Humber and North Yorkshire
Health and Care Partnership

PSIRF briefing for the ICB Board

13 September 2023

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Health and Care Partnership

The Patient Safety Incident Response Framework (PSIRF) – published August 2022

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

It will replace the current Serious Incident Framework (2015), providers are expected to still use this framework until transitioned to PSIRF

Shift from root cause analysis to systems-based methodology and is ultimately about culture, learning and sustained improvement

The Difference for Providers:

- Providers will develop plans, known as patient safety and incident response plans (PSIRPS) to identify what type of incidents will undergo what type of investigation

- The investigation will be proportionate to the incident however there are nationally mandated incident types that require a full patient safety incident investigation (PSII):-
  - Never events
  - Deaths clinically assessed as more likely than not due to problems in care
  - Maternity and neonatal incidents meeting HSIB criteria
  - Child deaths
  - Deaths in people with LD / autism
  - Some safeguarding incidents

Greater emphasis on engaging with patients, families and staff

Dedicated resource adequately trained and experienced

No mandated timescales, agreed with families

Provider boards will sign off investigation reports and be accountable for how its organisation responds to incidents and comply with the standards*

PSIRF Implementation timescales

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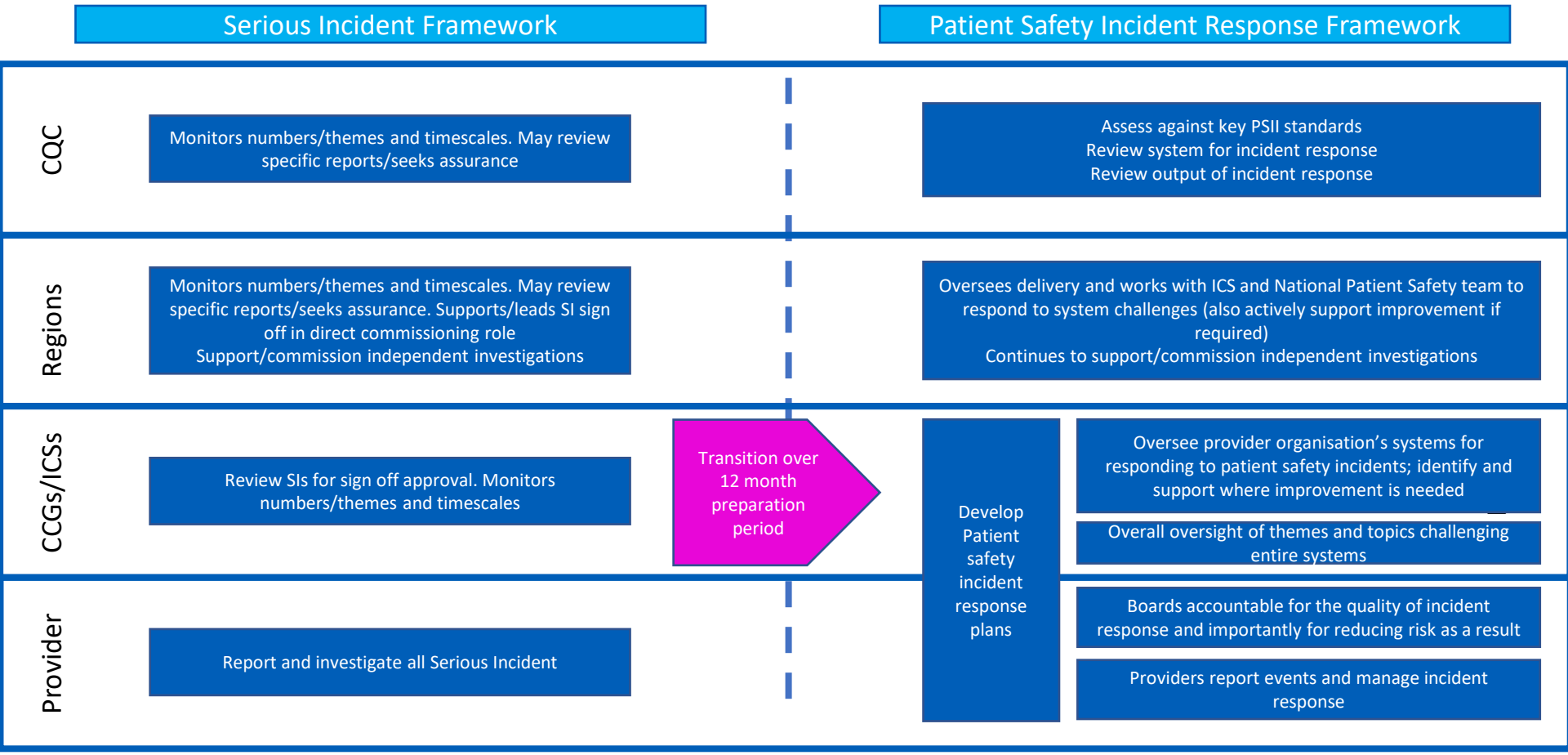
PSIRF Preparation Guide (Aug 2022)
Plan on a page

Month →	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Phase ↓	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
1	PSIRF orientation																				
2					Diagnostic and discovery																
3							Governance and quality monitoring														
4								Patient safety incident response planning													
5										Curation and agreement of the patient safety incident response policy and plan											
6													Transition – working under the patient safety incident response policy and plan								
7																Embedding sustainable change and improvement					

