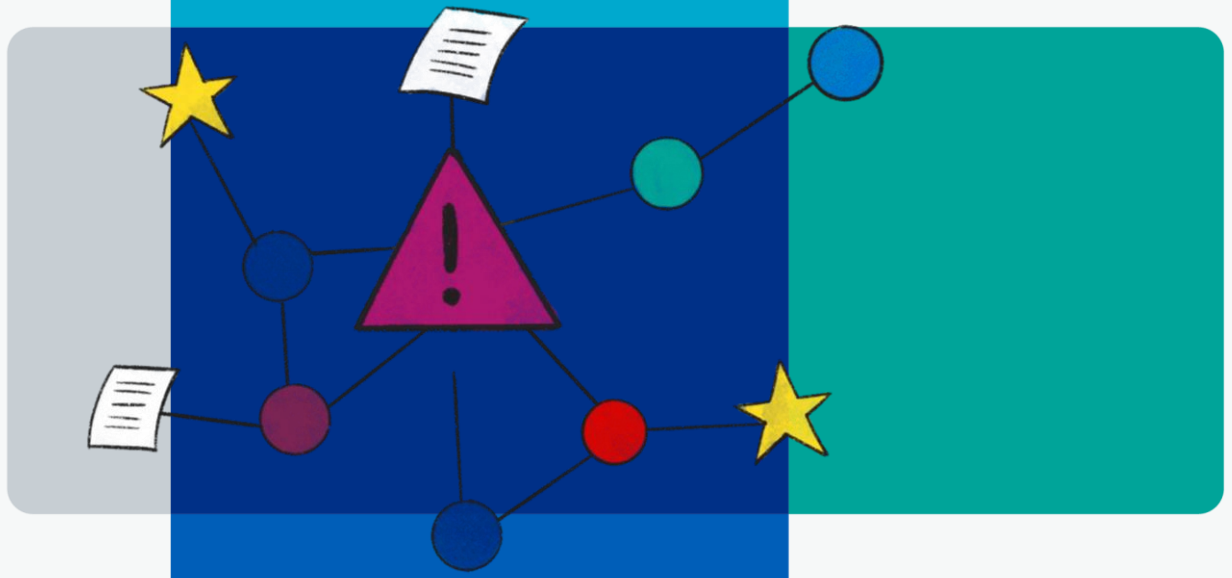
Freedom in a frame

What happens when organisations manage their safety work?

