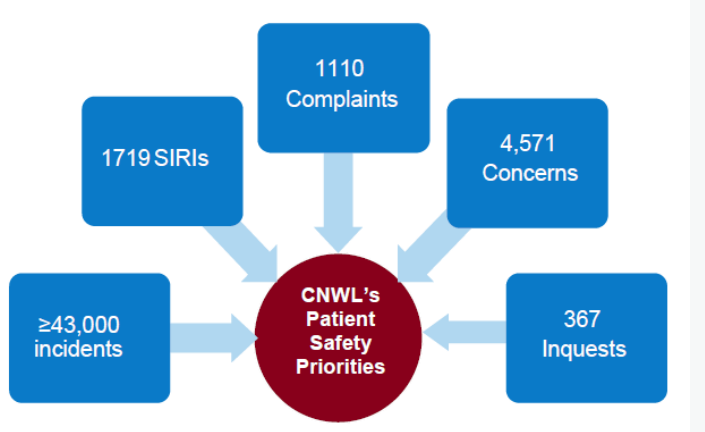
- Commissioners
- Expert safety forums (deteriorating patients, falls, pressure ulcers, medicines safety committee)
- Staff consulted via a mobile 'PSIRF trolley dash' to seek feedback
- Social media campaign
- Bespoke workshops
- Stalls in main thoroughfares and entrance to hospital
- External partners
- Mental health charity
- Carers and families of patients and service users
- Patient safety partners



What data are organisations reviewing?



Trafford General Hospital



Central and North West London NHS Foundation Trust

Avon and Wiltshire Mental Health Partnership NHS Trust

How are inequalities considered?

PSIRF and inequalities

Some patients are less safe than others in a healthcare setting. The PSIRF provides a mechanism to directly address these unfair and avoidable differences in risk of harm from healthcare:

- The PSIRF's more flexible approach makes it easier to address concerns specific to health inequalities: it provides the opportunity to learn from patient safety incidents that did not meet the definition of a 'Serious Incident'.
- PSIRF prompts consideration of inequalities in the development and maintenance of patient safety incident response policies and plans.
- Tools in [the patient safety incident response toolkit](#) prompt consideration of inequalities during the learning response process including when developing safety actions.
- [Engaging and involving patients, families and staff following a patient safety incident](#) gives guidance on engaging those with different needs.
- The framework endorses a system-based approach (instead of a 'person focused' approach) and is explicit about the training and skill development required to support an approach. This will support the development of a just culture and reduce the ethnicity gap in rates of disciplinary action across the NHS workforce.

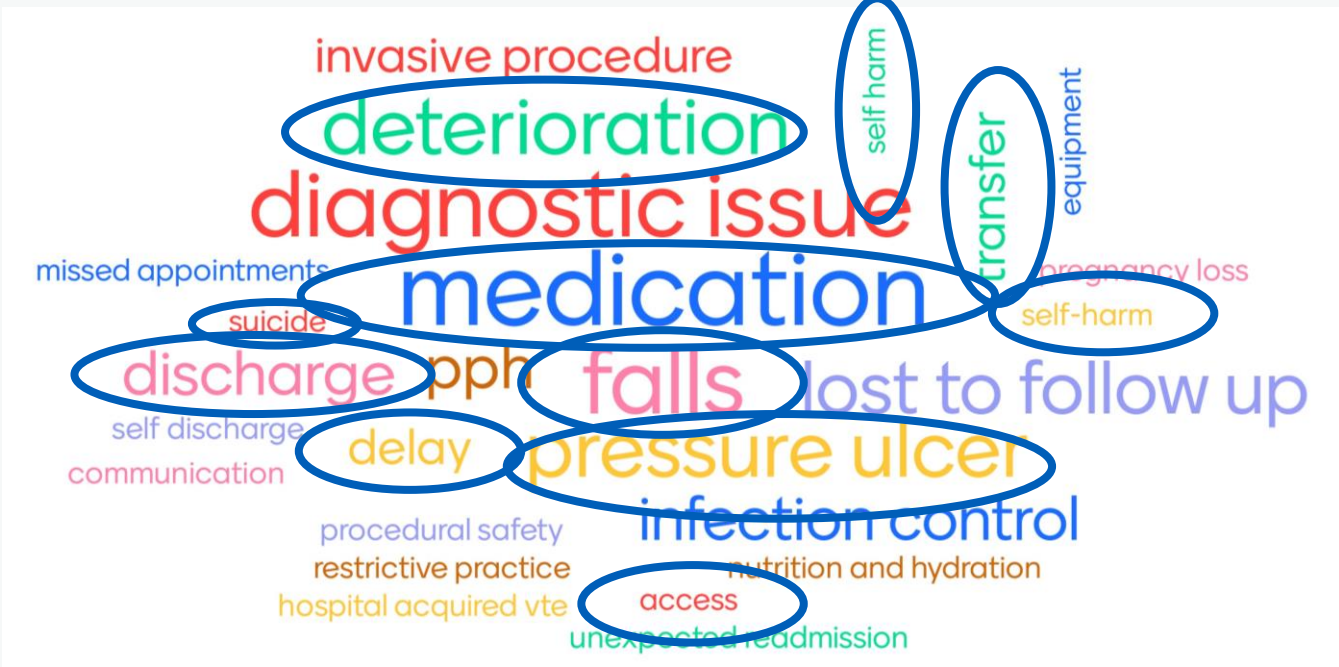
'Through our implementation of [PSIRF], we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to support tackling these. We are already actively considering language barriers and social deprivation in our incident reviews ~ Acute provider

