Patient Safety Incident Response Framework (PSIRF) Policy

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# Version History

| Version | Date | Author (Name and Title) | Summary of amendments made |
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| 0.2 | 16/08/2023 | Steve McEwen, Quality Manager  Karen Flitton, Patient Safety Specialist | Revision made to initial draft, in preparation for wider sharing/review |
| 0.3 | 24/08/2023 | Sally Hatt | Definitions added as an appendix |
| 0.4 | 29/08/2023 | Karen Flitton, Patient Safety Specialist | Revision of roles and responsibilities and additions into section 5.2 (sharing insights to improve safety), section 6 (Monitoring Compliance) addition of section 5.3 (Provider Patient Safety Incident Response and Plans) |
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| 0.5 | 04/09/2023 | Karen Flitton, Patient Safety Specialist | Circulated to ALL SINE members, ICB PSIRF Implementation Group and Nursing & Quality Senior Team for feedback and comments |
| 0.6 | 19/09/2023 | Steve McEwen, Quality Manager | Inclusion of feedback from above |
| 0.7 | 01/10/2023 | Karen Flitton, Patient Safety Specialist | Final revision including amendments to tables within content for accessibility (these were pictures) now amended. |
| 0.8 | 09/10/2023 | Karen Flitton, Patient Safety Specialist | Circulated to Staff Engagement Group – feedback was *“easy to follow and understand and I liked section 4 - definitions which was really clear”* |
| 0.9 | 22/10/2023 | Karen Flitton, Patient Safety Specialist and Steve McEwen, Quality Manager | Circulated to Quality Committee,  Feedback received from   1. *James Hickling* 2. *Ross Cracknell* 3. *Sara O’Connor* 4. *Owen Richards* |
| 0.10 | 27/10/2023 | Karen Flitton, Patient Safety Specialist | Approved at ICB Quality Committee |
| 1.0 | 16/11/2023 | Karen Flitton, Patient Safety Specialist | Approved by ICB Board. |
| 1.1 | 04/11/2024 | Karen Flitton, Patient Safety Specialist | No updates are currently required for this policy. Expansion of the Patient Safety Incident Response Framework (PSIRF) into primary care settings has not been mandated at this time. Therefore, it is recommended that the policy be renewed for a 18 months in its existing form, allowing for continued adherence to current patient safety practices without adjustments. This approach will ensure stability and alignment with present regulatory requirements. |
| 2.0 | 20/12/2024 | Helen Chasney, Gov Support Officer | Final – Approved version. |

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## Introduction

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

### The PSIRF replaces the Serious Incident Framework (SIF 2015) and makes no distinction between ‘patient safety incidents’ and ‘Serious Incidents’. As such it removes the ‘Serious Incidents’ classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

### The PSIRF is not a different way of describing what came before; it fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate. Instead, it:

* + - advocates a coordinated 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.

### Organisations are required to develop a thorough understanding of their patient safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programmes. To do so, information is collected and synthesised from a wide variety of sources, including wide stakeholder engagement. A patient safety incident response planning exercise is used to inform what the organisation’s proportionate response to patient safety incidents should be.

### The PSIRF approach is flexible and adapts as organisations learn and improve, so they explore patient safety incidents relevant to their context and the populations they serve.

### The principles and practices within the PSIRF embody all aspects of the NHS Patient Safety Strategy and wider initiatives under the Strategy including:

* + the introduction of Patient Safety Specialists.
  + development of a national patient safety syllabus.
  + development of the involving patients in patient safety framework.
  + introduction of the Learn From Patient Safety Events (LFPSE) service.

The NHS Patient Safety Strategy sits alongside and supports the NHS Long Term Plan.

## Purpose / Policy Statement

### The leadership and management functions of the PSIRF are multifaceted. The PSIRF advocates oversight that enables organisations to demonstrate improvement rather than compliance with prescriptive, centrally mandated measures. To achieve this, oversight of patient safety incident response under PSIRF must focus on engagement and empowerment rather than more traditional command and control.

### This policy sets out MSEICB’s approach to fulfilling the roles and responsibility requirements for ICB’s as defined in the PSIRF:

* Collaborate with providers in the development, maintenance and review of provider patient safety incident response policies and plans.
* Agree provider patient safety incident response policy and plans.
* Oversee and support effectiveness of systems to achieve improvement following patient safety incidents.
* Support co-ordination of cross-system learning responses.
* Share insights and information across organisations/services to improve safety.

## Definitions

| **Term / Abbreviation** | **Definition** |
| --- | --- |
| **Candour** | Any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it. |
| **Cross system learning** | The purpose of cross system learning is to support the delivery of the national patient safety strategy to ensure the benefits are realised and communicated amongst member organisations. The cross-system group will operate as a peer group to progress against the strategy objectives and work collectively to address barriers and challenges to implementation and identify solutions or mitigations and identify opportunities to collaborate and share resources. |
| **Duty of Candour** | Regulation sets out duty of candour with definitions of openness, transparency and candour used by Robert Francis in his report. |
| **Just Culture** | A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution’. The report goes on to say ‘generally in a just culture inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However, a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts. |
| **LFPSE** | The Learn from Patient Safety Events (LFPSE) service is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare. LFPSE is currently being introduced across the NHS as organisations switch to recording patient safety events onto the new LFPSE service, rather than the National Reporting and Learning System (NRLS) and Strategic Executive Information System (STEiS) it is replacing. (NRLS) and Strategic Executive Information System (STEiS) it is replacing. |
| **Openness** | Enabling concerns and complaints to be raised freely without fear and questions asked to be answered. |
| **NHS Patient Safety Strategy** | The NHS Patient Safety Strategy sets out how the NHS will support staff and providers to share safety insight and empower people – patients and staff – with the skills, confidence, and mechanisms to improve safety. |
| **Patient Safety Partners** | PSP involvement in organisational safety’ relates to the role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation’s governance and management processes for patient safety. Their role includes membership of safety and quality committees whose responsibilities include the review and analysis of safety data. |
| **Peer Review Forum** | A discussion forum where you can ask questions and share your experiences with people to share learning and gain feedback. |
| **PSII** | Patient Safety Incident Investigation - PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to address those system factors and help deliver safer care for our patients effectively and sustainably. |
| **PSIRF** | Patient Safety Incident Response Framework. Building on evidence gathered and the wider industry best-practice, the PSIRF is designed to enable a risk based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing the risk future risk. |
| **PSIRP** | Patient Safety Incident Response Plan A local plan sets out how we will carry out the PSIRF locally including a list of local priorities. |
| **Psychological Safety** | Is about being open, willing to admit mistakes and feeling supported to speak up. Psychological safety is not just being nice to people, nor is it protecting people by wrapping them up in cotton wool; it is about creating an environment of rewarded vulnerability. The premise of psychological safety is not measured by how warm and fuzzy people feel, but by how bold and brave they are at pushing the margins of the system |
| **Transparency** | Allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. |

## Scope

### The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers. This includes maternity and all specialised services.

### Secondary care providers that provide NHS-funded secondary care under the NHS Standard Contract but are not NHS trusts or foundation trusts (e.g., independent provider organisations) are required to adopt this framework for all aspects of NHS-funded care and may apply this approach to their other services for consistency. These organisations may not need to undertake the full analysis required for patient safety incident response planning (e.g., due to limitations on data availability), but processes such as stakeholder engagement and developing an incident management policy incorporating PSIRF principles are required.

### Primary care providers may wish to adopt this framework, but it is not a requirement. Primary care providers that wish to adopt PSIRF should collaborate with their ICB to do so. Equally, other providers who have a relationship with the ICB, such as hospices through grant funding, may also wish to adopt PSIRF and should also collaborate with the ICB during the implementation phase. Further exploration is required to ensure successful implementation of the PSIRF approaches within primary care. The National Patient Safety Team will work with a small number of primary care early adopters to explore how the PSIRF can be adapted to this sector.

### This policy is specific to roles and responsibilities in relation to patient safety incident responses conducted for the purpose of learning and improvement across the Mid and South Essex Integrated Care System.

### Providers will continue to report Serious Incidents under the SI framework until a transition date to the PSIRF is agreed with MSEICB.