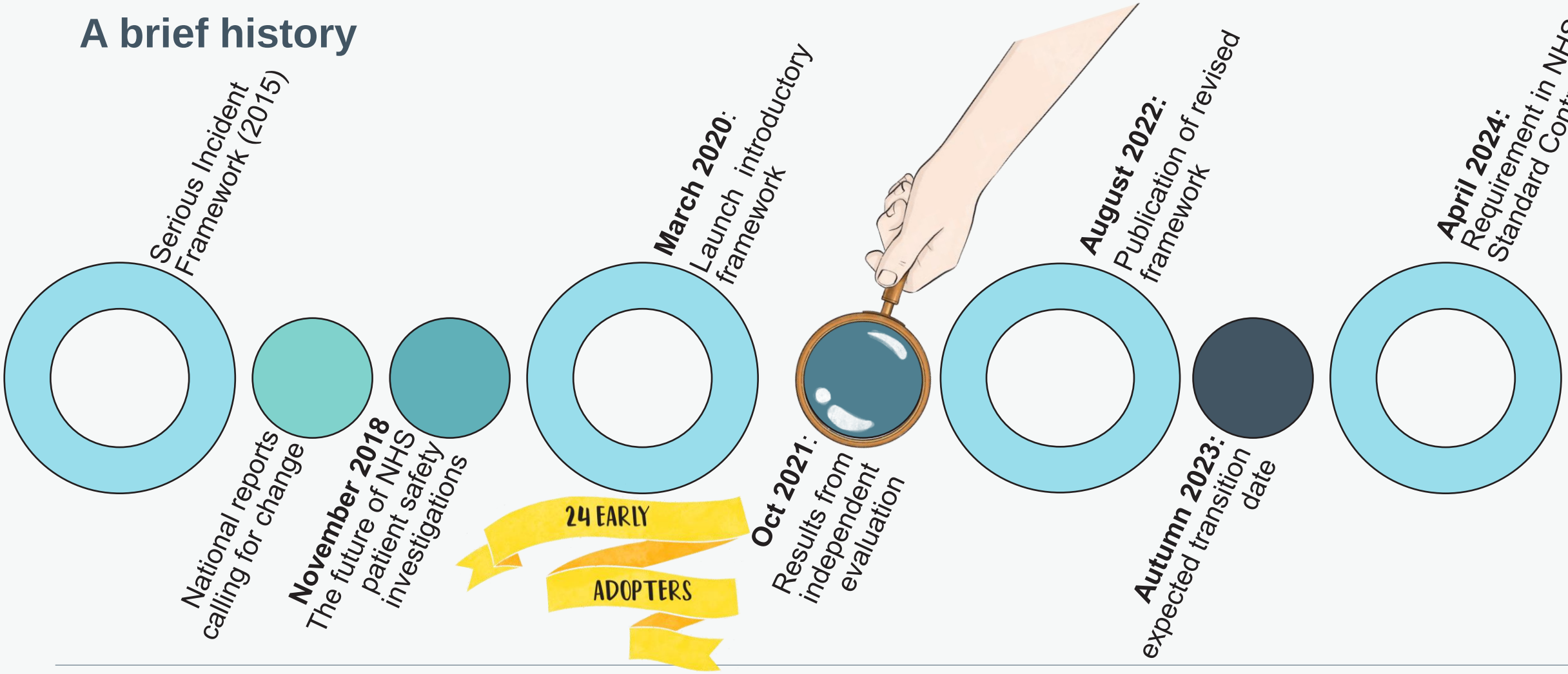


Tracey Herlihey, Head of Patient Safety Incident Response Policy, NHS England

Mark Smith, Patient Safety Partner, NHS England

The Patient safety incident response framework

A brief history



[NHS England » Patient Safety Incident Response Framework]

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:

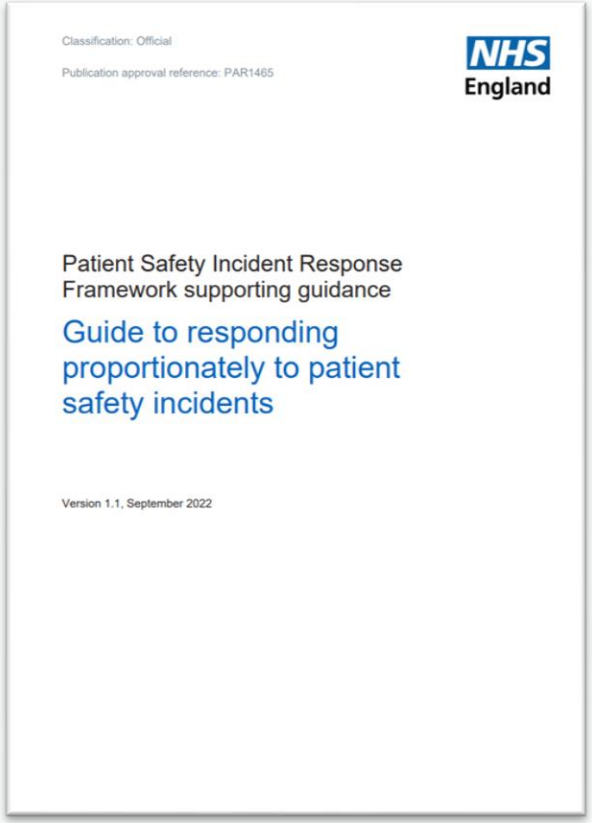
- Learning response toolkit replaces outdated investigation methodology
- Embedding safety within wider system of improvement
- Training and competency standards

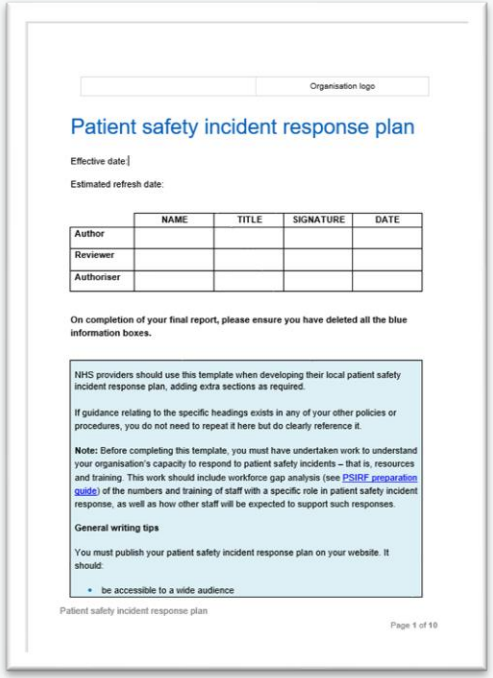
Supported:

- 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 (england.nhs.uk)

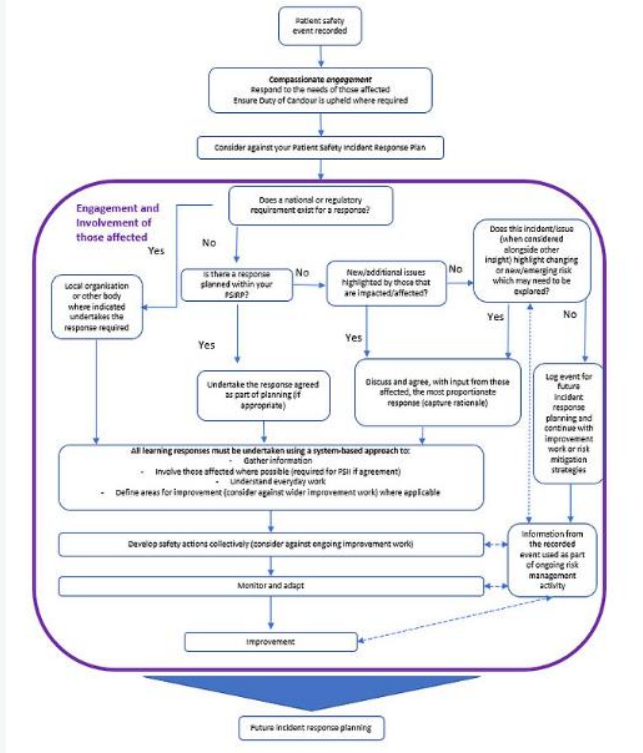
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-8.-Patient-safety-incident-response-plan-template-v1-FINAL.docx

