Welcome to learning from claims a London and South virtual forum on preparing for Patient Safety Incident Response Framework (PSIRF)

NHS Resolution

- Coronial expectations for new PSIRF
- Preparation guidance to support planning for PSIRF.
- Reflect and share experiences and challenges as an early adopter site within the national PSIRF pilot
- Legal insights
- New support resources to aid patient safety incident management

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Meet the team behind the scenes

NHS Resolution

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Preparation for PSIRF programme:

Patient Safety Incident Response Framework (PSIRF) virtual forum
Date: Thursday 17th March 2022
Time: 12.30 – 13.40
Eventbrite link to register:
https://nhsr-psirf.eventbrite.co.uk

Please note registration is restricted to NHS staff only

NHS Resolution's Safety and Learning team, in partnership with NHS England and Improvement's (NHSEI) safety team are hosting a virtual forum to support members prepare for the implementation phase of the Patient Safety Incident Response Framework (PSIRF) as well as hear experiences and the challenges in early implementer pilot of PSIRF. The purpose is to spread insight and experiential learning across health providers to support preparations for PSIRF.

The format is interactive, with panel discussion from our speakers.

Patient Safety Incident Response Framework (PSIRF) programme:

- Preparation guidance to support planning for PSIRF.
- Reflect and share experiences and challenges as an early adopter site within the national PSIRF pilot
- Managing expectation of the Coroner's Office – documentation needed to support PSIRF
- New support resources to aid patient safety incident management
- Coronial expectations for new PSIRF
- Legal insights

Contributors:

- Vicky Aldred - Deputy Director of Patient Safety and Patient Safety Specialist | NHSEI London
- Jess Peck - Clinical Quality Manager | NHSEI London
- Derek Winter - Deputy Chief Coroner of England and Wales and HM Senior Coroner for the City of Sunderland
- Jo Lloyd - Senior Partner | Bevan Brittan
- Helen Woolford - Head of Quality Improvement & Learning | London Ambulance Service (early adopter in PSIRF Pilot)
- Justine Sharpe - Safety and Learning Lead (London) | NHS Resolution

How to access the forum

Registration is via Eventbrite portal. This virtual forum will be hosted on Microsoft Teams once you have registered. Please place a diary hold in your electronic calendar. The link will be emailed before the event. Please report any difficulties experienced to safety@resolution.nhs.uk before the event.

You will need:

- a laptop or tablet with a working webcam
- to check that all equipment and broadband is in working order prior to the forum
- a quiet environment where you are unlikely to be disrupted for 60 minutes

Please avoid:

Please do not record the forum. This is in line with GDPR guidance, and to encourage open discussion.

Format: interactive

Duration: 70 minutes

Guest speakers:

- **Derek Winter –** Deputy Chief Coroner of England & Wales and HM Senior Coroner for City of Sunderland
- **Vicky Aldred–** Deputy Director of Patient Safety and Patient Safety Specialist | NHS England and Improvement NHSEI | London
- **Helen Woolford –** Head of Quality Improvement & Learning | London Ambulance Service
- **Jo Lloyd -** Senior Partner | Bevan Brittan
- **Chair- Justine Sharpe-** Safety & Learning Lead London | NHS Resolution

Housekeeping rules for today's session

- Please have your microphones on mute
- Please turn your camera off unless you are speaking
- Please feel free to put comments and questions in the chat box
- Please ask lots of questions and feedback any improvements that could spread the learning
- Chatham House Rule …

NHS Resolution purpose, functions and strategic focus:

Our purpose is to provide expertise to the NHS to resolve concerns fairly, share learning for improvement and preserve resources for patient care.

NHS Resolution has identified four key areas for strategic focus:

- Delivering fair resolution
- Sharing data for improvement
- Collaborating to improve maternity outcomes
- Investing in our people

Learning from best practice in triangulating information from claims, incidents, complaints

Interpreting data in order to converge on an accurate representation of reality

(Ref: Polit and Hungler)

1. Reviewing claims data, complaints, incidents (for site and for Board)
2. Acting on data – closer to the incident
3. Learning from patients - candour https://www.independent.co.uk/news/health/coronavirus-hospital-infections-nhs-candour-b1859757.html

A range of products for learning

Case story
Better joint working and specialist help benefits patients, families and the NHS

https://resolution.nhs.uk/resources/

Preparing for PSIRF | Coroner's Office

NHS Resolution

Derek Winter

Deputy Chief Coroner for England & Wales

Senior Coroner for City of Sunderland

- Podcasts https://ficmlearning.org/the-coroner-part-1/
- Coroner's Court competences and toolkit
  - Bar Standards Board https://www.barstandardsboard.org.uk/for-barristers/resources-for-the-bar/resources-for-practising-in-the-coroners-courts.html
  - Solicitors Regulatory Authority https://www.sra.org.uk/solicitors/resources/practising-coroners-court
  - CILEx Regulation https://cilexregulation.org.uk/regulated-individuals/coroners-court/

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Preparing for PSIRF | NHSEI

Vicky Aldred

Deputy Director of Patient Safety and Patient Safety Specialist

NHS England and Improvement London

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Preparing for the Patient Safety Incident Response Framework (PSIRF)

Patient Safety Team, NHS England and NHS Improvement, London – based on slides from the National Patient Safety Team

11 March 2022

NHS Patient Safety Strategy

PS Syllabus for training NHS staff

More effective National PS **Alerts**

National PS **Improvement Programme** delivered by Patient Safety Collaboratives

New **cultural metrics** to measure safety

National **medical examiner** service

New **Patient Safety Incident Response Framework** to improve how the NHS responds to harm

PS specialists to lead safety improvement

New digital incident reporting system for staff & patients. **LFPSE** (learn from patient safety events)

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New **Patient Safety Incident Response Framework** to improve how the NHS responds to harm

PS specialists to lead safety improvement

New digital incident reporting system for staff & patients. **LFPSE** (learn from patient safety events)

‘Our approach refocuses systems, processes and behaviours on delivering a sustained reduction in risk, rather than simply applying a reactive, bureaucratic process that too often does not lead to change.’

PSIRF Introductory Framework, March 2020

What does PSIRF hope to achieve?

Improved experience for those affected:

- Expectations are clearly set for informing, involving, and supporting those affected by patient safety incidents, particularly patients, families and staff
- Aligned with ongoing research around improving patient and family involvement

More proportionate and effective response:

- Changes blunt rules to determine what to learn from and what not to learn from
- Resource planning based on thorough understanding of patient safety incident profiles and ongoing improvement activity.
- Supports organisations to be more proportionate, sensitive and considered in their approach

Better range of methods for learning:

- Promotes a range of methods for responding to and learning from patient safety incidents
- Moves away from RCA, which does not represent best practice
- Timelines are more flexible and set in consultation with the patient and/or family
- Quality of response and resulting improvement work is the priority

Strengthened governance and oversight:

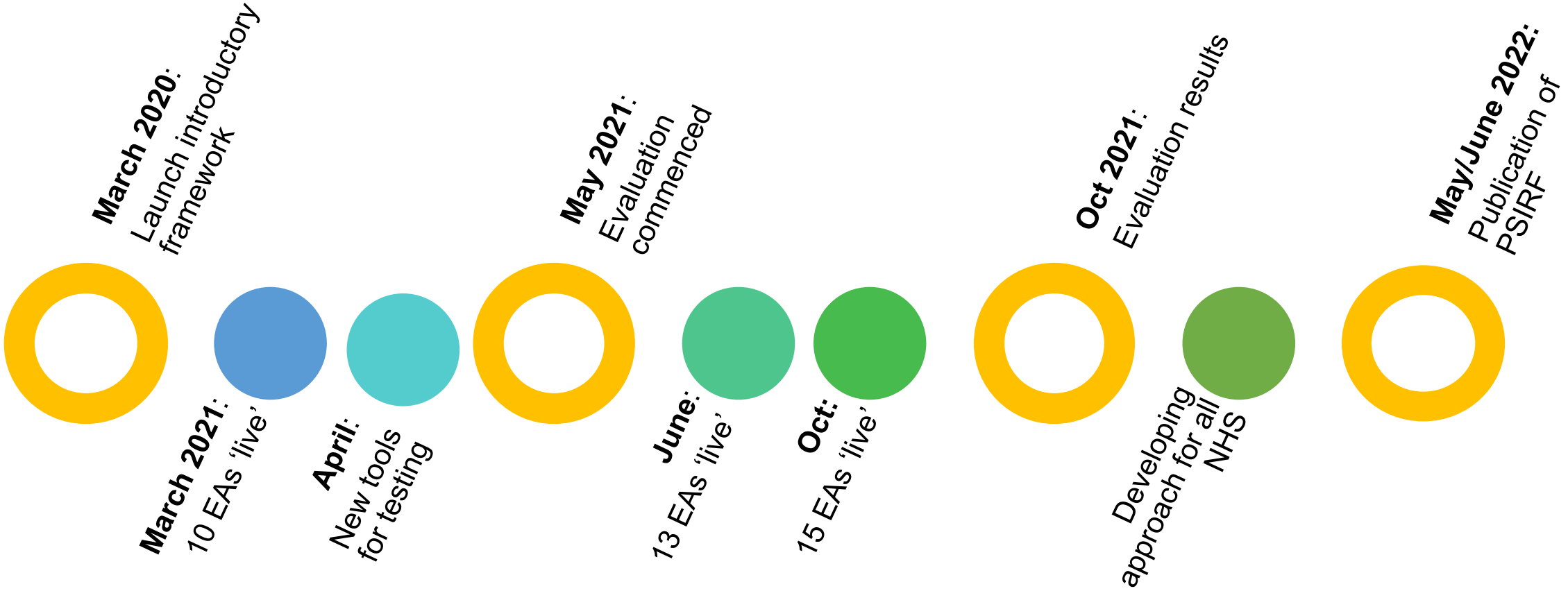
- Regulators and ICSs will consider the strength and effectiveness of organisations' incident response processes
- Makes leaders of organisations providing healthcare accountable for how their organisation responds and improves following patient safety incidents.

Early Adopter programme

18 provider organisations (acute, mental health, out of hours, ambulance, prison healthcare)

Plus CCGs and regional leads and 3 Patient partners.

London's early adopter is the London Ambulance Service



Evaluation findings

Headlines

Widespread support for PSIRF:

It's the right thing to do

PSIRF is a breath of fresh air

… a better way forward

- Better use of resources
- Openness around investigations
- Empowered to take local action

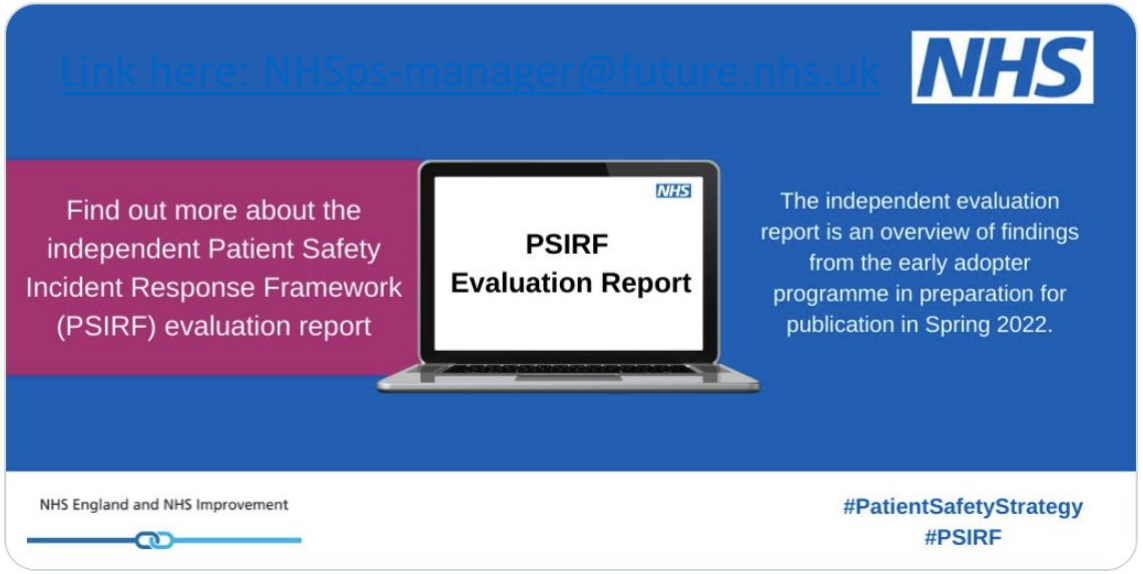
Details

- Incident response activity increases
- Preparation, engagement and planning is important, but also challenging
- Anecdotally family involvement improved, but not able to fully test
- Quality of investigations consistent
- A significant amount of support is required to apply PSIRF principles
- Further stakeholder engagement required (coroners, CQC)
- Indicators of success required
- Primary care not fully explored
- Governance changes found to be beneficial; reported as going well

PSIRF workspace

NHS Patient Safety
@ptsafetyNHS

The independent evaluation of our Patient Safety Incident Response Framework #PSIRF early adopter programme is now available online. To view the report, and listen to our first PSIRF podcast, email a request for access to: NHSps-manager@future.nhs.uk



PSIRF & tools published: Spring 2022

What does preparation look like?

Pre-framework publication work

Create the conditions for success

- Review relevant publications
- Assess the safety culture
- Assess & strengthen the systems that will support PSIRF

Months 1-3	Months 4-12			Months 5 - 12
Getting started	Create **Patient Safety Incident Response Plan** (including testing key aspects)			**Transition**
Establish the team and prepare partners - Create an implementation team - Create stakeholder list and plan engagement - Define governance structures for implementation - Develop communication strategy	**Review how work is organised** - Align learning and improvement approaches - Promote a climate that fosters a just culture - Conduct a workforce gap analysis - Review training provision -Ensure feedback is sought from those involved - Use systems-based tools	**Define PSIRF governance arrangements** - Map oversight of learning from patient safety incident response - Define how Sis will be managed during transition period	**Define the response to patient safety incidents** - Plan response methods - Confirm incident response processes - Confirm process for improvement following learning response completion	- Define measures of success for PSIRF - Board sign-off - Communications - Ongoing review

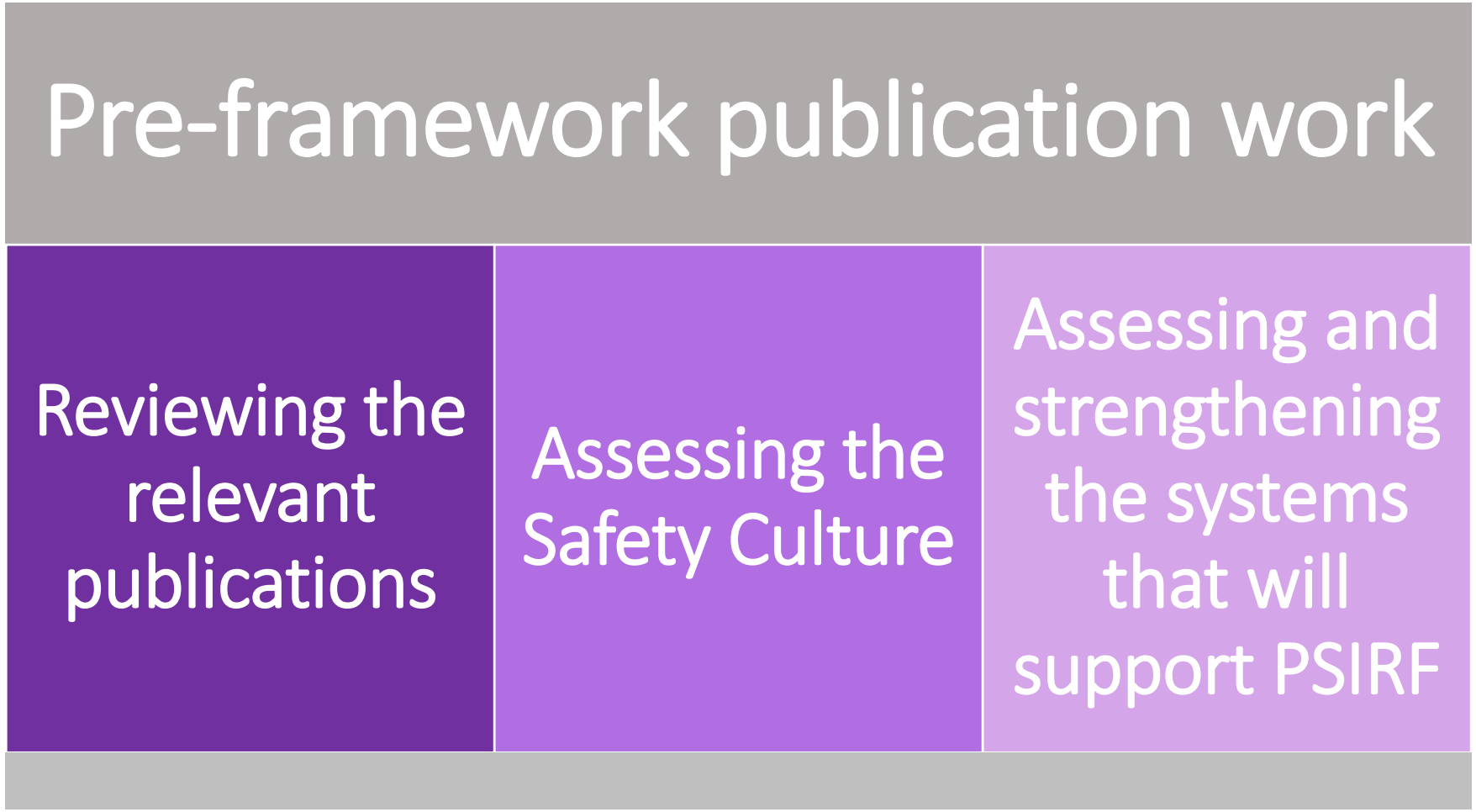
NB: The Serious Incident Framework applies until switch to PSIRF agreed for each organisation

Implementation approach

- The aim is for all organisations within a whole ICS to be supported to enter PSIRF at the same time
- This whole ICS approach will enable support resources to be directed most effectively
- There will be a process for determining which ICSs are ready to start transitioning
- Individual providers which are keen to start transitioning in advance of their ICS can request this, but likely to be agreed by exception only
- Patient Safety Collaboratives will be supporting ICSs to prepare for PSIRF and to transition: specific arrangements are being finalised

PSIRF preparatory work

Organisations are urged not to start work on specific elements of the PSIRF, such as Patient Safety Incident Response Plan (PSIRP) development or amending their policies to align with the framework at this early stage, but to focus on the areas set out in the next five slides :

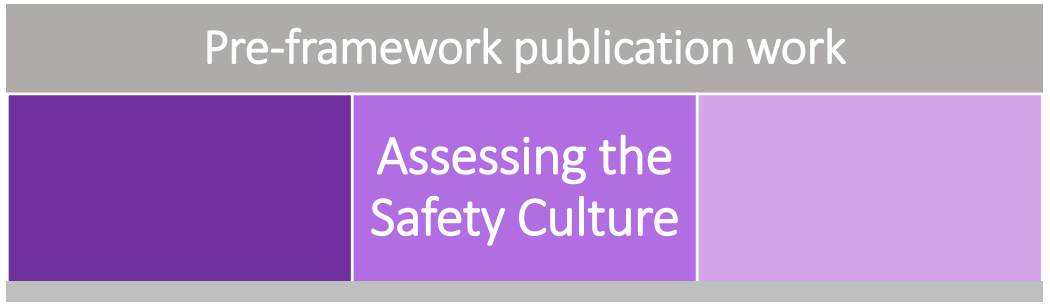


1. Review the introductory version of the framework

- To familiarise yourselves with the new approach to responding to patient safety incidents and begin to think about what your organisation will need to do to prepare ahead of introduction of the PSIRF.
- https://www.england.nhs.uk/wp-content/uploads/2020/08/200312_Introductory_version_of_Patient_Safety_Incident_Response_Framework_FINAL.pdf

2. Review the NHS Patient Safety Strategy – 2021 Update (February 2021)

- To ensure your organisation is sighted on the specific objectives for organisations a to consider how they will prepare for and support implementation of the PSIRF, including reviewing current resource (in terms of skills, experience, knowledge and personnel) for responding to patient safety incidents
- https://www.england.nhs.uk/wp-content/uploads/2021/02/B0225-NHS-Patient-Safety-Strategy-update-Feb-2021-Final-v2.pdf



1. NHS Staff Survey (Safety Culture related questions)

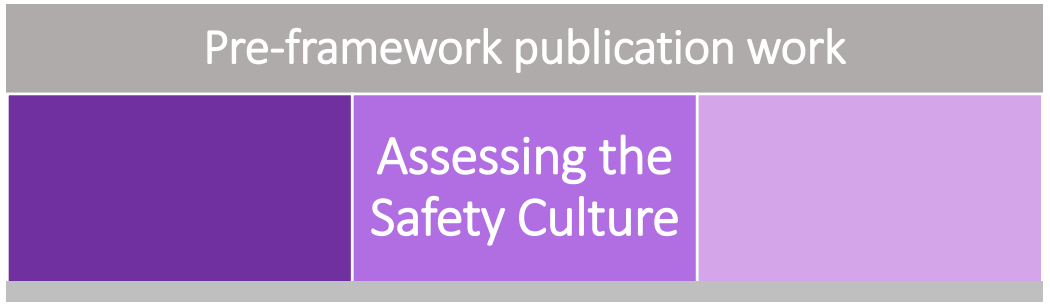
- In London, a patient safety data mining research study was commissioned by NHSEI and undertaken by a research team from the Institute for Global Health Innovation at Imperial College London.
- This research highlighted the NHS Staff Survey and Safety Culture theme as a barometer of safety culture within trusts, and organisations are urged to assess the strength of their safety culture for patients and staff, by reviewing the Safety Culture theme results, identifying areas for improvement and developing action plans and work programmes to achieve these https://www.nhsstaffsurveys.com/

2. Safety culture assessment tools and interventions

- Use assessment tools and interventions such as the Manchester Patient Safety Framework (MaPSaF) to assess and understand your organisation's patient safety culture http://www.ajustnhs.com/wp-content/uploads/2012/10/Manchester-Patient-Safety-Framework.pdf

3. Well-led framework

- Review your organisation's adherence to the well-led framework https://www.england.nhs.uk/well-led-framework/
- The framework, structured around eight key lines of enquiry, focuses on strong integrated governance and leadership with emphasis on organisational culture, improvement and system working. Providers are strongly encouraged to use the framework to undertake developmental reviews as part of their own continuous improvement.



4. National Patient Safety Alerts

- Review your organisation's National Patient Safety Alerts compliance data and ensure compliance for 100% of National Patient Safety Alerts is achieved and declared by their action complete deadlines
- Ensure your organisation has systems for planning and coordinating the actions required by any National Patient Safety Alert across your organisation, which must include executive oversight
- Declared compliance with alerts is a key safety indicator, and compliance with National Patient Safety Alerts is a focus of CQC inspection. https://www.england.nhs.uk/patient-safety/patient-safety-alerts/#national-patient-safety-alerts

5. A Just Culture Guide

- Review whether your organisation has adopted use of the 'Just Culture Guide' (or equivalent) and whether it is being used appropriately in your organisation https://www.england.nhs.uk/patient-safety/a-just-culture-guide/

6. Review of organisational data

- Consider reviewing other data sources that may provide insight to the safety culture in your organisation, for example:
  - Incident reporting patterns and incident investigation data (*is the focus on individuals or systems?)*
  - Complaints / PALS / claims data, Freedom To Speak Up (FTSU) data, staff exit interviews (*are these routes identifying patient safety issues not being reported through the appropriate route/s?)*
  - Potential proxy indicators for problematic cultures, such as levels of staff suspension and of anonymous incident reporting

1. Patient Safety Specialists

- Ensure that your organisation's patient safety specialists are developing a strong working relationship with the board and that the leadership of the organisation understands the role and the expectations of the board in supporting this work.
- Review whether your organisation has responded to the requests made in a letter sent to all Medical and Nursing Directors by the National Director of Patient Safety in England in August 2021. This included a request that organisations arrange a dedicated board discussion within the next six months (i.e. by end of February 2022) and to work with their patient safety specialist(s) to reflect on the board's expectations and responsibilities in patient safety.

2. NHS Patient Safety Syllabus training programme

- Support and encourage all staff in your organisation to undertake the *Essentials for patient safety* training and additional levels of the national patient safety syllabus training as relevant to their role in the organisation https://www.elfh.org.uk/programmes/patient-safety-syllabus-training/

3. National standards for patient safety investigation

- The *National standards for patient safety investigation (March 2020)* sets out guiding principles and standards for a local, systems approach to patient safety investigation in NHS-funded care https://www.england.nhs.uk/wpcontent/uploads/2020/08/Standards_for_PSI_Investigation.pdf
- Review the systems in place in your organisation against the standards and assess your organisation's capability to undertake effective investigations into patient safety incidents, identifying and addressing areas requiring improvement.

4. Involvement and support of patients / families / carers

- Review whether patients / families / carers are active and supported participants in patient safety incident investigations in line with the National standards for patient safety investigation and identify and address areas requiring improvement. New guidance will be available in Spring 2022.
- Additional information sources include the 'Being Open' principles in Appendix 1 of https://www.england.nhs.uk/wp-content/uploads/2020/08/200312_Introductory_version_of_Patient_Safety_Incident_Response_Framework_FINAL.pdf
- and CQC Duty of Candour guidance https://www.cqc.org.uk/sites/default/files/20210421%20The%20duty%20of%20candour%20-%20guidance%20for%20providers.pdf

5. Involvement and support of staff

- Review whether staff are active and supported participants in patient safety incident investigations in line with the National standards for patient safety investigation and identify and address areas requiring improvement. New guidance will be available in Spring 2022.

6. National Patient Safety Improvement Programmes and PS Collaboratives

- Understand how your organisation could / does contribute to the work of the Patient Safety Collaboratives including the Patient Safety Collaborative local improvement plans across the National Patient Safety Improvement Programmes https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/

7. Patient safety partners

- Review progress on implementation of the *Framework for involving patients in patient safety* and the engagement of patient safety partners in your organisation

Oversight arrangements

	Serious Incident Framework		Patient Safety Incident Response Framework
CQC	Monitors numbers/themes and timescales. May review specific reports/seeks assurance		Assess against key PSII standards Review system for incident response Review output of incident response
Regions	Monitors numbers/themes and timescales. May review specific reports/seek assurance. Supports/leads SI sign off in direct commissioning role Support/commission independent investigations		Oversees delivery and works with ICS and National Patient Safety team to respond to system challenges (also actively support improvement if required) Continues to support/commission independent investigations
CCGs/ICSs	Review SIs for sign off approval. Monitors numbers/themes and timescales	Transition over 12+ month preparation period	Develop Patient safety incident response plans Oversee provider organisation's systems for responding to patient safety incidents; identify and support where improvement is needed Overall oversight of themes and topics challenging entire systems
Provider	Report and investigate all Serious Incidents		Boards accountable for the quality of incident response and importantly for reducing risk as a result Providers report events and manage incident response

What to expect from the national patient safety team

- Regular national webinars
- Revised framework
- Updated planning template
- Preparation guide
- Revised PSII standards (‘learning from patient safety incidents’)
- Tools/templates for various methods to learn from patient safety incidents
- Training procurement framework (3 x lots)
- Clarity on how to involve those affected by patient safety incidents in the learning process
- Oversight training specification (for boards, ICSs)
- CQC inspection guide
- Support infrastructure development

Contact Information

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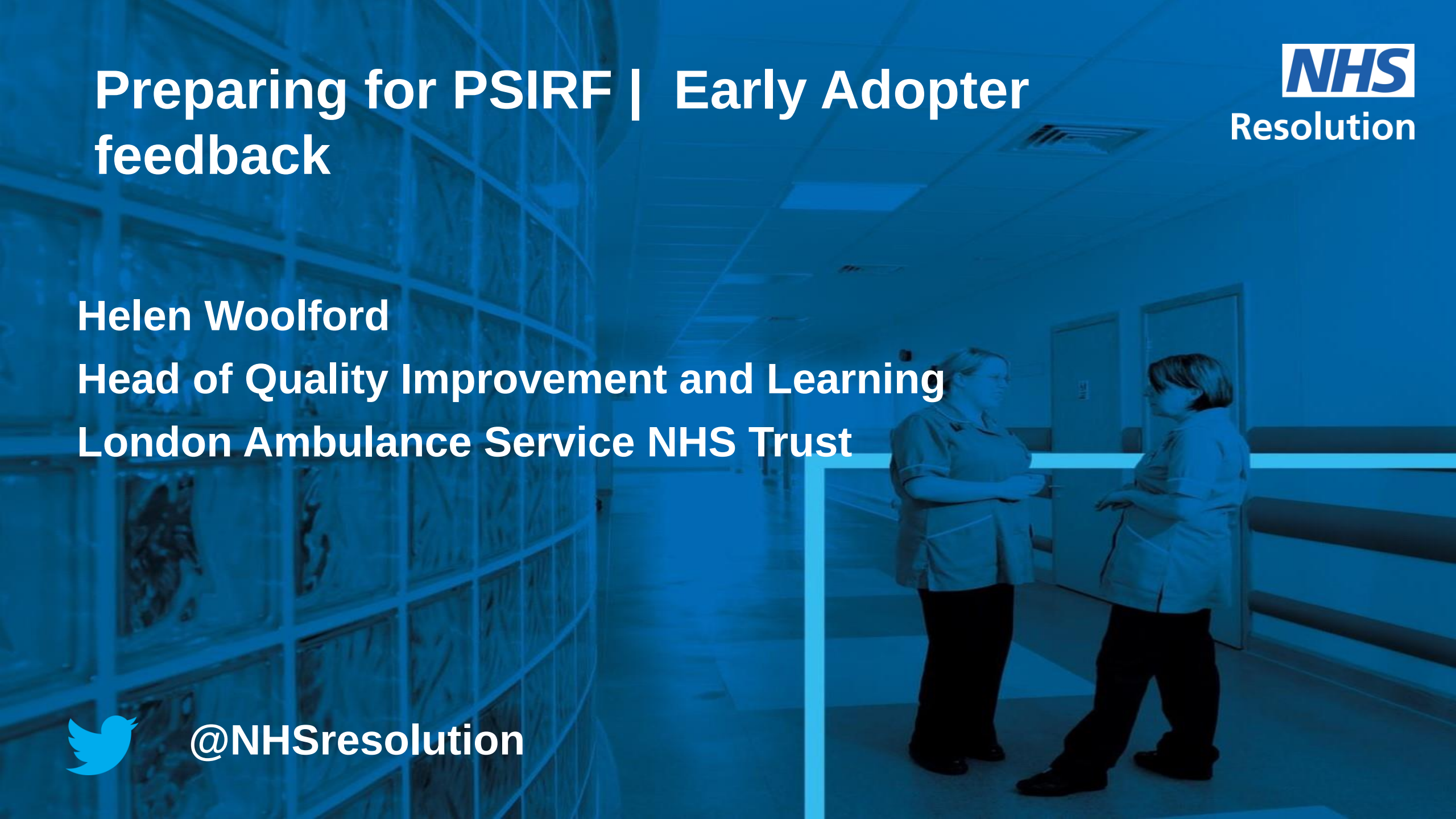
NHS England and NHS Improvement

Preparing for PSIRF | Early Adopter feedback

Helen Woolford
Head of Quality Improvement and Learning
London Ambulance Service NHS Trust



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Preparing for PSIRF | Legal Perspective

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Jo Lloyd
Senior Partner
Bevan Brittan

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PSIRF-a lawyer’s reflections

Joanna Lloyd

Partner- Clinical Risk Department

Bevan Brittan LLP

Under **PSIRF** a **PSI** is investigated or reviewed to understand the circumstances leading to it and for system learning and improvement and **NOT** to determine a cause of death or to hold an individual/ organisation to account

An organisation's **PSIRP** sets out its approach to the different types of PSI and this will include '**do not investigate**' or **'no response required'.**

Issues

- We need to ensure patients and families feel their concerns have been heard when there is no PSII. What will staff say to a pt in the immediate aftermath?
- Equally staff will need reassurance. No PSII doesn't mean the incident is not being taken seriously.
- SI reports mainstay of many inquests- how will we ensure Coroners are on-board?
- The SIF has created an 'industry of report writing' but will Boards get comfortable with reduced reporting?

Issues

- Will some organisations struggle to select local priorities for PSII-not all organisations have the same ability to theme based on incidents which reoccur
- Will the staff on the ground know how to carry out a systems based PSII?
- Do ICSs have the bandwidth to focus on PSIRF?

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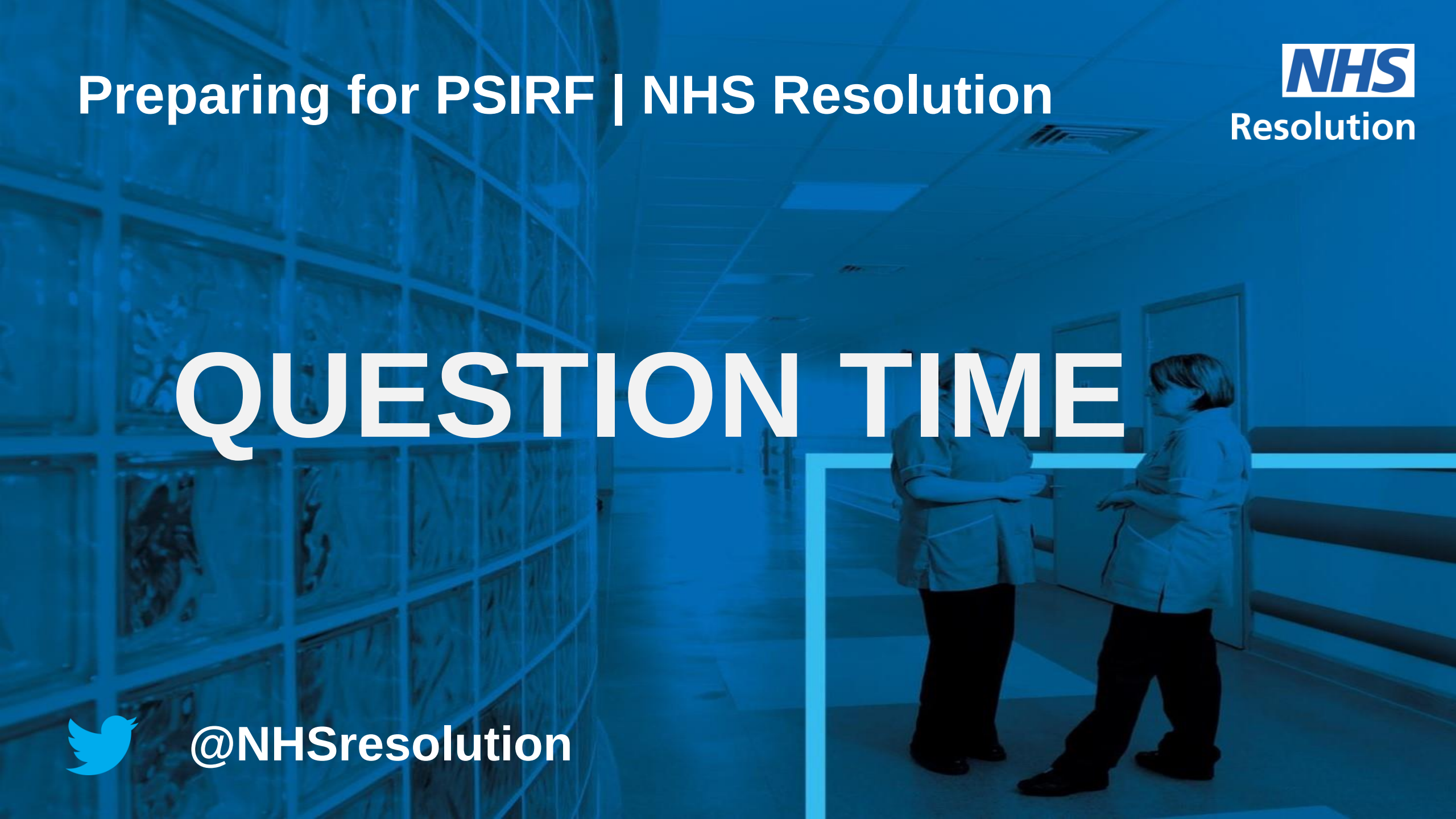
QUESTION TIME



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Summary - have we achieved our purpose?

- Gaining support and insights for preparing for PSIRF
- Sharing early adopter experience and challenges
- Legal and Coronial considerations
- nhsr.safety@nhs.net

Thank you for joining us

We would appreciate your feedback via the survey link which you will shortly receive by email

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www.resolution.nhs.uk