## Roles and Responsibilities

### Integrated Care Board

* + 1. ICBs have a responsibility to establish and maintain structures to support a co-ordinated approach to oversight of patient safety incident response in all the services within their system. ICBs should appoint an appropriate lead(s) or Patient Safety Specialist to collaborate with each provider in their system to:
    - Develop and maintain its local patient safety incident response policy and plan.
    - Understand its patient safety incident and improvement profiles.
    - Support the selection of appropriate response methods for anticipated patient safety incidents based on an understanding of potential for new learning and ongoing safety improvement work.
    - Oversee and support effectiveness of systems to achieve improvement following patient safety incidents.
    - Support co-ordination of cross-system learning responses by liaising with relevant providers (and other ICBs if necessary) to agree how learning responses will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

### Quality Committee (QC)

* + 1. The QC is responsible for monitoring outcomes from the PSIRF declared by providers for which the ICBs are the lead commissioner and escalating any concerns to the ICB Board.
    2. The QC is also responsible for monitoring compliance with this policy.

### Chief Executive

* + 1. The Chief Executive of the ICB has overall accountability for implementing this policy.

### Executive PSIRF Lead / Executive Chief Nurse

* + 1. To provide executive leadership and oversight of the PSIRF.
    2. To ensure PSIRF is central to the ICB’s overarching clinical governance arrangements.

### Director of Nursing

* + 1. To provide strategic leadership and oversight of the PSIRF.
    2. To ensure PSIRF is central to the ICB’s Quality Framework.

### Deputy Director of Nursing

* + 1. To provide operational leadership and oversight of the PSIRF.
    2. To develop and maintain the PSIRF policy and related procedures and processes.
    3. To ensure PSIRF is embedded within relevant policies, processes, and procedures.
    4. To provide specialist quality support, advice, and guidance to those implementing PSIRF.

### Patient Safety Specialist

* + 1. To lead on the implementation of the NHS Patient Safety Strategy, of which PSIRF is a core foundation.
    2. To chair the System Response Group, ensuring the related procedure supports effective coordination of system responses.
    3. To coordinate and convene the PSIRF Peer Forum, working in conjunction with forum facilitators.
    4. To monitor progress against safety improvement plans.
    5. To provide specialist safety support, advice, and guidance to those implementing PSIRF.

### Senior Leaders within Nursing & Quality Directorate

* + 1. To support oversight activities (e.g., review of learning responses) and provide expert advice and guidance related to the delivery of learning responses.
    2. Provide expert advice and guidance regarding the escalation of incidents within their areas of responsibility and facilitate connections with relevant stakeholders/groups.
    3. Share learning from investigations in a timely manner with relevant stakeholders and/or groups.
    4. To ensure PSIRF is embedded within relevant policies, processes, and procedures.
    5. To provide specialist quality support, advice, and guidance to those implementing PSIRF.
    6. To be compliant with national PSIRF training requirements and ensure their staff and compliant with the relevant national PSIRF training requirements.

### Senior Leaders across MSE ICB

* + 1. To ensure that this policy and associated procedures/processes are implemented within their areas of responsibility.
    2. To report/escalate patient safety incidents in accordance with this policy.
    3. To take responsibility for analysis and sharing the learning from learning response output.
    4. To ensure that staff are compliant with the relevant national PSIRF training requirements.

### Quality Support Nurse Managers

* + 1. To act as the central point of contact for providers working within the PSIRF.
    2. To identify themes for systemic learning and ensure learning from patient safety events and changes in practice are shared across the health economy.
    3. Agree provider patient safety incident response policies and plans.
    4. To monitor progress against PSIRF Policy and Plans
    5. To ensure issues are escalated in a timely manner.
    6. Oversee and support effectiveness of systems to achieve improvement following patient safety incidents.
    7. Support co-ordination of cross-system learning responses.
    8. Share insights and information across organisations/services to improve safety.

### Infection Prevention and Control Team

* + 1. To act as the central point of contact for provider IPC teams working within the PSIRF.
    2. To identify themes for systemic learning and ensure learning from patient safety events and changes in practice are shared across the health economy, via the Healthcare Associated Infection (HCAI) Network.
    3. Provide oversight relating to IPC patient safety incident responses and pathways.
    4. To ensure issues are escalated in a timely manner.
    5. Oversee and support effectiveness of systems to achieve improvement following patient safety incidents in relation to IPC and HCAI.
    6. Support co-ordination of cross-system learning responses.
    7. Share insights and information across organisations/services to improve safety.

### Quality team Administrators

* + 1. To provide administrative support to the PSIRF programme and the groups that underpin it;
    2. To coordinate PSIRF meetings and events; and
    3. To maintain the PSIRF Plan Register

### Patient Safety Partners

* + 1. To attend the ICB Quality Committee and System Quality Group.
    2. To attend/host the ICS Patient Safety Partner Network.
    3. To be compliant with national PSIRF training requirements.