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

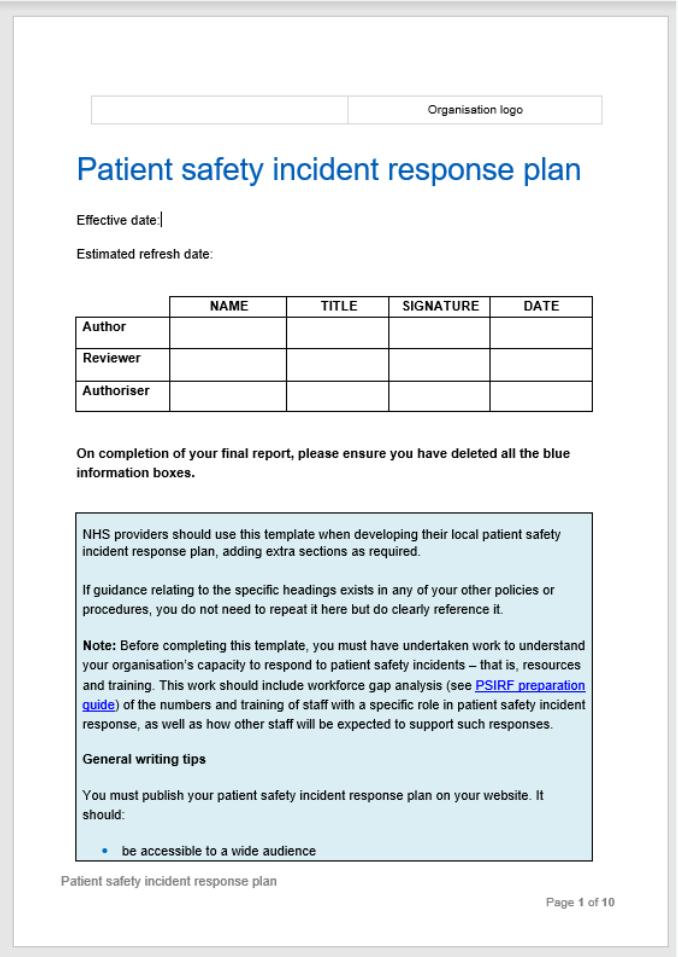


[Patient safety incident response decision making flowchart - NHS Patient Safety - FutureNHS Collaboration Platform]

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



Organisation logo

Patient safety incident response plan

Effective date:

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
Author				
Reviewer				
Authoriser				

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?

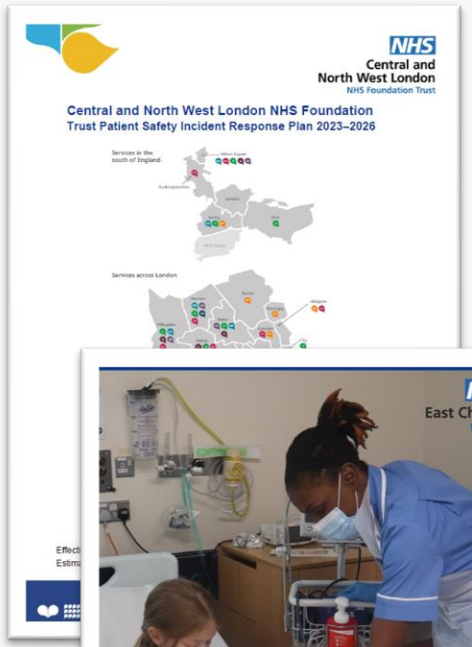
Engagement with public and Local Healthwatch?

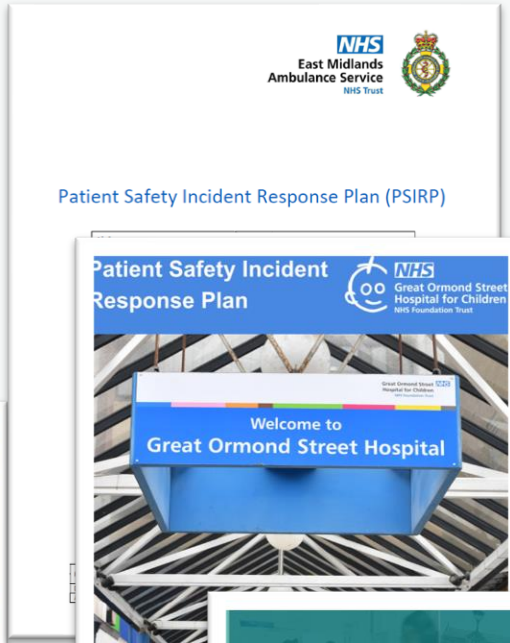
Consideration of harm/good catches in learning response decision making

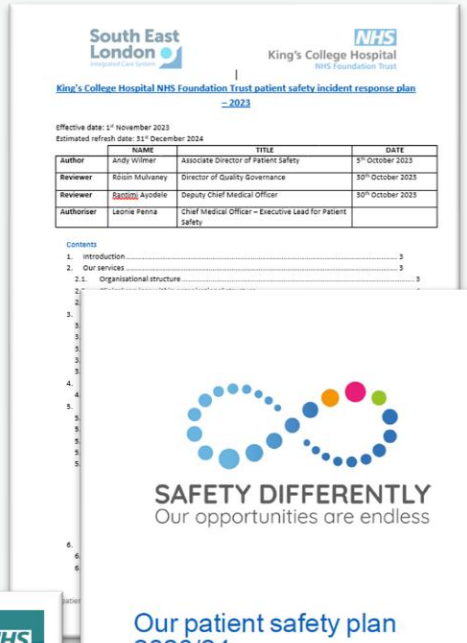
Reflections on priorities

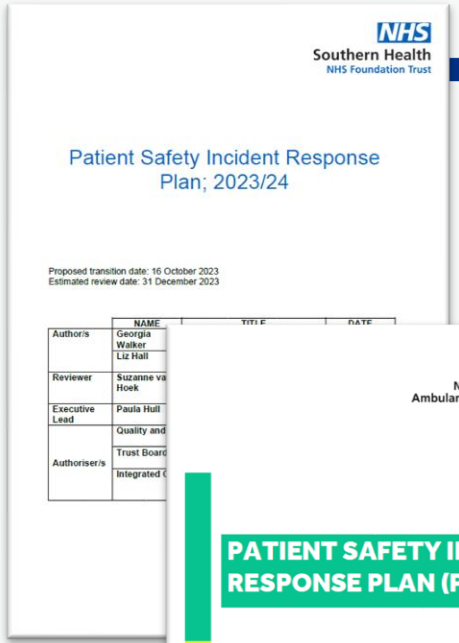
Note: Only PSIRF Plans reviewed. PSIRF Policies were not considered
These may include

- 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 Midlands Ambulance Service
NHS Trust
Patient Safety Incident Response Plan (PSIRP)


South East London
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
Contents


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


NHS
East Cheshire
NHS Trust

Patient Safety Incident Response Plan
NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust
Welcome to
Great Ormond Street Hospital

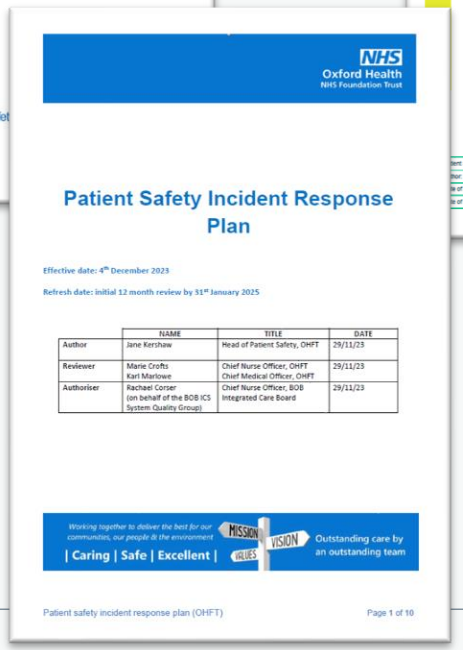

NHS
Hampshire Hospitals
NHS Foundation Trust
2023

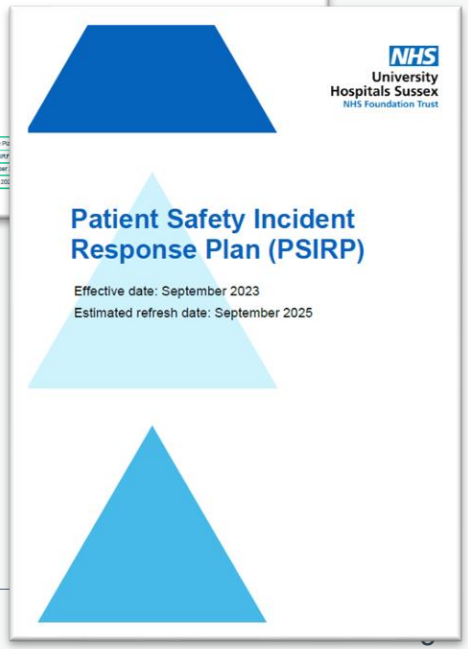
SAFETY DIFFERENTLY
Our opportunities are endless
Our patient safety plan 2023/24:
Our care is safe: we continuously, systematically and consistently prioritise patient safety in everything we do.