Phase	1. Orientation		Diagnostic & discovery		Governance & quality		PSIRP		Draft policy & plan		Transition		Embedding	
Month	Months 1-3		Months 4-7		Months 6-9		Months 7-10		Months 9-12		Months 12-16		Months 15 onwards	
Actions	1.1	Create an implementation team	2.1	What is being done to support open and transparent reporting?	3.1	Develop processes for incident response decision making	4.1	Map your services	5.1	Populate the policy and plan templates and sahre these with stakeholders	Here be dragons.....			
	1.2	Allocate time for reading and reflection	2.2	How do you engage and involve those affected by patient safety incidents?	3.2	Define how system effectiveness will be monitored	4.2	Examine patient safety incident records and safety data	5.2	Respond to stakeholder feedback on the draft policy and plan				
	1.3	Identify knowledge and support needs for getting started	2.3	What is being done to support the development of a just culture?	3.3	Develop processes for reporting cross-system issues	4.3	Describe the safety issues revealed by the data	5.3	Agree how to manage transition				
	1.4	Create a stakeholder list and plan engagement	2.4	What is your incident response capacity and what are your training needs?	3.4	Define how system effectiveness will be monitored	4.4	Identify work underway to address contributory factors	5.4	Ensure commitment to delivering required improvement				
	1.5	Agree structures and process for programme management	2.5	How do you use learning from incident responses to inform improvement?			4.5	Agree how you intend to respond to issues listed in your patient safety incident profile	5.5	Seek policy and plan approval / sign off and agree 'transition date'				
	1.6	Set ambition for PSIRF implementation	2.6	What do you need to do next?										

- PSIRF requires teams to adapt and implement new ways of working
- There is a need for relationship building and undoing entrenched habits

Oversight arrangements



Understanding ICBs oversight of provider patient safety learning response systems - can be used to support the understanding of organisational safety rather than via reports or data

1. ICBs have a responsibility to establish and maintain structures to support a coordinated approach to oversight of patient safety incident response in all the services within their system – over 100 NHSE providers.
2. Policy, planning and governance

How are we doing this?

- Improved governance via PSIRF Implementation group feeding into ICB Quality Committee (QC), implementation, comms and training plan with an agreed ToR
- Members have undergone relevant training
- ICB exec lead with responsibility & Lead SRO for patient safety
- Working in collaboration with providers to develop their plans allowing sharing of good practice and challenges across the system
- Approved PSIRF Policy across the ICB, providers must meet the standards and have their plans signed off before being able to proceed with full launch of PSIRF
- Stakeholder briefings e.g. safeguarding boards, coroners etc

Continued from previous slide

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3. Competence and capacity

4. Proportionate responses

5. Safety actions and improvement

6. Engagement and involvement of those affected by patient safety incidents

How are we doing this?

ICB Board awareness & training
Patient safety partners employed to provide additional independent oversight of arrangements (all providers also have these roles within their organization)
Training needs analysis for ICB staff with mandatory and role appropriate additional training
Collaboration and assurance of provider plans which must include all the above elements

The Role of the ICB

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1. Oversee and support effectiveness of systems to achieve improvement following patient safety incidents

Following a patient safety incident the ICB lead(s) should collaborate with the provider to assess whether systems and processes put in place to respond to incidents, are effective and where they are not, offer support such as linking in with other organisations

Continued from previous slide - role of the ICB

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2. To support with cross system learning

Learning responses should be managed as locally as possible, However, where a response involving multiple providers and/or services across a care pathway is too complex for a single provider to manage, ICBs should support the co-ordination of cross-system response..

Where required an ICB can commission an investigation that is independent of the provider. This may occur when:

- an organisation is too small (ie does not have the workforce) to provide an objective response and analysis
- an investigation independent of the provider is deemed necessary to ensure public confidence in the investigation integrity
- a multi-agency incident occurs, and no single provider is the clear lead for an investigation
- the incident(s) represent significant learning potential for the wider system (regional or national).

Continued from previous slide – role of ICB

3. Share insights and information across organisations/services to improve safety

Quality improvement and patient safety approaches must align, inclusive of improvement plans across the ICB and wider local system PSIRF ICB leads will consider how learning from patient safety incident response is translated into safety actions and whether processes meet Patient safety incident response standards. For example can the organisation describe safety improvement in progress, what they aim to achieve and their interim successes and challenges? And what is the provider board doing to support local teams on challenges in patient safety improvement?

4. Identify and share areas of good practice in relation to patient safety incident response

Should we be assured or worried about the move to PSIRF?

The principles are absolutely right to move away from a rigid mechanism of counting incidents and root cause analysis to systems learning and improved safety culture. Letting go of that way of working won't be easy. Closing down legacy SI's needs to be robust.

We must use all the tools in our armour to understand, learn and share e.g. PSIIs, medical examiners and coroners information, patient and staff experience etc.

PSIRF doesn't cover some areas of provision even though part of our ICB e.g. primary care, but then neither did the SI Framework.

There are some blind spots now (smaller providers, specialist services, primary care etc) and the ICB will need to ensure line of sight to providers even if PSIRF doesn't apply. There is learning to be shared and understood in those places. This requires data, intelligence and good relationships.

The principles of PSIRF are predicated on having open and honest organisations with a just culture. Where this isn't in place attaining the national standards related to PSIRF should help.

Being able to speak up is crucial , we must get this right for people.

Recommendations:

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i) note the content of the briefing.

ii) gain assurance on the progress made by the ICB and our providers of NHS care in the implementation of PSIRF.

iii) discuss PSIRF in light of the verdict in the Lucy Letby case and advise if further assurance or work is to be undertaken in relation to PSIRF, in this regard.

iv) agree that the ICB Board undergoes the PSIRF Board

level training (NHSE provided)

NHS England » Patient Safety Incident Response Framework and supporting guidance

B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk)