CityCare

POLICY

Patient Safety Incident Response Framework Policy

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If the review date of this policy or procedure has expired staff should seek advice from their clinical lead or manager regarding the appropriate action to be taken.

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1. Introduction, Background and Purpose

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. PSIRF replaces the Serious Incident Framework (2015) and is a contractual requirement and is mandatory for providers of NHS-funded care. All providers are expected to transition to PSIRF by autumn 2023. This paper presents CityCare's response to PSIRF.

PSIRF is a core element of the NHS Patient Safety Strategy and establishes the NHS's approach to the development and maintenance of mechanisms for responding to patient safety incidents (PSIs) to maximise learning and improvement.

PSIRF is less prescriptive than the Serious Incident Framework and encourages learning from patient safety incidents, no longer differentiating between patient safety incidents and serious incidents. Two of the main differences between PSIRF and the Serious Incident Framework are that:

- PSIRF allows for all incidents to be investigated and for learning response resources to focus on areas with the greatest potential for patient safety improvement.
- It does not mandate investigation as the only method for learning from patient safety incidents or prescribe what to investigate.

NHS healthcare organisations are expected to take up to 12 months to transition to PSIRF. To comply with the PSIRF, organisations must develop an understanding of their patient safety incident profile, ongoing safety actions in response to investigation recommendations, as well as established programmes of improvement. To facilitate this, organisations will be expected to collect information from a multitude of sources, including broad engagement with relevant stakeholders. This analysis and engagement have led to the development of the organisation's Incident Policy and Patient Safety Incident Response Plan, which are two key components providers are required to produce for PSIRF. Similarly, the Patient Safety Incident Response Plan (PSIRP) must also comply with the national guidance.

The Patient Safety Incident Response Plan identifies:

- the patient safety themes.
- the improvement work to address the themes.
- the responses to patient safety incidents.
- organisational priorities for patient safety incident investigations (the most in-depth investigation) in addition to the mandated incidents for patient safety incident investigations
- network patient safety improvement plans.
- how the organisation will measure whether the PSIRP (plan) is effective.

The PSIRF oversight standards set out the executive lead responsibilities:

- Ensure the organisation meets national patient safety incident response standards.
- Ensure PSIRF is central to overarching safety governance arrangements.
- Quality assure learning response outputs.
- The Integrated Care Boards (ICB) are required to approve and sign off incident response policies and plans.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- 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.
- Supportive oversight focused on strengthening response system functioning and improvement.

2. Abbreviations and Definitions

AAR – After Action Review/Report
CDOP – Child Death Overview Panel
ICB – Integrated Care Board
LfPSE – Learning from Patient Safety Events (*supersedes NRLS*)
LRL – Learning Response Lead(s)
LRMS – Local Risk Management System
NRLS – National Reporting and Learning System
PIDS – Post Incident Debrief
PFA – Psychological First Aid
PSIRF – Patient Safety Incident Response Framework
PSP – Patient Safety Partner
PSIRP(s) - Patient Safety Incident Response Plan/Policy
PSI – Patient Safety Incident
PSII – Patient Safety Incident Investigation
PEACE - Planning/Preparation, Engage/Explain, Account, Closure, Evaluation
RCA – Root Cause Analysis
RLR – Rapid Learning Review
RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SEIPS – Systems Engineering Initiative for Patient Safety. An investigation tool that takes a systems approach.
SLA – Service Level Agreement
SMART - Specific, Measurable, Achievable/Action-related, Relevant, Time-specific
StEIS – Strategic Executive Information System
Systems approach - Involves an examination of the components of a system - including a person(s), tasks, tools and technology, the environment, and the wider organisation – to gain a deeper understanding of how their interdependencies might impact patient safety. Uses tools to explore multiple interacting contributory factors rather than forcing a single analytical pathway so does not use root cause analysis.

3. Evidence Base and Interaction with Other Policies and Procedures

List any local or national guidelines this document has been developed in accordance with and reference any other relevant documents.

4. Scope and Responsibilities

This policy applies to all staff working for the organisation including agency, bank, students,

and contractors.

The PSIRF policy is specific to patient safety event responses conducted solely for the purpose of learning and improvement across the organisation.

This policy applies to all permanent and temporary staff employed, those with honorary contracts or those working under contract for services or under service level agreement, within the organisation.

Responsibility for oversight of the PSIRF sits with the Board. The Executive Lead is the Director of Nursing and AHPs and Quality and has responsibility for effective monitoring and oversight of PSIRF. CityCare is committed to close working, in partnership, with the ICB and other national commissioning bodies as required. Representatives from the ICB will be invited to sit on PSIRF implementation groups.

There are specialist roles in CityCare to support and provide expert advice for patient safety incidents.

- Head of Quality (Patient Safety Specialist) and Medical Devices Officer/CAS alerts
- Quality Lead (Patient Safety Specialist)
- Head of Infection Prevention and Control
- Head of Medicines Management
- Head of Tissue Viability

Service responsibility
Deputy Directors of Operations
Assistant Directors of Clinical Services
Heads of Service

5. Policy

Patient Safety Partners

The Patient Safety Partner (PSP) is a new and evolving role outlined in the national Patient Safety Strategy (2019) to help improve patient safety across the NHS in the UK.

The organisation is working towards developing the role of the PSPs who will offer support alongside our staff, patients, families/carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

This exciting new role across the NHS will evolve during the transition phase and the main purpose of the role is to be a voice for the patients and community who utilise our services, those that provide assisted living support for service users and to ensure that patient safety is at the forefront of all that we do.

PSPs can act as ‘knowledge brokers’ as they may often have insight as a user of services across different parts of the NHS, or may have experience of avoidable harm, and can therefore help inform learning and holistic safety solutions that cross organisational boundaries. They provide a different perspective on patient safety, one that is not influenced by organisational bias or historical systems. By reinforcing the patient voice at all levels in an organisation and across integrated care systems, PSPs can support a patient-centred approach to safer healthcare. The organisation welcomes the insight and experience that PSPs will contribute to CityCare’s governance and management processes for patient safety.

Addressing Health Inequalities

Health inequalities are avoidable, unfair, and systematic differences in health between different groups of people. The term is also used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives (Williams et al, 2022).
Health inequalities can affect those with protected characteristics under the Equality Act, 2010 and those in social inclusion groups (NHSE, 2024). Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement for both adults and older adults and children and young people.

On 27 November 2023 NHS England (NHSE) published a statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006). The purpose of the statement is to help providers and Integrated Care Boards (ICBs) identify key data and information on health inequalities and outline how they have responded to this information within their annual reports.
The organisation is committed to delivering on its statutory and regulatory obligations in this area. This allows us to demonstrate we are discharging our duties related o health inequalities under the National Health Service Act 2006, Equality Act 2010, and the Social Care Act (2012).

Engaging and Involving Patients, Families and Staff following a Patient Safety Incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). Compassionate engagement and involvement mean working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident, and signpost them to support as required. When a patient safety incident investigation or other learning response is undertaken, we will meaningfully involve those affected, where, and how, they wish to be involved.

The organisation is committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence. CityCare recognises and acknowledges the significant impact patient safety incidents can have on patients, their families, carers, and staff.

Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide. Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.

As well as meeting regulatory and professional requirements for Duty of Candour, the organisation will be open and transparent with patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident. Saying sorry is always the right thing to do. It is not an admission of liability. It acknowledges that something could have gone better and is the first step to learning from what happened and to prevent it happening again.

Supporting Staff

When things go wrong in healthcare, the staff who are involved can be impacted significantly. The emotions and stress involved can impact their health and ability to continue to work. Following any patient safety incident, managers should offer immediate support to the team through appropriate debriefing with the team and re-assurance to staff.

Senior managers may feel it appropriate to refer individual staff or a team to the Post incident debrief service (PIDS) delivered by the organisation's psychology team.

There is an Employee Assistance Programme (EAP) which offers 24/7 support including:

- Counselling (up to eight face-to-face sessions or telephone support)
- Rapid access to mental health services for acute distress

Patient Safety Incident Response Planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. There are nationally set requirements for incidents that require investigation. In addition, CityCare will explore patient safety incidents relevant to its context and the population rather than only those that meet a certain defined threshold. These have been prioritised and are set out in the organisation's Patient Safety Incident Response Plan (PSIRP) which can be found on the policies and procedures section of the intranet page.

CityCare will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising safety improvement. To fulfil this, the organisation has undertaken planning of is current resource for patient safety responses and existing safety improvement workstreams. The organisation has undertaken analysis of patient safety data from a variety of sources both qualitative and quantitative to identify its safety culture position.

The focus will be on areas where there is the greatest potential for learning by using alternative responses to facilitate efficient and effective practice.

Resources and Training to Support Patient Safety Incident Response
The Quality and Governance function will host a professional panel of patient safety incident investigators who are formally educated in SEIPS (Systems Engineering Initiative for Patient Safety) methodologies and compliant with PSIRF Standards in leading on all Alternative Responses.

The Learning Response Leads led by Governance will be a central resource for Care Group based Learning Response Leads to work in collaboration to co-produce systems thinking/Safety II PSIIs for the purpose of identifying immediate safety improvements to prevent recurrence and control emerging patient safety risks.

The Care Group based Learning Response Leads will have continual professional development in SEIPS methodologies, which will ensure proactive safety improvement plans are sustainably generated following Care Group scrutiny of all local patient safety event data; regardless of reporter grading, as per PSIRFs data driven approach to learning from all safety events.

Patient Safety Incident Response Framework Plan (PSIRP)

Patient Safety Incident Response Framework Plan (PSIRP) sets out how the organisation will respond to patient safety incidents. It outlines the patient safety priorities for CityCare and the types of learning responses that will be undertaken over the next 12-18 months. The plan is agile and is a living/working document that allows for flexibility and consideration for specific circumstances in which patient safety events have occurred and the needs of those affected.

The Patient Safety Incident Response Framework Plan (PSIRP) is available on the organisation's website for all staff and public to view.

Training Requirements

CityCare has a PSIRF training needs analysis (TNA) that details all relevant roles within the organisation and the type and level of training required. Compliance with the TNA will be monitored and reported into the Quality and Patient Safety Group via the monthly PSIRF Positional Report.

Reviewing of Patient Safety Incident Response Policy and Plan

The PSIRF Policy will have a rigorous planning exercise undertaken every three years or more frequently if appropriate (as agreed with our Integrated Care Board – ICB).
The PSIRF Plan will be reviewed as per the Patient Safety Incident Response Framework Plan section above.

Patient Safety Incident Reporting Arrangements

All staff have access to the organisation's local risk management system (LRMS) to report all patient safety events.

As per the CityCare Patient Safety Incident Reporting and Management Standard Operating Procedure all staff are responsible for reporting near miss and actual patient safety events and managing them in accordance with this and other associated arrangements (for example Duty of Candor).

Patient Safety Incident Response Decision making

Patient safety incident response decision making is divided into two categories – nationally and locally defined as detailed in the PSIRF Plan. Below is a breakdown:

- National – All incident types that have been nationally defined as requiring a specific response.
- Local – All incident types based on the patient safety priorities as described in the local focus section of the PSIRF Plan.

The plan details the learning response to each safety event in the above categories to facilitate decision making and the timeframes for completion.

Safety Action Development and Monitoring Improvement

The organisation acknowledges that any form of patient safety learning response (PSII or review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed.

CityCare has systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. The organisation will generate safety actions in relation to each of these defined areas for improvement. Following this, the organisation will have measures to monitor any safety action and set out review steps. The Patient Safety Incident Triage Panel Groups will monitor local or Care Group safety actions. The CityCare Quality and Patient Safety Group will maintain oversight of any organisation-wide safety actions.