### Caldicott Guardian

* + 1. This sits with the Executive Chief Nurse who is responsible for ensuring that the protection and use of patient identifiable information is used appropriately, which may be used during the PSIRF process.

### Policy Authors

* + 1. The policy authors will have responsibility for reviewing and updating the policy.

### All Staff

* + 1. All members of staff have a responsibility to familiarise themselves with the content of the PSIRF Policy.
    2. All members of staff have a duty to work within the standards and guidelines as specified in this Policy.
    3. All members of staff have a duty to ensure colleagues, patients, their relatives, and carers are not discriminated against or treated in any way less favourably in relation to PSIRF.
    4. All members of staff will review their practice as a result of any learning identified from PSIRF investigations.
    5. To take part in organisational events related to patient safety and learning, particularly in their own areas of work.
    6. To ensure they have completed Level 1 of the Patient Safety Syllabus.

## Policy Detail

### Oversight and Assurance

* + 1. The leadership and management functions of the PSIRF oversight are wider and more multi-faceted compared to previous response approaches. 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.
    2. Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control.
    3. The following mindset principles should underpin the oversight of patient safety incident response:

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.

### Oversight Approach

* + 1. In line with NHS England guidance, our oversight approach draws on a mixture of qualitative/quantitative data, process/outcome measures and tacit/explicit learning outputs to get a clear understanding of the effectiveness of the patient safety incident response systems.

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| **Responsibilities** |
| These are the responsibilities the ICB holds as part of PSIRF |

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| **Oversight questions** | **Support questions** |
| Answering these questions helps the ICB to understand how PSIRF is being implemented and to what extent this is leading to learning and improvement | Answering these questions helps the ICB to understand what support is required to ensure the MSE safety system supports improvement |

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| **Touchpoints** |
| When inside generated as part of activities is explored and discussed to help answer the oversight and support questions |

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| **Activities** |
| These are insight generation opportunities with a specific function and/or purpose. |

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| **Tools** |
| These are examples of insight that should be used to inform the oversight and support activities. Tools include dashboards, reports and outputs from learning activities. |

* + 1. Patients, families, and staff affected by patient safety incidents can provide some of the best and most pertinent warnings of poorly functioning patient safety incident response systems. Priority should be given to capturing meaningful patient, family and staff-centred metrics for learning and improvement.
    2. Organisations should ensure that patient safety partners participate in developing and delivering PSIRF oversight processes, and patient groups such as local Healthwatch and Maternity Voice Partnerships should be involved to provide insight into the strength of patient safety incident response systems.

### Provider Patient Safety Incident Response Policies and Plans

* + 1. Organisations within Mid & South Essex Integrated Care System delivering NHS-funded care are required to develop a Patient Safety Incident Response Plan and Policy.
    2. An organisation’s Patient Safety Incident Response Plan specifies the methods it intends to use to maximise learning and improvement, and how these will be applied to different patient safety incidents. It is based on a thorough understanding of the organisation’s patient safety incident profile, ongoing improvement priorities, available resources, and the priorities of stakeholders, including patients and local Healthwatch.
    3. An organisation’s Patient Safety Incident Response Policy implements the requirements of the Patient Safety Incident Response Framework and sets out the provider organisation’s approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety. 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. The Policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF.

Within the Patient Safety Incident Response Framework, the Integrated Care Board has the responsibility to:

* Collaborate with providers in the development, maintenance and review of provider patient safety incident response policies and plans; and
* Agree provider patient safety incident response policy and plans.

For more information on the collaboration and agreement process for provider policies and plans, please request Standard Operating Procedures for Main NHS Providers and Smaller Providers via [mseicb.me.patientsafety@nhs.net](mailto:mseicb.me.patientsafety@nhs.net)

### Duty of Candour

* + 1. The requirement to comply with Duty of Candour Regulations is unchanged: that is, all providers must inform the patient / family / carers of any notifiable patient safety incident and follow all the requirements of the Duty of Candour.
    2. While legal obligations associated with Duty of Candour apply to those in receipt of care, the moral obligation to be open, honest, supportive, and inclusive must be upheld for all affected.
    3. If a partner organisation has rationale for not undertaking Duty of Candour then a conversation between the ICB DON and provider DON should take place to agree this.