Where it has been possible, we have considered elements of the data regarding health inequalities ~Ambulance provider

Using the original patient safety incident data, we made a first attempt to understand whether patients experienced incidents and harm disproportionately in relation to protected characteristics... There were some gaps in data for protected characteristics... initial indications would need future in-depth data validation and analysis. ~Acute provider

What priorities are selected?





Acute providers



Mental health providers

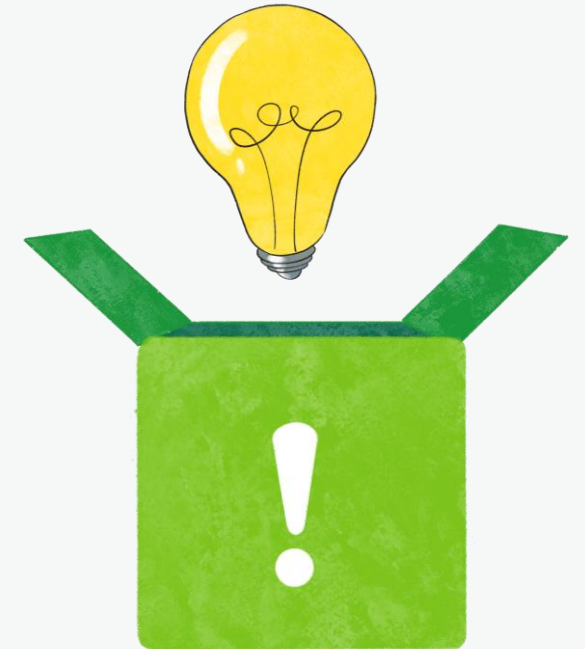
How are organisations responding to safety events?

Providing the richest insight

Flexible method application aligned with national toolbox

Criteria used to decide how to respond:

- The views of those affected, including patients and their families
- Alignment with patient safety priorities
- Expected potential for new insight
- Capacity available to undertake a learning response
- What is known about the factors that led to the incident
- Whether improvement work is having the intended effect
- If trust/ICB satisfied risks are being appropriately managed





Is the Learning Response Clear?

Looked at PSIRF Plan as a patient, or family member that has been involved in an event / incident.

Can I understand what would be the learning response in this case?

In only a fifth of PSIRF plans this was not clear.

Could the PSIRF Plan response be clearer to patients and families?



Engagement with public and Local Healthwatch

Just over a half of plans mentioned public involvement

Only about ten percent engaged with their local Healthwatch



Is the plan based upon level of harm?

The need for or mention of moderate harm or above has been excluded from this analysis in relation to duty of candour.

Only about a third of the plans did not base the learning response on the level of harm.

