

Board of Directors

Item 2.5

Subject: Patient Safety Incident Response Framework
Date of Meeting: 7th February 2023
Presented by: Karan Wheatcroft, Director of Risk and Improvement
Purpose of Report: To Note

BAF Ref	Impact on BAF
BAF 1	To provide assurance to the Board that implementation of the new Patient Safety Incident Response Framework is underway, with an update of progress within the Trust.

1. Executive Summary

The Patient Safety Strategy sets out what the NHS will do to achieve its vision to continuously improve patient safety. One part of the strategy is the introduction of the Patient Safety Incident Response Framework (PSIRF) which will replace the Serious Incident Framework (2015). The 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.

The implementation of PSIRF is much more than just a change in policy and this paper sets out the Trust's plan to implement PSIRF by Autumn 2023, and the steps taken thus far with regards to implementation.

The Board of Directors is asked to note the update and proposal that further assurances are provided through the Quality Committee.

2. Background

The 'Serious Incident' classification and its threshold (which has been in place since 2015) will be removed, and no distinction will be made between these and 'patient safety incidents'. PSIRF will not provide us with a framework that prescribes what we should investigate, instead it:

- advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents.
- embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Implementation of PSIRF will not be achieved by a change in policy alone, and it cannot be implemented in days or weeks as it requires work to design a new set of systems and processes, along with a cultural change in the way we identify and investigate incidents.

Introduction of the Patient Safety Incident Response Framework to improve the response to an investigation of incidents has been set out in key phases, each one sets out a guide to how LHCH should implement change and prepare for PSIRF transition. Organisations are expected to transition

to PSIRF within 12 months of its publication, and transition should be completed by Autumn 2023. The preparation guide breaks PSIRF preparation into six phases to ease transition and provide detail around discrete activities that will set strong foundations for implementing the framework.

There will be a strong focus on the importance of learning from what goes well, as well as identifying incidents, recognising the needs of those affected, undertaking meaningful analysis and responding to reduce the risk of recurrence to improve safety. The PSIRF will support the NHS to operate systems, underpinned by behaviours, decisions and actions, that assist learning and improvement, and allow organisations to examine incidents openly without fear of inappropriate sanction, support those affected and improve services.

3. Current stage of LHCH preparation and implementation

The Risk Management Lead Nurse will lead on the implementation, supported by the PSIRF implementation team. The core team includes the Director and Deputy Director of Nursing, Director of Risk and Improvement, Trust Patient Safety Lead, Divisional Directors of Nursing, Quality Improvement Lead, Head of Risk Management and the Risk Team.

The framework released in late August 2022 sets out a clear guide of what LHCH is expected to achieve and our plan to implement these over the next 12 months (See Appendix 1 timeline).

Stage 1 of the preparation plan (PSIRF orientation) has been completed, with an in-depth review of the supporting documents, orientation to the new framework both locally and nationally and awareness shared across a variety of forums.

As a Trust, LHCH are currently working within Stage 2 of the PSIRF Implementation Plan – Diagnostic and Discovery. This phase allows us to develop an in-depth understanding of our systems and processes, with response to patient safety incidents, for the purpose of learning and improvement and the alignment to PSIRF.

Working closely with the Quality Improvement Team, our current processes for patient safety incident responses are being mapped and discussed with those involved. Areas such as current Serious Incident processes, Freedom to Speak Up and Complaints have been reviewed and feedback received from those involved to distinguish any areas for improvement for the purpose of learning as well as the strengths of the current processes where they meet the PSIRF standards.

These findings will then be shared and discussed within the core PSIRF Implementation Team to support decision making.

Other key areas progressing are:

- the introduction of Patient Safety Partners (PSPs), a specific role which will continue LHCH's drive of establishing a good patient safety relationship with the Trust; welcoming a patient perspective on safer care. A Patient Safety Partner Policy has been written. PSPs will be involved in the Infection Prevention Committee and the Quality and Safety Committee, as well as involved in the revision of our current patient safety incident response and the writing of our PSIRF policy and plan. We have employed 3 PSPs to the Trust and we will be introducing them to the forums over the coming months.
- Training requirements are key as part of the transition, as LHCH deliver the NHS's first system-wide and consistent patient safety syllabus, training and education framework to our teams including:
 - Patient safety syllabus training campaign has been created to provide awareness to all staff of the new strategy and training involved. This will ensure staff and their line managers are prepared for the implementation of the training and the mandatory requirement.

- The Health Education England (HEE) patient safety training has been applied to ESR by our Education team, with relevant modules (dependant on roles) applied to staff members profiles. More modules are to be introduced over the coming months supporting the PSIRF systematic way of thinking with regards to patient safety. We are currently at 79% compliant across the Trust for Level 1 and 2 training. Syllabus module Levels 3-5 to be added in addition this month.
- We are currently in discussions with the Cheshire and Merseyside Integrated Care Board (ICB) PSIRF lead to establish a regional collaborative approach to procuring training on learning from patient safety incidents and to train a team of specific Patient Safety Incident Investigators (PSIIs). PSIIs will investigate incidents to the PSIRF standards and will carry out in-depth qualitative investigations on those that the Trust deem required, such as Never Events or incidents that the Trust believe learning and improvement can be achieved. Importantly, the framework will include three types of training:
 - ✓ two-day training courses in learning from patient safety incidents
 - ✓ one day training course in the oversight of learning from patient safety incidents
 - ✓ one day training course covering family and staff involvement alongside Duty of Candour

4. Incident Investigation changes under PSIRF

PSIRF will allow us to review our current processes on reporting incidents and how we learn from these going forward, with a focus on a systems based approach to the investigation. Discussions are currently underway regarding who will conduct Patient Safety Incident Investigations (PSII's) and therefore require the standardised training, with the assistance of subject matter experts as required; and overall Divisional responsibility remaining.

National Priorities such as Never Events will remain mandatory and continue to require a full investigation (PSII), as well as the Trust agreed Local Priorities, which will be areas an investigation is required for the purpose to learning and improvement. Under PSIRF only incidents posing the most significant of risks, incidents arising in particular defined areas, or exceptional cases with the most significant opportunity for learning, will be expected to have a formal investigation (PSII). It can also be used where factors contributing to an individual incident are not well understood.

Importantly, if an organisation and its ICB are satisfied that risks are already being appropriately managed and/or improvement work is ongoing to address known contributing factors in relation to an identified type of patient safety incident, it is acceptable under the PSIRF not to undertake an individual response to an incident (other than to engage with those affected and record that the incident occurred). This aspect of PSIRF is likely to take some getting used to, not least for patients and their families.

All other incidents can instead be addressed with a range of different tools from the national 'learning response toolkit', such as informal reviews, debriefs and training.

The amount of Serious Incidents (PSII's) will reduce in number under PSIRF, however due to the in-depth systematic nature of the investigations will mean they take longer to conduct, with a lot greater involvement and engagement of patients, relatives and staff.

5. Learning from Patient Safety Events Transition

Within the National Patient Safety Strategy, another key transition that LHCH will be required to go through is the replacement of the National Reporting and Learning System (NRLS) and StEIS with a new safety learning system - LFPSE (Learning From Patient Safety Incidents). This is an entire shift

in how incidents are uploaded and viewed by a wider audience nationally and will require work to be conducted adapting our incident reporting system to align with the LFPSE system. As a Trust, we have until September 2023 to transition to the new system.

The implementation of LFPSE is being managed separately to PSIRF but any interdependencies will be considered as this progresses. We are also currently in the process of business case approval to procure a new incident reporting system which will allow us to design and build our reporting system around the needs of the Trust and to ensure LFPSE compliance as well as supporting PSIRF.

6. Conclusion

When patients are harmed, it has an impact on them, their loved ones, our staff, and others who work in the healthcare system. It is crucial that all staff, whatever our roles, see safety not just as our collective *responsibility*, but as a key *priority*. We all need to *think differently* about what patient safety means and how we can make improvements.

Overall, we can make healthcare safer by: identifying and reducing risk before harm, creating a positive patient safety culture, building safer systems of care and recognising everyone's role in patient safety and learning from what goes well; which the new Patient Safety Strategy and frameworks will help us achieve.

The move to PSIRF is a huge change for NHS organisations which will require a large amount of planning, implementation and roll-out, as well as the drive and support for the transition itself over a period of 12+ months. It is vital that LHCH have a robust implementation plan and in addition to the high-level plan in Appendix A we are working with the Quality Improvement Team to work through a detailed project plan.

7. Recommendations

The Board of Directors is asked to note the Patient Safety Incident Response Framework implementation plan for LHCH, the progress updates and the recommended requirements for roll-out and transition by Autumn 2023. The proposal is for the Quality Committee to receive further updates and assurances throughout the implementation.

Appendix 1 – LHCH High Level PSIRF Implementation Plan

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