To achieve successful improvement, safety action development will be completed in a collaborative way with a flexible approach from Care Groups and the support of the Quality Team to utilise their expertise.

Safety Action Development

CityCare will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows.

1. Agree areas for improvement – specify where improvement is needed, without defining solutions.
2. Define the context – this will allow agreement on the approach to be taken to safety action development.
3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved.
4. Prioritise safety actions to decide on testing for implementation.
5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics.
6. Safety actions will be clearly written and follow SMART principles and have a designated owner.

Safety Action Monitoring

Safety actions must continue to be monitored within the Care Group governance arrangements to ensure that any actions put in place remain impactful and sustainable. This will have oversight by the Quality and Patient Safety Group cycle of business.

Safety Improvement Plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. CityCare has several overarching safety improvement plans in place which are adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes.

The organisational patient safety incident response plan has outlined CityCare's priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where we believe the additional learning could be found that would be able to feed into existing improvement plans and programmes.

CityCare will use the outcomes from patient safety incident investigations, previously completed root cause analyses (RCAs), and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work. The Care Groups will work collaboratively with the Quality Team and others to ensure there is an aligned approach to development of plans and resultant improvement efforts.
Where overarching system issues are identified by learning responses outside of CityCare's local priorities, a safety improvement plan will be developed.

Safety improvement plans will be a mixture of approaches depending on the incident. CityCare will:

- Create an organisation-wide safety improvement plan summarising improvement work.
- Create individual safety improvement plans that focus on a specific service, pathway, or location.
- Collectively review output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues
- Utilise SEIPS methodology to address broad system issues including the PEACE model (Planning/Preparation, Engage/Explain, Account, Closure, Evaluation)

Whichever approach is taken the rationale for that approach will be fully explained in the learning response process and agreed with stakeholders.

6. Equality & Diversity

CityCare is committed to embracing diversity and embedding inclusion in all aspects of our business, in relation to the communities that we serve and staff at all levels within the organisation. CityCare recognises and endorses responsibilities placed on us by equality and diversity legislation, and is fully committed to promoting equality, diversity and inclusion whilst achieving the elimination of unlawful discrimination. We recognise that in valuing and investing in our staff we will grow a positive, motivated workforce, working to build healthier communities and deliver the best possible outcomes for the people that we provide services to.

Less favourable treatment of anyone on the grounds of their age, disability, gender, marital status, being pregnant or on maternity leave, race/ethnicity, religion or belief, sexual orientation, gender reassignment, responsibility for dependents, trade union or political activities, or any other reason which cannot be shown to be justified will not be tolerated. Positive action may be taken to improve the diversity of our workforce to reflect the city's population and to encourage people from protected groups to participate where their level of participation is disproportionately low. (Equality and Diversity Policy 2023)

Equality Impact Assessment Form (Short)

		YES/NO	COMMENT
1.	**Does the policy affect one group less or more favourably than another on the basis of:**		
	Age	N	
	Disability – learning disabilities, physical disability, sensory impairment and mental health problems	N	
	Gender Reassignment	N	
	Marriage/Civil Partnership	N	
	Pregnancy/Maternity	N	
	Race	N	
	Religion or Belief	N	
	Sex	N	
	Sexual Orientation	N	
2.	**Is there any evidence that some groups are affected differently?**	N	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	NA	
4.	**Is the impact of the policy/guidance likely to be negative?**	NA	
5.	**If so, can the impact be avoided?**	NA	
6.	**What alternatives are there to achieving the policy without the impact?**	NA	
7.	**How can the impact be reduced by taking different action?**	NA	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the sponsoring director; together with any suggestions as to the action required to avoid/reduce this impact.

7. Risk Management

The PSIRPs will support the identification of emerging risks and trends and provide direction and recommendations to promote network and organisation-wide learning and improvements in care, treatment, and staff safety.
Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

8. Further Guidance

If you have any concerns or issues with the contents of this policy or have difficulty understanding how this policy relates to you and/or your role, please contact the Quality Team.