Quick reference guide to getting started with PSIRF

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This document is a quick reference guide to the various PSIRF documents and resources and is designed for Patient Safety Collaborative workstream leads to use as a resource with regional, ICB and provider leads. Please do send any updates or feedback through to nathalie.delaney@nhs.net

The most up-to-date version of this document will be on the Patient Safety Collaborative Workstream Leads FutureNHS site under **Resources.**

Contents

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1. Orientation

Patient Safety Incident Response Framework (PSIRF) was published on 16 August 2022 with a launch webinar on 5 September.

Key messages about PSIRF…

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.

- Replaces the Serious Incident Framework and removes the 'serious incident' classification and threshold for it.
- Embeds patient safety incident response within a wider system of improvement.
- Prompts a significant cultural shift towards systematic patient safety management.
- It does not mandate investigation as the only method for learning from patient safety incidents or prescribe what to investigate.

Overview of key PSIRF documentation

- PSIRF webpage – the PSIRF webpage is the central hub for all information about PSIRF. From this page you can find links to all PSIRF related documents and other resources.
- PSIRF preparation guide . This is an extremely helpful step by step guide for how to implement PSIRF across all levels of the system (Provider/ ICB/ NHSE/ PSC). There is also an interactive version.
- There are four supporting **guidance documents**:
  - Engaging and involving patients, families and staff following a patient safety incident
  - Guide to responding proportionately to patient safety incidents
  - Oversight roles and responsibilities specification
  - Patient safety incident response standards
- There are two supporting **templates** for the key outputs:
  - Patient Safety Incident Response Policy
  - Patient Safety Incident Response Plan

Supporting resources

- PSIRF podcasts:
  - Engaging with patients, families and staff.
  - Overview of training requirements
- PSIRF videos:
  - Animation (4 mins) provides a general overview of PSIRF and can be shared with colleagues to introduce them to the key concepts.
  - PSIRF Early adopter videos – four videos sharing the experience of some of early adopters in piloting PSIRF in their organisations over the last two years.

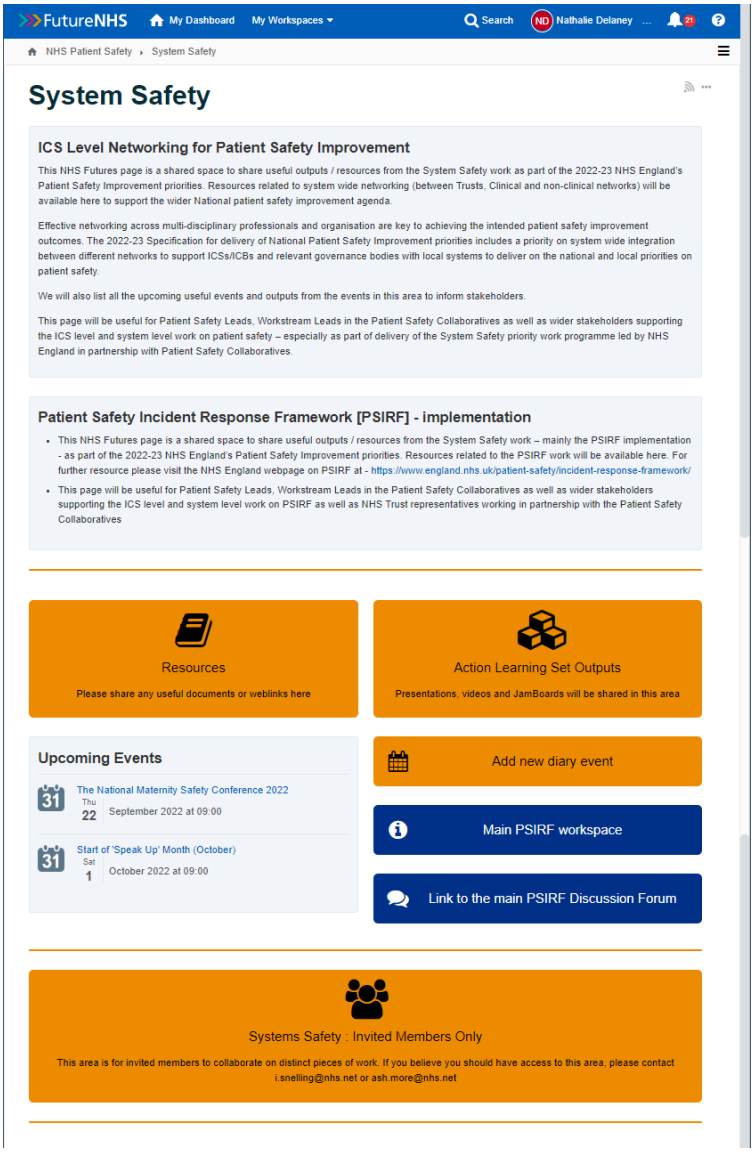
Some documents are only available via NHS Futures and include:

- PSIRF comms toolkit . A toolkit containing a range of key messages and template articles to support you to communicate about PSIRF within your organisation and to stakeholders. This

is found on the NHS Futures NHS Patient Safety page, under the PSIRF section, in the additional resources folder.

- PSIRF discussion forum where you can ask questions and share your experiences with people in organisations across England working to prepare for PSIRF.
- Responses to the questions from the PSIRF launch webinar
- Example Patient safety incident response plans
- Slides from a recent presentation to the North West and North Wales Coroners' Society Meeting
- Training procurement framework — NB HSIB (Healthcare Safety Investigation Branch) has a range of courses available at https://www.hsib.org.uk/investigation-education/our-courses/
- Plan on a page prep guide
- Project workbook

There is also a Patient Safety Collaborative Workstream Leads FutureNHS site



Please add resources that can be shared with a wider audience into the **Resources** folder, and anything that is only for workstream leads (for example if it contains contact details or sensitive information) into the **Invited Members only** section.

Definitions and terms used in the documents

PSIRF: Patient Safety Incident Response Framework

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients.

PSIRF Executive Lead is a provider board-level lead with specific responsibilities set out in the Oversight roles and responsibilities specification and competencies set out in the Patient Safety Incident Response Standards.

ICB Lead may be the person with overarching responsibility for quality or, more specifically, patient safety, e.g., an ICB patient safety specialist with specific responsibilities set out in the **Oversight roles and responsibilities specification** and competencies set out in the **Patient Safety Incident Response Standards**.

Patient safety incident investigation (PSII): A system-based response to a patient safety incident for learning and improvement. Typically, a PSII includes four phases: planning, information gathering, synthesis, and interpreting and improving.

SEIPS Systems Engineering Initiative for Patient Safety replaces the contributory factors classification framework. This is made up of six factors or elements that when considered together cover all elements of a 'system.' All the national PSIRF tools are based on SEIPS.

Learning response. Any response to a patient safety incident that incorporates a system-based approach to capturing learning to inform safety actions for improvement. This may be a patient safety incident investigation, but other methods can be used such as multidisciplinary team debriefs, huddles and after-action reviews. A final report should be produced for all individual Patient Safety Incident Investigations (PSII).

Those affected include staff and families in the broadest sense; that is: the person or patient (the individual) to whom the incident occurred, their family and close relations. Family and close relations may include parents, partners, siblings, children, guardians, carers, and others who have a direct and close relationship with the individual to whom the incident occurred.

Engagement lead is anyone who leads on engaging with and involving those affected by a patient safety incident. This may be a person leading a learning response or a family liaison officer (or similar).

Engagement is everything an organisation does to communicate with and involve people affected by a patient safety incident in a learning response. This may include the Duty of Candour notification or discussion, and actively engaging patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened. **Compassionate engagement** describes an approach that prioritises and respects the needs of people who have been affected by a patient safety incident.

Involvement is part of wider engagement activity but specifically describes the process that enables patients, families, and healthcare staff to contribute to a learning response.

Everyday work describes the reality of how work is done and how people performing tasks routinely adjust what they do to match the ever-changing conditions and demands of work.

The four key principles behind PSIRF…

Compassionate engagement and involvement of those affected by patient safety incidents.

Application of a range of **system-based approaches** to learn from patient safety incidents.

Considered and proportionate responses to patient safety incidents.

Supportive oversight focused on strengthening response system function and improvement.

The two key output documents are:

Produced by each **provider** (engaging with relevant **stakeholders**) and signed off by **providers**, and **ICB** leads.

- Patient Safety Incident Response Policy
- Patient Safety Incident Response Plan

The policy document covers cross-cutting themes:

- Patient Safety Culture
- Patient Safety Partners
- Addressing Health Inequalities
- Engaging and involving patients, families and staff following a patient safety incident

The policy document describes how the provider will develop the **Patient Safety Incident Response Plan**, how they will **respond to patient safety incidents**, sets out **oversight roles and responsibilities** and the process for complaints and appeals.

Key messages about who PSIRF applies to and by when…

- All providers contracted under the NHS standard contract have been asked to begin preparing to transition to PSIRF from 1 September 2022.
- Preparation is expected to take 12 months with organisations transitioning to PSIRF by Autumn 2023.
- Following transition organisations will continue to learn and evolve over future years.
- Primary care providers may also wish to adopt PSIRF, but it is not a requirement at this stage.

Key people in implementation and oversight of PSIRF are:

- Provider boards and the **PSIRF Executive Lead**.
- Integrated Care Boards and the **ICB Lead**.
- NHS England regional **PSIRF lead**.

The guidance documents also set out standards and approaches for **learning response leads** and those working directly with people affected by patient safety incidents (**engagement leads**).

There is a much wider stakeholder map including:

- Perinatal quality surveillance and improvement — board-level maternity safety champions, Local maternity, and Neonatal Systems, and regional Midwifes.
- Interfaces with other organisations including CQC, HSIB, coroners, medical examiners, NHS England Regional Independent Investigation Teams.
- Arrangements for peer support and review.
- Plus, others!

2. Suggested pathways to familiarise yourself with the key documents

There is a lot of information available in the PSIRF and support guidance. The following pathways are suggested to guide you through the key parts of the documents that apply to your role.

PSIRF executive leads

1. If not already done, complete Patient Safety Syllabus levels 1 and 2 eLearning.
2. Watch the introductory animation and read the introductory PSIRF document.
3. You may find it helpful to have a copy of the Patient Safety Incident Response standards and Patient Safety Incident Response Policy as key documents to cross-reference to as you read the guidance documents.
4. Start by reading the Oversight roles and responsibilities specification. p7. **Organisational responsibilities** is a helpful diagram in understanding roles, responsibilities, and relationships across the system. Cross-reference to the Patient Safety Incident Response standards sections 10 and 11.
5. Then read **Part A** of the guide to engaging and involving patients, families and staff following a patient safety incident.
6. Read an introduction to the SEIPS framework if this is not familiar to you.
7. Read Guide to responding proportionately to patient safety incidents in particular **Appendix A** and p7-11 which sets out planning guidance for completing the organisational Patient Safety Incident Response Plan. p12-19 sets out guidance on different system-based learning responses and cross-references to the learning response toolkit .
8. Review the preparation guide p9-27.
9. Start to plan to complete any gaps in the training requirements for role (set out p15 and 16 of Patient Safety Incident Response standards) as needed.

ICB leads

1. If not already done, complete Patient Safety Syllabus levels 1 and 2 eLearning.
2. Watch the introductory animation and read the introductory PSIRF document.
3. You may find it helpful to have a copy of the Patient Safety Incident Response standards and Patient Safety Incident Response Policy as key documents to cross-reference to as you read the guidance documents.
4. Start by reading the Oversight roles and responsibilities specification. p7. **Organisational responsibilities** is a helpful diagram in understanding roles, responsibilities, and relationships across the system. Cross-reference to the Patient Safety Incident Response standards sections 10 and 11.
5. Then read **Part A** of the guide to engaging and involving patients, families and staff following a patient safety incident.
6. Read an introduction to the SEIPS framework if this is not familiar to you.
7. Read Guide to responding proportionately to patient safety incidents in particular **Appendix A** and p7-11 which sets out planning guidance for completing the organisational Patient Safety Incident Response Plan.
8. Review the preparation guide p28-36.

9. Start to plan to complete any gaps in the training requirements for role (set out p15 and 16 of Patient Safety Incident Response standards) as needed.

Engagement leads

1. If not already done, complete Patient Safety Syllabus levels 1 and 2 eLearning.
2. Watch the introductory animation and read the introductory PSIRF document.
3. Read the whole of the Guide to engaging and involving patients, families and staff following a patient safety incident and cross-reference to Patient Safety Incident Response standards sections 8 and 9, as well as 12 and 13 and access Learn Together downloads.
4. Start to plan to complete any gaps in the training requirements for role (set out p15 and 16 of Patient Safety Incident Response standards) as needed.
5. Read an introduction to the SEIPS framework if this is not familiar to you.
6. Read Patient Safety Incident Investigation guide for an overview of the process.

Learning response leads

1. If not already done, complete Patient Safety Syllabus levels 1 and 2 eLearning.
2. Watch the introductory animation and read the introductory PSIRF document.
3. Read an introduction to the SEIPS framework if this is not familiar to you.
4. Read the Guide to responding proportionately to patient safety incidents and cross-reference to Patient Safety Incident Response standards sections 4 to 8 and 14 to 17.
5. Cross-reference p12-19 of Guide to responding proportionately to patient safety incidents where needed to the learning response toolkit .
6. Read Patient Safety Incident Investigation guide for an overview of the process.
7. Read **Part B** of Guide to engaging and involving patients, families and staff following a patient safety incident and access Learn Together downloads.
8. Start to plan to complete any gaps in the training requirements for role (set out p15 and 16 of Patient Safety Incident Response standards) as needed.

Perinatal specific guidance:

There are some key parts of the documents that may be of interest to those working in perinatal quality and safety:

- Oversight roles and responsibilities specification.
- Appendix B (p24) of Guide to responding proportionately to patient safety incidents.

Patient Safety Collaborative Workstream leads

1. If not already done, complete Patient Safety Syllabus levels 1 and 2 e-learning.
2. Watch the introductory animation and read the introductory PSIRF document.
3. Read an introduction to the SEIPS framework if this is not familiar to you.
4. Have a high-level overview of the key guidance documents and supporting resources to be able to signpost people towards (see summary below).

3. Summary of guidance documents

Compassionate engagement and involvement of those affected by patient safety incidents.

Key resource: — hub including the guide itself, podcast, patient story videos and supporting guidance including Learn Together downloads (patient/ family information, investigator guidance, staff information, and an investigation resource. These are *draft* versions but available to download and use.)

Compassionate engagement describes an approach that prioritises and respects the needs of people who have been affected by a patient safety incident. Those affected: includes families AND staff in the broadest sense.

Those affected by a patient safety incident may have a range of needs (including clinical needs) as a result and these must be met where possible.

This is part of our duty of care.

Engaging with those affected by a patient safety incident improves our understanding of what happened, and potentially how to prevent a similar incident in future.

- **Part A: Creating the right foundations** is for those responsible for PSIRF implementation and in system oversight roles. Summary one-page version.
- **Part B: Engagement and involvement** is aimed at those working directly with people affected by patient safety incidents (e.g., learning response leads and family liaison officers). Summary one-page version.

Engagement principles:

1. Apologies are meaningful.
2. Approach is individualised.
3. Timing is sensitive.
4. Those affected are treated with respect and compassion.
5. All communications and materials need to clearly describe the process and its purpose, and not assume any prior understanding.
6. Those affected are 'heard.'
7. Approach is collaborative and open.
8. Subjectivity is accepted. Everyone will experience the same incident in different ways.