### Providers of NHS Funded Care

* + 1. The Trust Board, or leadership team in the case of organisations without Boards, is responsible and accountable for effective patient safety incident management in their organisation. This includes supporting and participating in cross-system / multi-agency responses and / or independent Patient Safety Incident Investigations (PSIIs) where required.
    2. The PSIRF should be central to overarching safety governance arrangements and patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress should be discussed at the Board or leadership team’s relevant sub-committee(s).
    3. Organisations must have processes to ensure that all safety actions implemented in response to learning or wider safety improvement plan(s) are monitored, to check they are delivering the required improvement.

### Local Support Networks including Local Maternity and Neonatal Systems

* + 1. Local support networks including Local Maternity and Neonatal Systems (LMNSs) play a crucial role in supporting improvement and facilitating review of patient safety incident responses, therefore organisations should engage with their local support networks as key stakeholders in the development of their patient safety incident response plan.
    2. Organisations should use their local support networks to facilitate review of incident responses between peers, so that they can learn from each other’s incident response approaches and reduce the risk of becoming isolated and accepting lower quality incident response standards.

### Oversight of Maternity PSIRF

* + 1. As with all aspects of incident response under PSIRF, a provider board / leadership team are accountable for the quality of incident response and most importantly for reducing risk as a result. This is particularly relevant to the organisation’s board-level maternity safety champion and the non-executive appointed to work alongside them.
    2. ICBs are responsible for agreeing and signing off an organisations’ patient safety incident response plan, including relevant maternity content.
    3. Regional maternity teams should be involved in developing and agreeing organisations’ patient safety incident response plan, as should LMNSs.
    4. Organisations should also use their LMNSs to facilitate peer review of maternity incident responses and encourage partnership with another organisation to support collaborative learning wherever possible.

### National Investigation Bodies

* + 1. These investigations aim to improve healthcare systems and processes to reduce risk and improve safety. They undertake patient safety investigations through two programmes:
    - Health Services Safety Investigation Body (HSSIB): Can encompass any patient safety concern that occurred within NHS-funded care in England after 01 April 2017. Incidents for national investigation are selected based on the scale of risk and harm, the impact on individuals involved and on public confidence in the healthcare system, as well as the potential for learning to prevent future harm.
    - Care Quality Commission (CQC): From 01 October 2023, the Maternity and Newborn Safety Investigations (MNSI) programme is hosted by the Care Quality Commission (CQC) and are responsible for all patient safety investigations of maternity incidents occurring in the NHS that meet the criteria of the Each Baby Counts programme. The purpose of this programme is rapid learning and improvement in maternity services, and to identify common themes that offer opportunity for system-wide change.

### NHS England Regional Leads

* + 1. Should support ICB PSIRF leads to establish systems and processes for responding to and overseeing patient safety incidents, including facilitating patient safety incident response policy and plan development where required.
    2. Should support collaboration within and between ICBs, other commissioning leads and / or regional leads as required and advise on the development of relevant skills and capacity to deliver PSIRF.
    3. Will collaborate with relevant teams / leads where a system, or provider(s) within a system, experience significant challenges in responding to patient safety incidents e.g. a breakdown of governance infrastructure across local systems.
    4. Should share insights and information between organisations and services to improve patient safety incident response systems and improvement activity.
    5. Should work with ICBs to develop the relevant systems to support cross-system learning responses at a local system level.
    6. Will support co-ordination of system-focused responses to high profile or complex incidents where this activity cannot be managed at a local system level by the ICB.

### Care Quality Commission (CQC)

* + 1. The CQC’s assessment of a provider’s leadership and safety considers an organisation’s ability to respond effectively to patient safety incidents, including whether change and improvement follow its response to patient safety incidents.
    2. CQC teams will apply the PSIRF and associated patient safety incident response standards as part of its assessment of the strength of an organisation’s systems and processes for preparing for and responding to patient safety incidents.
    3. CQC will expect to be informed (via the regional relationship lead) of high profile and complex incidents as part of the co-ordinated response, as well as being provided with all statutory notifications as required by the Health and Social Care Act (2008).

### Coroners

* + 1. Organisations should establish good relationships with their coroner, involve them in Patient Safety Incident Response Plan development and respond when they ask for information. The PSIRF requires all deaths to be investigated where the death is thought more likely than not to have been due to problems in care.