NHS
North West Ambulance Service
NHS Trust
PATIENT SAFETY INCIDENT RESPONSE PLAN (PSIRP)


PATIENT SAFETY INCIDENT RESPONSE PLAN
NHS
Essex Partnership University
NHS Foundation Trust
2023
2025
Estimated refresh date: 28 February 2025


NHS
Humber Teaching
NHS Foundation Trust
Patient Safety Incident Response Plan 2023-2025

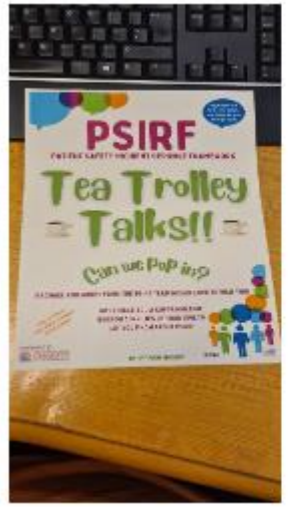

NHS
Oxford Health
NHS Foundation Trust
Patient Safety Incident Response Plan
Effective date: 4th December 2023
Refresh date: initial 12 month review by 31st January 2025
Working together to deliver the best for our communities, our people & the environment
MISSION
VISION
VALUES
| Caring | Safe | Excellent |
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

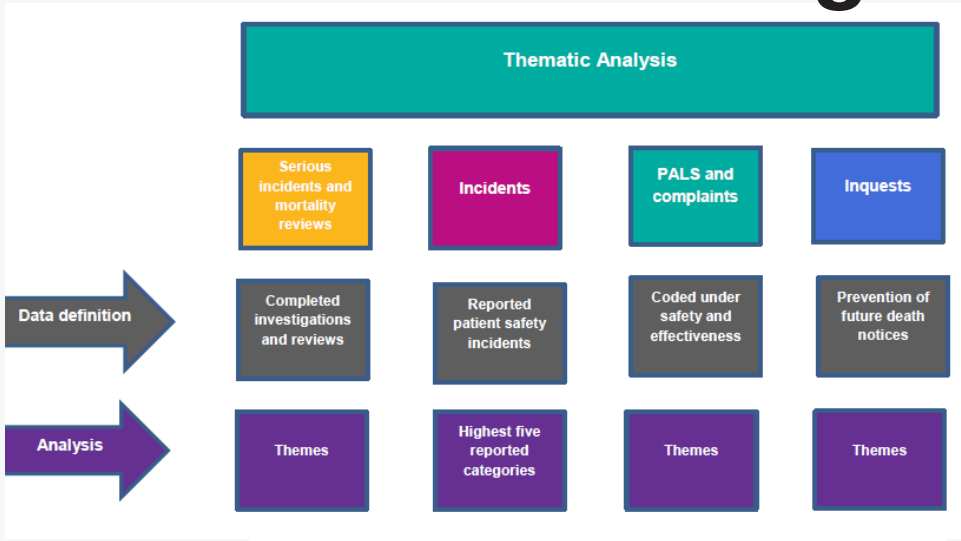
Who are organisations involving in plan development?

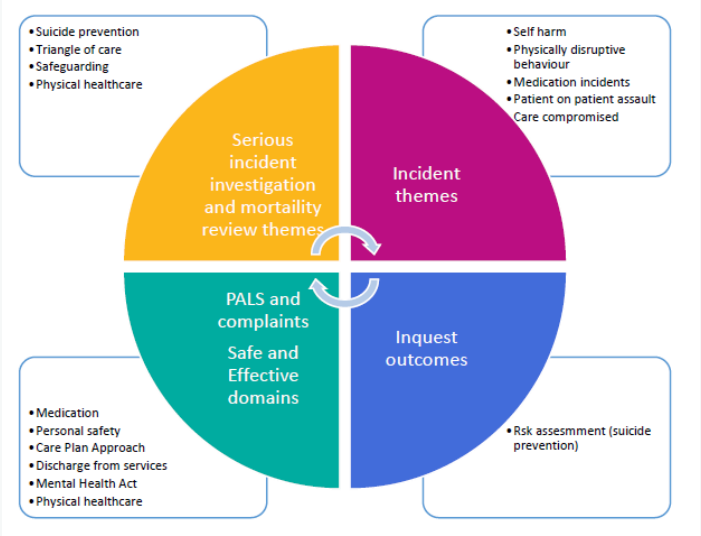
Stakeholder engagement

- 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?