9. Strive for equity.

Creating the right foundations

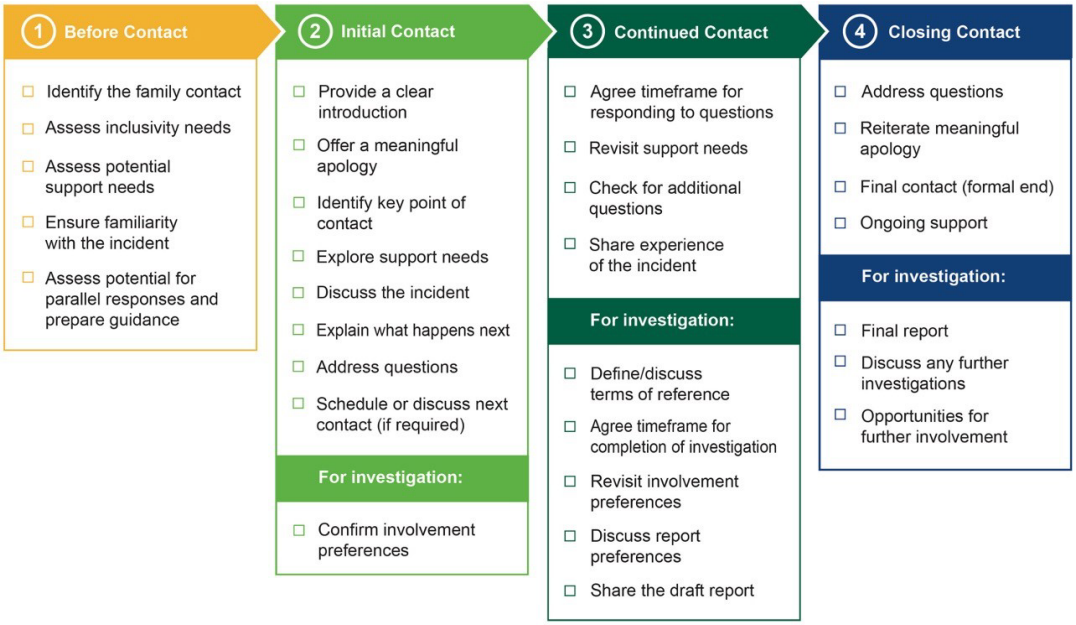
Seven areas are set out for consideration to create the right conditions:

1. Leadership.
2. Training and competencies.
3. Support systems.
4. Ensuring inclusivity.
5. Information resources.
6. Processes for seeking and acting on feedback.
7. Processes for managing dissatisfaction.

Engagement and involvement process

Guidance is given for the four key stage of engagement, noting that not all steps may be required, some steps may be repeated, and the process may not be as linear as implied.

Engagement and level of involvement must be in keeping with the wishes of those affected as far as possible.



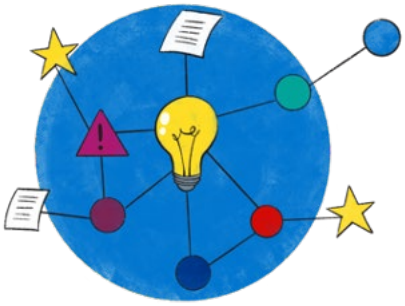
Additional considerations

The third part of the guide gives practical guidance on some areas that may be considerations at any stage of the process:

- Risk assessment throughout engagement.
- Keeping good records.
- Addressing communication barriers.
- Using language services.

- When communication breaks down.
- Consideration and interfaces with other responses including complaints, fitness to practice, HSE (Health and Safety Executive) investigations, HSIB (Healthcare Safety Investigation Branch), Coroner's Inquests, Litigation, NHS Resolution, Police investigations, social services.
- Media involvement.
- Working with representatives and indirect communication.
- When attempts to contact family or staff are unsuccessful.
- Further reading and references.
- Example survey question for seeking feedback after patient safety incident investigations and engagement.

Application of a range of system-based approaches to learn from patient safety incidents.



Key documents: Patient safety incident response standards and Guide to responding proportionately to patient safety incidents.

All the national PSIRF tools are based on the SEIPS framework (**Systems Engineering Initiative for Patient Safety**). therefore, if this framework is not familiar to you it may be helpful to read the first.

See also SEIPS 2.0: A human factors framework for studying and improving the work of healthcare professionals and patients

How is the PSIRF approach different to RCA?

- Recognise outcomes result from interactions between multiple factors not one single root cause
- Does not distinguish between care and service delivery problems – explores contributory factors (including 'individual acts') in the context of the whole system
- Tools explore interacting contributory factors rather than a single linear pathway
- SEIPS replaces the contributory factors classification framework

The learning response toolkit contains a range of tools and templates which will be useful to **learning response** and **engagement leads**:

Patient safety incident investigation report template. This should be adopted unamended.

An overview of SEIPS (quick reference guide and work system explorer). SEIPS is a framework for understanding outcomes within complex sociotechnical systems. SEIPS blank template .

Four tools are available to help in the initial stages of a learning response:

- Information gathering log
- Stakeholder map (simple)
- Stakeholder map (visual)
- Terms of reference (ToR) for investigation template

Four guides to help to inform a response to a patient safety incident or cluster of incidents:

- After action review
- Multidisciplinary team review

- Patient safety incident investigation overview — A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.
- Swarm huddle – Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.

Understanding **everyday work**. Everyday work describes the reality of how work is done and how people performing tasks routinely adjust what they do to match the ever-changing conditions and demands of work.

Four guides are available to support the exploration of everyday work:

- Interview tool
- Brief guide to link analysis
- Brief guide to conducting observations
- A brief guide to walkthrough analysis

Patient safety risks or **broad patient safety issues** may benefit from focused improvement efforts rather than further incident responses. Two tools are available to enable organisations to respond:

- Thinking thematically: top tips for completing a thematic review
- Horizon scanning tool

Two tools are available to support information gathering and synthesis of information:

- Timeline mapping
- Work system scan

Safety action development starts by identifying and agreeing those aspects of the work system where change could reduce risk and potential for harm (i.e., 'areas for improvement' or system issues). Actions to reduce risk (i.e., safety actions) are then generated in relation to each defined area for improvement. Following this, measures to monitor safety actions and the review steps are defined.

- Safety action development guide
- SHARE debrief tool

It may also be helpful to refer to the Just Culture guide as appropriate.

- Just culture one page guide.
- Scenarios to support training in using a just culture guide.

Considered and proportionate responses to patient safety incidents.

- Key document: Guide to responding proportionately to patient safety incidents.
- Appendix A (p19) sets out types of events that require a specific type of response as set out in policies or regulations.
- p7-11 sets out planning guidance for completing the organisational Patient Safety Incident Response Plan.
- p12-19 sets out guidance on different system-based learning responses and cross-references to the learning response toolkit .

Using incident response resources to maximise improvement, rather than repeatedly responding to patient safety incidents based on a threshold of 'seriousness' where learning may be limited.

PSIRF does not change any expectations in relation to patient safety incident recording.

Some patient safety incidents, such as Never Events and those meeting the Learning from Deaths criteria for investigation all require specific recording and/or review processes to be followed.

PSIRF sets no further thresholds to determine what needs to be learned from to inform improvement.

It is acceptable to NOT undertake an individual response to an incident (other than to engage with those affected and record that the incident occurred) Some guidance for small providers:

- The way you approach planning may vary
- You may choose to partner with larger organisation(s) you are associated with already (you may have your own section/sub section within an overarching plan)
- You may be supported by a national planning effort where a national contract is in place
- You might plan with other small providers offering similar care in your area (this could allow resources to be pooled)
- Data may be limited BUT you can still think about which systems-based response methods to use and when.
- You can use this opportunity to focus on issues where incidents have not yet occurred too!

Supportive oversight focused on strengthening response system function and improvement.

Key resource: Oversight roles and responsibilities specification.

p7. **Organisational responsibilities** is a helpful diagram in understanding roles, responsibilities, and relationships across the system.

Organisations should uphold the patient safety incident response standards to ensure they meet the minimum expectations of the Patient Safety Incident Response Framework (PSIRF).

Standards cover the following aspects of PSIRF:

- Planning, policy, and oversight
- Competency and capability
- Engagement and involvement of those affected by patient safety incidents - Proportionate responses

The document describes key actions for:

- Providers of NHS-funded care.
- Integrated Care Boards.
- NHS England regional teams.

The document also describes how support networks (including Local Maternity and Neonatal Systems), and Care Quality Commission (CQC) fit within the oversight structure as well as interfaces with Healthcare Safety Investigation Branch (HSIB), Coroners, Medical Examiner system, and arrangements for peer review.

When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures."

Aim for **engagement and empowerment** rather than command and control.

p3 Mindset principles:

1. Improvement is the focus.
2. Blame restricts insight.

3. Learning from patient safety incidents is a proactive step towards improvement.
4. Collaboration is key.
5. Psychological safety allows learning to occur.
6. Curiosity is powerful. p4. **Oversight approach**:
1. Use a variety of data.
2. Reduce the information collection burden.
3. Oversight is not 'one size fits all.'
4. Capture meaningful insight from patients, families, and staff.
5. Metrics require clarity and purpose.
6. Be aware of perverse incentives.