### Medical Examiner System

* + 1. Medical examiners do not conduct in-depth patient safety review, but when they identify concerns, they will refer them to appropriate governance leads which may include an organisation’s mortality lead and / or PSIRF lead.
    2. These leads will then ensure the death is considered for a response in line with the organisation’s learning from deaths policy and patient safety incident response plan. Where evidence, however identified, suggests problems in care were more likely than not to have led to the death occurring at the time that it did, a PSII must be undertaken.

### Improving incident response through collaborative external review

* + 1. External peer review of an organisation’s learning response reports that have been signed off by the board / leadership team is encouraged to support collaborative learning.
    2. Organisations should specify the proportion of responses to be externally reviewed and note in their patient safety incident response policy how this will be facilitated.
    3. Where possible, services with similar characteristics (including the population they serve) should partner with one another to review reports to support collaborative learning.
    4. The ICB PSIRF Peer Review Forum will oversee this external review process.

### Publication of sensitive and confidential information in independent patient safety investigation reports

* + 1. Independent PSII reports must be shared with internal and external stakeholders, including the affected individuals and families, and should be written in a clear and accessible way. Where possible independent PSIIs will be published in full.
    2. The impact of publishing an independent PSII report can have on those affected must be carefully considered, especially when individuals may be identifiable. Where a patient, the family of a deceased patient or another affected person does not consent to publication, their rights must be balanced against the wider public interest when deciding whether to publish.

### Our Restorative Just Culture

* + 1. A Restorative Just Culture is a learning approach to dealing with adverse events which focuses on harm done rather than blame.
    2. MSEICB’s commitment to our workforce, patients, organisation, and the wider system, is to take every opportunity to listen, act, learn, improve, support and create an environment that enables people to be the very best they can be and to do the very best they can do.
    3. MSEICB is raising awareness and empowering staff to challenge poor behaviour and choosing respect, civility and a positive culture aligned with key themes such as psychological safety, team-based working, and co-produced values.

### Patient Safety Partners

* + 1. The NHS Patient Safety Strategy promotes the involvement of patients, families, and carers as partners both in their own care and in the wider oversight of healthcare. Such involvement in oversight is of specific value in the development of an organisation’s patient safety incident response policy and plan. Patient Safety Partners (PSPs) should also play an important role on incident response oversight committees.
    2. PSP involvement in organisational safety’ relates to the role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation’s governance and management processes for patient safety. Roles for PSPs can include:
* Membership of quality and safety committees.
* Involvement in patient safety improvement projects.
* Working with organisation boards to consider how to improve safety.
* Involvement in staff patient safety training.
* Participation in investigation oversight groups.

### Addressing Health Inequalities

* + 1. Some patients due to their age, mental capacity/vulnerability, etc. are less safe than others in a healthcare setting. The PSIRF provides a mechanism to directly address these unfair and avoidable differences in risk of harm from healthcare:
* The PSIRF’s more flexible approach makes it easier to address concerns specific to health inequalities: it provides the opportunity to learn from patient safety incidents that did not meet the definition of a Serious Incident.
* PSIRF prompts consideration of inequalities in the development and maintenance of patient safety incident response policies and plans.
* Tools in the patient safety incident response toolkit prompt consideration of inequalities during the learning response process, including when developing safety actions.
* The NHSE document ‘Engaging and involving patients, families and staff following a patient safety incident’ gives guidance on engaging those with different needs.
* The framework endorses a system-based approach (instead of a ‘person focused’ approach) and is explicit about the training and skill development required to support an approach. This will support the development of a just culture and reduce the ethnicity gap in rates of disciplinary action across the NHS workforce.

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

* + 1. The PSIRF promotes systematic, compassionate, and proportionate responses to patient safety incidents, anchored in the principles of openness, fair accountability, learning and continuous improvement – and with the aim of learning how to reduce risk and associated harm.
    2. The PSIRF recognises that meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. The PSIRF supports development of a patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents.

### Supporting the Effectiveness of Systems to Achieve Improvement

The patient incident response standards can be used to guide ICB oversight of provider patient safety incident response. They support a formative (continuous) understanding of organisational safety, which is more meaningful than a summative (final) judgement. In providing the following subjects, our ICB can work across a range of issues, focusing on those questions within a subject that feels most relevant to local circumstances:

* Engagement and involvement of those affected by patient safety incidents.
* Policy, planning and governance.
* Competence and capacity.
* Proportionate responses.
* Safety actions and improvement.

### Supporting Cross System Response

* + 1. All healthcare organisations providing and overseeing NHS-funded care must work collaboratively, with a common understanding of the aims of the PSIRF framework, to provide an effective governance structure around the NHS response to patient safety incidents. The PSIRF expects ICBs to facilitate collaboration at both place and local system level to ensure cross-system response. The PSIRF requires regulators and ICBs to consider the strength and effectiveness of NHS providers’ incident response processes.
    2. Accountability for the quality of learning responses to individual incidents sits with provider leaders. Providers are not required to seek sign off for incident response reports from their ICB; however, they must be open with information relating to patient safety incidents and findings from incident responses, including formal reports, to support continuous development of an effective incident cross-system response.

### Supporting High Profile Cases

* + 1. Local arrangements for supporting patients, families and carers in high profile cases should incorporate the following:
* Early recognition and communication.
* Media plan.
* Liaison with relevant partner organisations.
* Links with specialise services i.e., Safeguarding, Local Authorities, Emergency Services, Police, Coroner, Legal Services etc.

### Sharing Insights to Improve Safety

* + 1. The Patient Safety Incident Response Framework represents a particular perspective on safety; the safety remit of the ICB and providers within the ICS is much broader and requires input from a range of stakeholders. A range of stakeholders within the ICB also hold responsibilities related to assurance and oversight that relate to and in some cases overlap with the responsibilities of the patient safety function (i.e. safeguarding, local maternity & neonatal system, quality).
    2. In order to ensure oversight is not focused only on those incident types contained within a providers’ Patient Safety Incident Response Plan, and to support the broader ICS to explore where safety risks may exist outside of the Patient Safety Incident Response Framework, the MSE ICS Patient Safety Steering Group will bring together a range of ICS stakeholders with an interest or involvement in patient safety to review the state of play across the footprint.
    3. MSE Safety Summit – The MSE ICS Patient Safety Summit will bring together all interested parties across Mid & South Essex to explore the work undertaken within the ICS related to patient safety and improvement. The summit intends to raise awareness of patient safety and provide opportunities for sharing learning and networking. The summit will be delivered in a conference fashion, with attendance open to all those working and living in Mid & South Essex.

### Complaints and Appeals

Patient experience and feedback offers learning opportunities that allows us to understand whether our services are meeting the standards we set and addressing patients’ expectations and concerns. With these objectives very much in mind, we take all patient and stakeholder feedback very seriously, clearly identifying any lessons and using these to improve our service. With the implementation of PSIRF we will continue to manage complaints in the usual way in accordance with the ICB Complaints Policy with close liaison with the Patient Safety Team in relation to any complaints about incidents that are also the subject of cross-system learning.

## Monitoring Compliance

### This policy will be monitored by the ICB Quality Committee. The diagram below details the process by which information flows up to the committee:

|  |
| --- |
| **MSE ICB Board** |

|  |
| --- |
| **Quality Committee** |

|  |
| --- |
| **MSE Patient Safety Collaborative**  **(Bi-monthly)** |

|  |  |  |
| --- | --- | --- |
| **MSE ICS Cross System Incident Response Group**  **(stood up as required)** |  | **MSE ICS PSIRF**  **Peer Review Forum**  **(Bi-monthly)** |

### The Executive Chief Nurse of the ICB will have overall responsibility for monitoring the policy.

### The leadership and management functions of the PSIRF oversight are wider and more multi-faceted compared to previous response approaches. When working under PSIRF, NHS providers, Integrated Care Boards (ICBs), Healthwatch 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.

Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control.

The mindset principles listed in 7.1.3 should underpin the oversight of patient safety incident response.

## Staff Training

### It is an expectation from NHSE/I that all staff, up to and including Board Level will complete online Patient Safety Awareness Training level 1.

### Levels 2 will be considered appropriate for staff who have a patient-facing function.

* 1. Levels 3-5 will be allocated to job roles once cascaded by NHS England.

### Those staff with responsibility for providing advice and support regarding the management of patient safety incidents will be required to undertake appropriate additional training relating to the management of conflicts of interest available on Electronic Staff Record (ESR) or e-Learning for Health (eLfH).