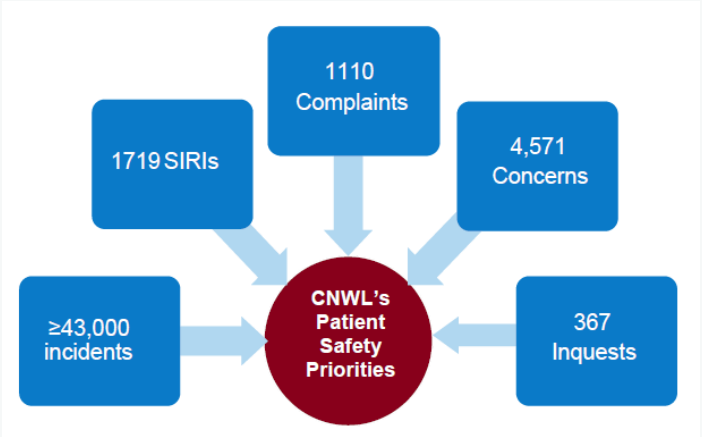




Avon and Wiltshire Mental Health Partnership NHS Trust

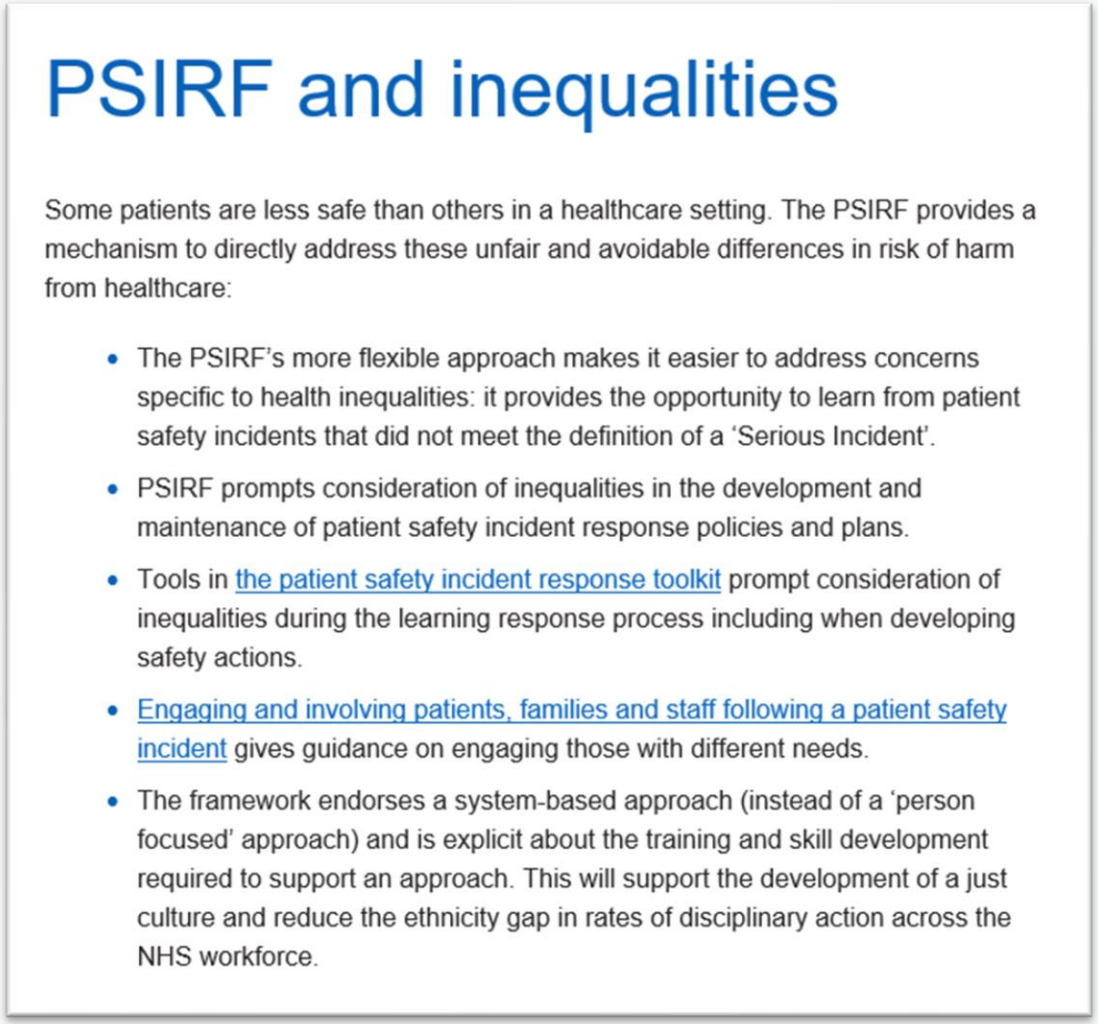
University Hospitals Bristol and Weston NHS Foundation Trust

Trafford General Hospital



Central and North West London NHS Foundation 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.