Supporting documents:

- A framework for measuring and monitoring safety.

Other resources that may be helpful

- Presentation from Early Adopter Christopher Brooks-Daw at North Bristol NHS Trust
- Yorkshire Contributory Factors Framework https://www.improvementacademy.org/resource/yorkshire-contributory-factorsframework/
- Second victim support https://secondvictim.co.uk
- Civility Saves Lives https://www.civilitysaveslives.com
- Psychological Safety https://psychsafety.co.uk
- RCOG (Royal College of Obstetricians and Gynaecologists) safety thinking toolkit https://www.rcog.org.uk/about-us/groupsand-societies/the-rcog-centre-for-quality-improvement-and-clinical-audit/each-baby-counts-learn-support/safety-thinking-toolkit/
- Humanistic Systems varieties of human work series https://humanisticsystems.com/2020/10/28/proxies-for-work-as-done-1-work-asimagined/ and https://humanisticsystems.com/series/
- Learning from Excellence https://learningfromexcellence.com

4. Some questions to get you started

Questions for PSIRF executive leads in providers

- Provider focus = PSIRF implementation (and operationalisation with other factors, e.g., LFPSE).
- Who is in your implementation team?
- Who is your sponsor on the Board?
- How are you planning to hold the full/ ½ day session reflecting and planning? (Do you want help with that?)
- Who is your ICB lead?
- Do you have the resources you need?
- Any gaps/ barriers/ issues?
- Stakeholder mapping, key messages, and comms plan
- What is your plan for 3–6-month diagnostic/ discovery phase
- Some assessment of their baseline knowledge/ confidence in Safety II and core concepts (e.g., work as imagined vs work as done, just culture)

Questions for ICB leads

- ICB focus = provider implementation and cross-system incidents Do you have contacts in all providers?
- Are you trained up to the level specified in the guidance?
- Where/ how are you going to stay in contact and connect with all providers in your region?
- Who else needs to know in your ICB (comms and engagement plan) e.g., LMNS/ safeguarding?
- How will you know where all your providers are in implementation?
- How are you going to coordinate in your role looking at cross-system incidents? What happens now?

Questions for NHSE regional leads

- Regional focus: communication and coordination with wider NHS system (i.e., outside of PSS structures), governance
- Do you have a list of all ICB contacts?
- How will ICB leads connect and share experience and progress?
- How will you know where all ICBs are in their implementation?
- How and where is this reporting into system quality group/ regional quality/ other groups in your structure?
- Who else needs to know and be informed? e.g., specialist commissioners, regional chief midwife
- Who else is in our wider network beyond (PSC/IBC/regional/provider) PSIRF leads?

5. Answers to some FAQs

How does PSIRF interact with other parts of the National Patient Safety Strategy?

- **Incident reporting**. Learn From Patient Safety Events service (LFPSE) will replace reporting to the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS). Until this time, all patient safety incidents must be reported to NRLS via the trust's local risk management system and all patient safety incidents for which an independent or provider led PSII is undertaken must be reported to StEIS. Once an organisation starts reporting to LFPSE it only needs to make one incident report.
- **Patient Safety Specialists** are individuals in healthcare organisations (in NHS providers and CCGs, but also in some independent providers and arms-length bodies) who have been designated to provide dynamic senior patient safety leadership. Patient Safety Specialists have been asked to support several priorities, including local implementation of PSIRF.
- **Patient Safety Partners**. The NHS Patient Safety Strategy includes the ambition for all safety-related clinical governance committees (or equivalents) in NHS organisations to include two PSPs by June 2022, and for them to have received the required training by June 2023. Wherever possible, patient safety partners should be involved in co-producing the design, delivery, and review of the processes in the PSIRF guidance. See **Framework for involving patients in patient safety** and practical guidance to support recruitment and training of PSPs is available on NHS Futures at https://future.nhs.uk/ NHSps/view?objectId=33508304.
- **See also the FAQ from 5 September launch event**