Less than a tenth of the plans mentioned good catches / near misses.

Good catches can result in learning that can be used to help prevent events / incidents



Has Infection Prevention and Control been mentioned?

On 16 August 2023, NHS England issued Guidance Publication Reference PRN00689, on the alignment of Infection Prevention and Control with the Patient Safety Incident Response Framework.

Over a half of PSIRF plans do not mention Infection Prevention and Control.



Other Safety Specialist Areas

Less than a tenth of PSIRF Plans mentioned equipment, medical devices, digital systems.

About a quarter of PSIRF plans did not mention medication events / incidents.

The majority that referred to medication events/ incidents did not refer to specific area of medicine safety.

Will this result in an effective improvement programme?

Retrospective

From a framework to a movement

- “Not implementing a framework, leading a culture change”
- Plan enables more informed decision making moving away from reactive/bureaucratic approach
- Rich source of data about safety concerns across trusts in England
- Overlap in safety concerns = prompts for collaboration/shared learning



Just the beginning of the safety journey

Opportunities to:

- Improve clarity for patients
- Be more proactive
- Focus more on inequalities
- Focus on ‘improvement’ priorities rather than ‘response’ priorities

Find out more

NHS England

About us | Our work | Commissioning | Get involved | Coronavirus

Home > Patient safety > Patient Safety Incident Response Framework

Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to maintaining effective systems and processes for responding to patient safety incidents, learning and improving patient safety.

- [The Patient Safety Incident Response Framework document and supporting guidance](#)

Aidan Fowler, National Director of Patient Safety framework represents a significant shift in the NHS's increasing focus on understanding how patient safety incidents contribute to them.

Contents

- [A new approach to responding to patient safety incidents](#)
- [Who does PSIRF apply to?](#)
- [Videos – Early adopters share their experience](#)
- [Preparing for PSIRF](#)
- [Supporting documents](#)
- [Engaging and involving patients, families and staff](#)
- [Learning response toolkit](#)
- [Join our PSIRF FutureNHS workspace](#)
- [Developing PSIRF](#)
- [List of early adopters](#)
- [Get in touch](#)

Rt Hon Jeremy Hunt, MP – “The new Patient Safety Incident Response Framework is very welcome. It is great to see the involvement of those affected by patient safety incidents at its heart and the emphasis on learning and improvement are vital if we are to reduce avoidable harm across the NHS.”

FutureNHS | My Dashboard | My Workspaces

Patient Safety Incident Response Framework (PSIRF)

To support the NHS to further improve patient safety, we are preparing for the introduction of a new Patient Safety Incident Response Framework (PSIRF), outlining how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted.

PSIRF Discussion Forum

PSIRF Training
Information and Other Resources

PSIRF Presentations
Find all PSIRF presentation slides here

PSIRF Podcasts

Additional Resources and Tools
Click here for more PSIRF content. Includes PSIRF Prep Guide, Communications Toolkit, Letter from Aidan Fowler, Video Playlist and Learning Response Tools

PSIRF Document Overview

The NHS patient safety workspace is open to all to access.

You do not need an NHS email address.

If you are not already a FutureNHS user, you can request access by emailing NHSps-manager@future.nhs.uk

Additional Resources and Tools

Learning Response Tools
Looking for more learning response resources, click here!

Resources to inform transition

Example staff/patient PSIRF leaflets

PSIRF myth busting
Separating fact from fiction

Incident response decision making flowchart

Stakeholders (Coroners, MHRA, OJC)

Job descriptions

Example Patient Safety Incident Response Plans
Examples using current templates and from our early adopter programme

Preparing for PSIRF
Useful tools, guides and contacts

Recording responses to patient safety incidents during transition to LIPSE and PSIRF

Select the appropriate button.

PSIRF Communications Toolkit

Comms for staff - what is PSIRF?
Kindly shared by Fay Walker, Risk & Assurance Coordinator, Solihull HMG Foundation Trust

Video Playlist
Includes Animation and Early Adopter Videos

Sector specific pages

PSIRF Health & Justice

Maternity

Independent providers

Infection Prevention and Control

Thank You

 @ptsafetyNHS



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