Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Patient Safety Incident Response Framework (PSIRF)

Excellent care with compassion

Always Safety First

@LancsHospitals

Contents

Foreword

Patient Safety Incident Response Framework (PSIRF) is a new and innovative approach to how the NHS responds to patient safety incidents. This is not a change which involves us doing the same thing it highlights that we need to do something different. It is a cultural and system shift in our thinking and response to patient safety incidents and how we work to prevent an incident happening again.

Our challenge is to move the focus away from investigating incidents to produce a report because it might meet specific criteria in a framework and instead, towards an emphasis on the outcomes of patient safety incident responses that support our learning and continuous improvement methodologies to prevent incidents happening again.

Where previously we have had set timescales and external organisations have needed to approve what we do, PSIRF gives us a set of principles that we will work to and although this could seem daunting, we welcome the opportunity to take accountability for the management of our responses to patient safety incidents with the aim of learning and improvement.

We know that we investigate incidents to learn although we acknowledge that we have been distracted by the previous emphasis on the production of a report, as that is how we are being measured, rather than on showing how we have made meaningful changes to what we do to keep our patients safe.

We need to engage meaningfully with our patients, service users, families and carers to ensure that their voice is the golden thread in any of our patient safety investigations. PSIRF sets out best principles for this involvement and our move to engaging with patient safety partners will make sure that the patient voice is heard at all stages of our patient safety processes.

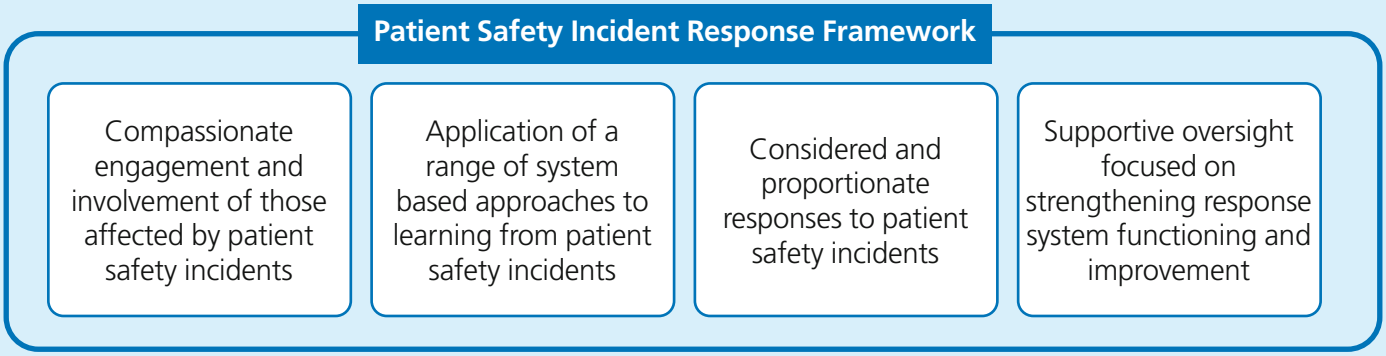
Our recent work in moving towards a restorative and just culture underpins how we will approach our incident responses. We are an organisation who fosters a culture in which people feel they can highlight incidents knowing they will be psychologically safe.

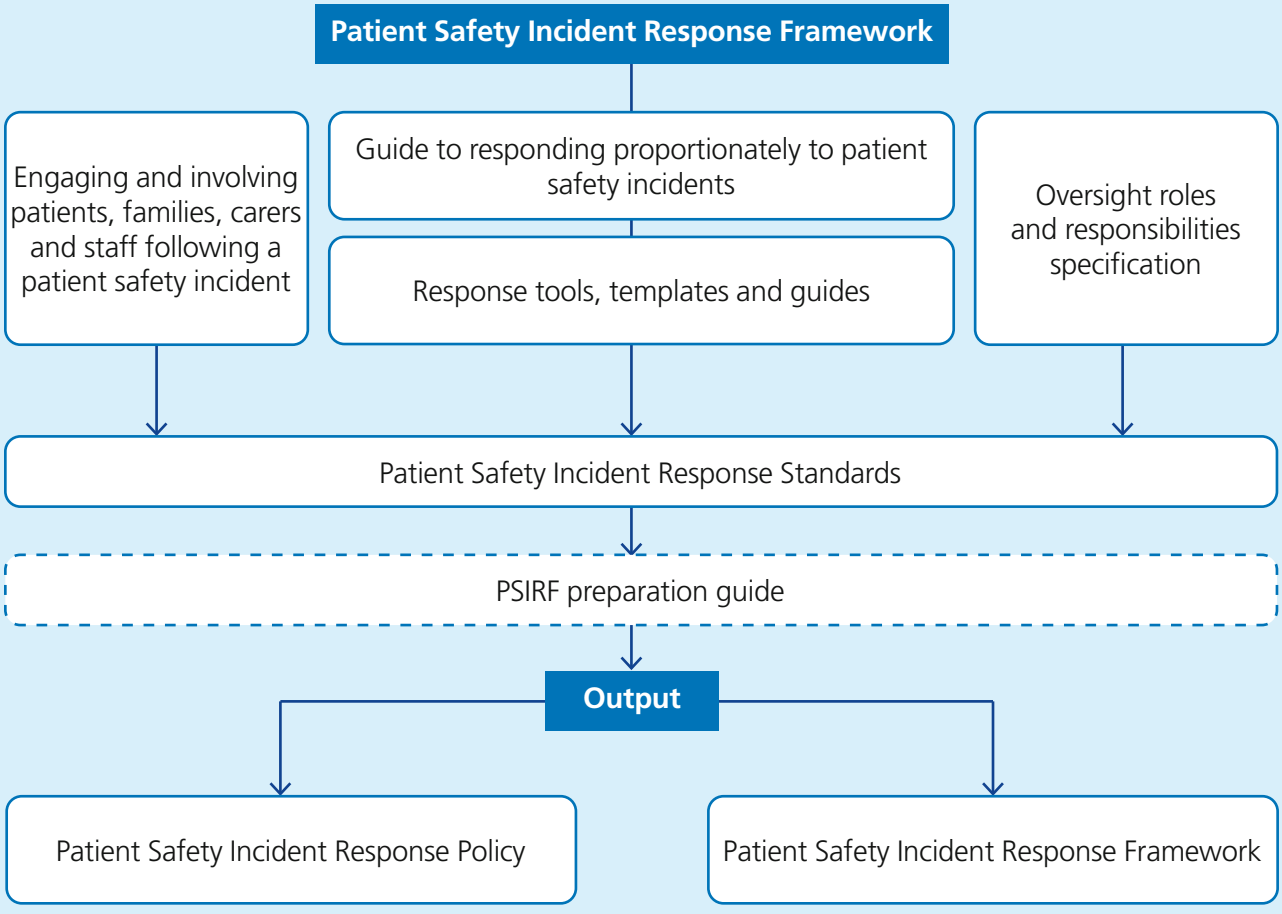
PSIRF asks that we have conversations where people have been affected by a patient safety incident, no matter how difficult that is and we will continue work on how we can equip and support those affected to best hear the voice of those involved. The process of reviewing an incident can help our staff validate the decisions they made in caring for and treating a patient and facilitate psychological closure, these are part of our PSIRF core objectives.

As we move into adopting this new way of managing our patient safety learning responses, we accept that we may not get it right at the beginning, however we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to. In this we have been supported by our commissioners, partner providers and other stakeholders to allow us to embark on this nationally driven change.

Most importantly though, PSIRF offers us the opportunity to learn and improve to promote the safe, effective and compassionate care of our patients, service users, their families and carers whilst also protecting the wellbeing of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead.

Patient Safety Incident Response Framework





How PSIRF is different

PSIRF represents a move away from the Serious Incident Framework which provided a structure and guidance on how to identify, report and investigate an incident resulting in severe harm or death. PSIRF should be thought of as a framework that allows for learning and improvement emphasising the system and culture to make that improvement sustained and keep our patients and service users safer.

Our Trust Vision is to provide Excellent Care With Compassion.

We firmly believe that implementing PSIRF will help us realise this vision. PSIRF also embodies a series of principles which match our Trust values.

Continuous improvement focuses on:

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

What will PSIRF mean?

Removal of the serious incident process does not mean do nothing, it means responding in the right way depending on the type of incident and associated factors;

We will respond to patient safety incidents using a systems based approach, responses do not take a 'person focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident;

Other processes such as claims, human resources or professional standards investigations and coronial inquests, for example, are outside the scope of PSIRF;

Our Trust Board will have increased accountability for the oversight of patient safety incident investigation through the following; Weekly Safety and Learning group meetings; Monthly Always Safety First Group meetings; Safety and Quality Board meetings.

Our incident prioritisation process

To fully implement PSIRF, the Trust has completed a review of what types of patient safety incident occur, to understand what needs to be learned from to improve.

We have consulted widely with internal and external stakeholders and with PSIRF early adopters to enable us to know our safety profile and identify our local priorities for review. With the publication of PSIRF documents in August 2022 we have been able to follow the national model in our approach.

We have used the key documents provided by NHS England to guide the development of our PSIRF Plan and Policy. Our plan sets out our response to the national priorities that NHS England has defined for us.

To decide upon our local priorities, we used the 'Guide to responding proportionately to patient safety incidents'. Our plan includes full details of the process we followed.

As well as looking at what incident and other data shows us about our safety profile, we have considered the resource we need to respond to incidents and how this can be organised to ensure a safe implementation of PSIRF across the Trust.

Incidents
65,845

Safeguarding concerns
2,380

Complaints
973

PALS concerns
4,508

Risks
476

Serious incidents
180

Mortality reviews
1,923

Claims
206

CQC enquiries
144

Friends and Family Test
104,913

Freedom to Speak Up concerns
2 years

Numbers in period from Sept 2021 to Sept 2023

PSIRF, our national priorities

PSIRF acknowledges that organisations have finite resources for patient safety incident response.

Some patient safety incidents will always require a full Patient Safety Incident Investigation (PSII) to learn and improve, whilst others may have a clearly defined specific reporting and / or review process.

These are listed as the national priorities below, along with our intended response as specified by NHS England.

1. Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) and Special Healthcare Authority referral criteria (referred to HSIB).
2. Child death (LTHTR PSII where required).
3. Death of a person who has lived with a Learning Disability or autism (LTHTR PSII where required).
4. Safeguarding incidents of the following types (referred to a local authority).
5. Babies, children or young people are on a child protection plan; looked after plan or a victim of wilful neglect domestic abuse / violence
   - Adults over 18 years old are in receipt
   - T of care and support needs from their local authority
   - The incident relates to female genital mutilation (FGM), Prevent(radicalisation to terrorism), modern slavery and human trafficking or domestic abuse / violence (referred to Safeguarding)
   - Domestic homicide (as guided by Police).
6. Incidents in screening programmes (referred to UK Health Security Agency).
7. Patient safety incidents meeting the Never Event criteria 2018 or its replacement (LTHTR PSII).
8. Death of patients in custody / prison / probation (referred to Prison and Probations Ombudsman / Independent Office for Police Conduct).
9. Deaths of patients detained under the MHA (1983) or where the MCA (2005) applies, where there is reason to think that the death may be linked to problems in care (LTHTR PSII).
10. Patient safety incidents resulting in death where the death is thought more likely than not to be due to problems in care (LTHTR PSII).

Our local priorities

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served.

Through our analysis of our patient safety insights, based on the review of incidents and engagement meetings and workshops we have determined that the Trust requires five patient safety priorities as our local focus.

We have selected this number due to the breadth of services that the Trust provides.

We will undertake a minimum of five index case PSII in each of the types of incidents proposed.

This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

We will use the outcomes of PSII to inform our patient safety improvement planning and work.

No.	Local Priorities	Response approach
1	Delayed recognition of a deteriorating patient, due to gaps in monitoring (including all pregnant women)	Patient Safety Incident Investigation
2	Delayed, missed or incorrect cancer diagnosis	Patient Safety Incident Investigation
3	Prescribing or administration error or near miss of anticoagulation medication	Patient Safety Incident Investigation
4	Adverse Discharge due to gaps in communication or misinformation	Patient Safety Incident Investigation
5	Delay in responding to a critical pathology finding	Patient Safety Incident Investigation

The Patient Safety Incident Response Framework can be seen on our webiste or scan the QR code.

To contact the PSIRF Team email **PSIRF@lthtr.nhs.uk**