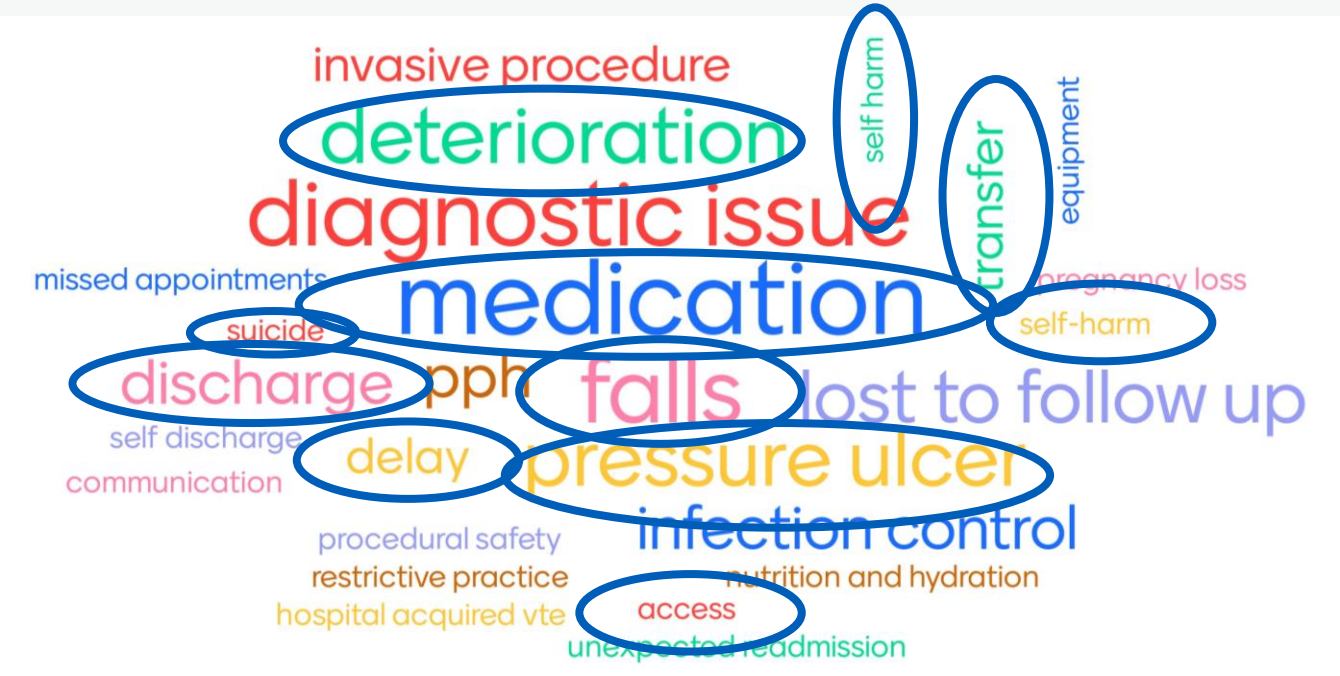
'*Through our implementation of* [PSIRF], *we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to support tackling these. We are already actively considering language barriers and social deprivation in our incident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

p7-8 B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk)

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

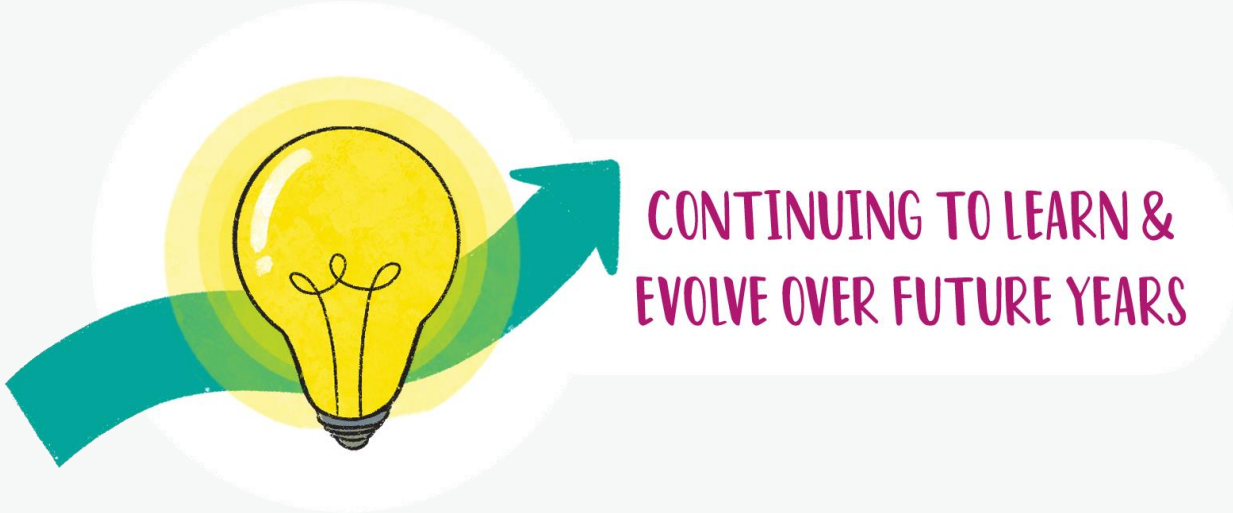
Less than a tenth of PSIRF Plans mentioned equipment, medical devices, digital systems.

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

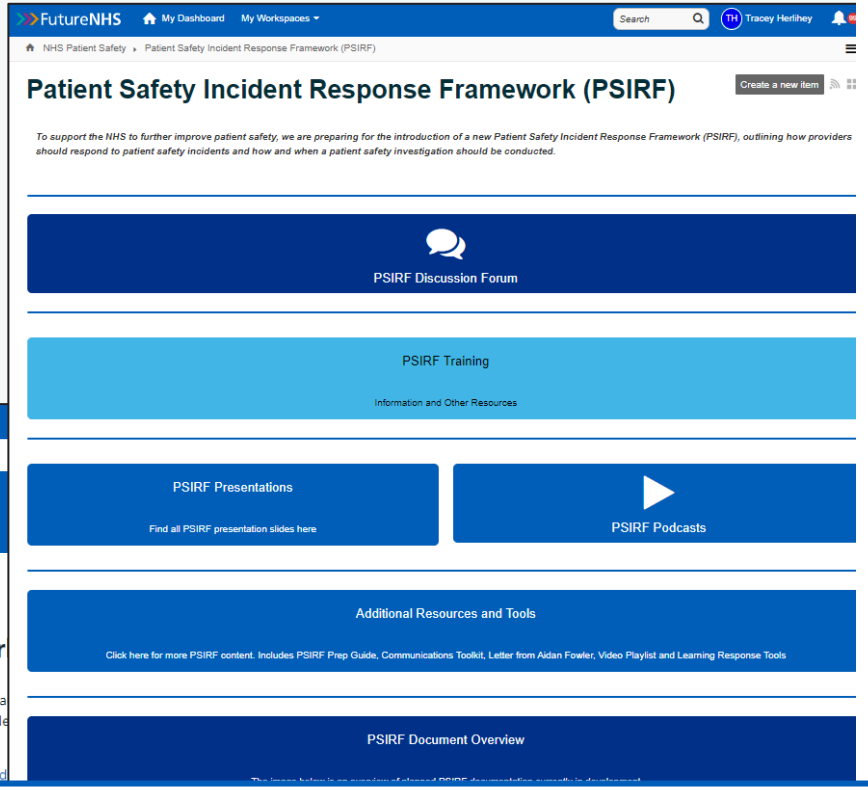
- “Not implementing a framework, leading a culture change”
- Plan enables more informed decision making moving away from reactive/bureaucratic approach
- Rich source of data about safety concerns across trusts in England
- Overlap in safety concerns = prompts for collaboration/shared learning

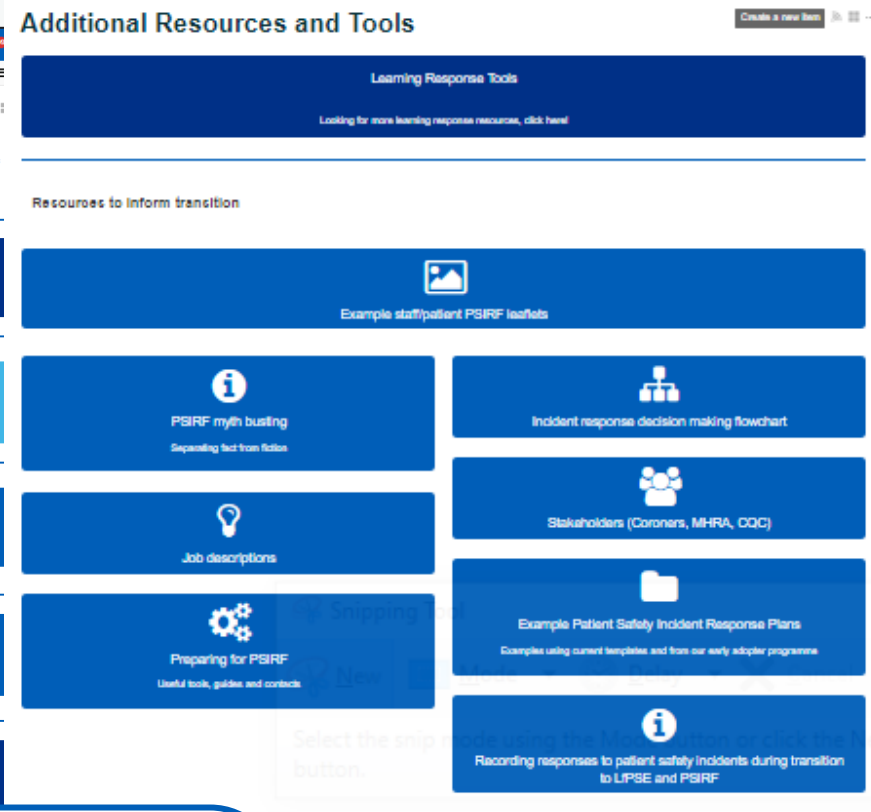
Just the beginning of the safety journey

Opportunities to:

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

Find out more





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

Thank You

@ptsafetyNHS

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