8.5 Completion of mandatory training will be monitored and reported to the relevant Committees, and action taken to address completion rates where necessary. Staff will be expected to maintain mandated training and local recommended training, where indicated.

## Arrangements For Review

* 1. This policy represents the first of its kind and is intended to outline the core approach we will take.
  2. If only minor changes are required, the sponsoring Committee has authority to make these changes without referral to the Integrated Care Board. If more significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the Integrated Care Board.
  3. A comprehensive review of our patient safety policy will be undertaken after 12 months to reflect the fact this time period is an initial implementation phase of the programme, and a significant amount of learning will be generated from this work. Following the initial one-year review, further review of the policy will take place every two years as minimum.
  4. For any support with this policy please contact the Mid & South Essex ICB Nursing & Quality Team: [mseicb-me.patientsafety@nhs.net](mailto:mseicb-me.patientsafety@nhs.net)

## Associated Policies, Guidance And Documents

#### Associated Policies

* Incident Reporting Policy.
* Safeguarding Adults and Children (including Children in Care/Looked After Children) Policy.
* Freedom of Information Policy.
* Health & Safety Policy.
* Complaints Policy.
* Disciplinary Policy.
* Information Governance Policy.
* Raising Concerns Policy (due to be replaced by the Freedom to Speak up policy)

## Equality Impact Assessment

* 1. The EIA has identified no equality issues with this policy.
  2. The EIA has been included as **Appendix A**.

## Appendix A - Equality Impact Assessment

**INITIAL INFORMATION**

|  |  |
| --- | --- |
| **Name of policy:**  Patient Safety Incident Response Framework  **Version number (if relevant):**  1.0 | **Directorate/Service**:  Nursing & Quality |
| **Assessor’s Name and Job Title:**  Steve McEwen, Quality Manager | **Date:**  August 2023 |

|  |
| --- |
| **OUTCOMES** |
| *Briefly describe the aim of the policy and state the intended outcomes for staff* |
| This policy is designed to set out how the Nursing & Quality directorate will monitor and manage the Patient Safety Incident Response Framework.  This provides staff involved with the process to understand the required steps and for staff not directly involved to understand how the process works. |
| **EVIDENCE** |
| *What data / information have you used to assess how this policy might impact on protected groups?* |
| The ICB monitors the composition of its workforce under the nine protected equality characteristics and reports on this annually. This information helps the ICB to assess the potential impact of its policies upon staff. |
| *Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?* |
| The policy is based on the NHS England guidance for Patient Safety Incident Response Framework. [NHS England » PSIRF](https://www.england.nhs.uk/patient-safety/incident-response-framework/)  The Staff Engagement Group have been consulted on the policy and their feedback was considered before the policy was finalised. |

**ANALYSIS OF IMPACT ON EQUALITY**

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

* ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups.*
* ***Negative outcome*** *–**protected group(s) could be disadvantaged or discriminated against.*
* ***Neutral outcome***  *–**there is no effect currently on protected groups.*

Please tick to show if outcome is likely to be positive, negative or neutral. Consider direct and indirect discrimination, harassment and victimisation.

| Protected  Group | Positive  outcome | Negative  outcome | Neutral  outcome | Reason(s) for outcome |
| --- | --- | --- | --- | --- |
| Age |  |  | X | The management of the Patient Safety Incident Response Framework is not influenced by protected characteristics |
| Disability  (Physical and Mental/Learning) |  |  | X | As above |
| Religion or belief |  |  | X | As above |
| Sex (Gender) |  |  | X | As above |
| Sexual  Orientation |  |  | X | As above |
| Transgender / Gender Reassignment |  |  | X | As above |
| Race and ethnicity | X |  |  | It is noted that this policy includes a section on health inequalities (e.g. higher rates of disciplinary amongst ethnic groups). As a result of the change in culture due to PSIRF, this may have a positive impact. |
| Pregnancy and maternity (including breastfeeding mothers) |  |  | X | As above |
| Marriage or Civil Partnership |  |  | X | As above |

|  |
| --- |
| **MONITORING OUTCOMES** |
| Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals. |
| *What methods will you use to monitor outcomes on protected groups?* |
| By attendance at system partner meetings |

|  |
| --- |
| **REVIEW** |
| *How often will you review this policy / service?* |
| We will review this policy in one years’ time, but review ahead of this if found necessary |
| *If a review process is not in place, what plans do you have to establish one?* |
| N/A |