Setting high standards

Compassionate engagement is at the heart of the Patient Safety Incident Response Framework

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Despite millions of incidents reported and investigated nationally, patients still experience avoidable harm, with no real improvement in the last 20 years. There is significant change in the air for patient safety in NHS England. The Serious Incident Response Framework (SIF) adopted nine years ago has been replaced by the Patient Safety Incident Response Framework (PSIRF).

The concept has been applied by a number of early adopter Trusts over the last few years, with all other Trusts expected to transition. Each Trust was expected to have PSIRF policies and plans in place by autumn 2023, and published by spring 2024.

FOUR PRICIPLES

PSIRF sets out to employ compassionate engagement with those involved in patient safety incidents, setting standards for the most important of its four principles: compassionate engagement, systems-approach, proportionate responses and supportive oversight. When things have gone wrong in the past patients and carers have been shielded, and often excluded from the truth and subsequent investigations.

The Francis, Ockenden, Kirkups and other inquiries time and again cite the lack of engagement with patients when safety incidents happen. These inquiries refer to avoidable harm to patients from healthcare organisations, although there are many personal patient stories.

Professional and legal duty of candour, saying sorry, still apply under PSIRF. A new Engagement Lead role in PSIRF has evolved to support patients and carers with meaningful empathy. Patients and carers should also be involved, and may be invited to play an active part in their own safety investigation.

Engagement Leads are also responsible for steering and supporting staff who may have in the past felt blamed or victimised. There will be no more: "I need a statement on my desk by the end of the day"; rather: "Can we please have a conversation about how this happened?"

While staff are still accountable for their actions, this does not form part of the investigation process. Dekker's Restorative Just Culture Checklist will be applied, including: who is hurt, what do they need and whose obligation is it to meet that need? The NHS England 'Just culture guide' often referred to is applied by human resources in cases where staff performance issues are suspected.

SYSTEM-BASED APPROACHES

The focus is no longer entirely on investigation and actions, because there is an increase in the number of tools available to respond to incidents, with an emphasis on learning. Tools recommended by NHS England and adopted by many Trusts in their PSIRF policies include swarm huddles, which occur immediately after the incident, and similar after action reviews happening some days later.

These two responses require a trained facilitator and a safe space with the questions asked of staff aimed at identifying immediate learning: what was supposed to happen, what actually happened, why was there a difference and what can we learn from this?

It is likely these two methods will be the mainstay for PSIRF responses. More complex and multiple incidents of the same type may be assigned to a thematic review, multi-disciplinary team review and/or a more in-depth patient safety incident investigation.

The response will concentrate on 'work as done' not 'work as imagined', the latter often being found in NHS organisations' standard operating procedures and policies. Systems thinking is applied to each PSIRF response with most NHS organisations utilising the Systems Engineering Initiative for Patient Safety (SEIPS) model, first presented by Caryon and colleagues as a concept in 2006.

There will be no more simplistic linear concepts of Fishbone, 5 Whys, the Swiss cheese model or root cause analysis, acknowledging the complex socio-technical system that is the NHS. SEIPS explores the system elements that allow an incident to occur from the people, organisation (internal and external), environment, tasks, and tools and technologies, and how they influence each other.

Following on, it examines how the system affects the processes and outcomes for patients and staff, and in turn how they influence the system.

As well as PSIRF Engagement Lead role, the role of Learning Response Lead has emerged. Training as set out by NHS England is prescriptive, with one day for the Engagement Lead and two days for the Learning Response Lead all the time focusing on the systems approach.

PROPORTIONATE RESPONSES

It is recognised that while incident investigation can be necessary, resources are finite and there will be fewer high-quality investigations, with an emphasis on learning and improvement. The same investigation will not be repeated time and again without attempting meaningful change.

As previously under SIF, level of harm or time-linked investigations are no longer the priority in PSIRF. Patient safety priorities requiring a PSRIF response have been identified nationally – for example, those meeting the never event, learning from deaths criteria, or death of a patient under the Mental Health Act.

In addition, Trusts spent much of last year identifying their local priorities also requiring a PSIRF response, based on local patient safety themes gathered often using the SEIPs model.

These now feature in Trusts' published Patient Safety Incident Response Plans and might include three to 10 local priority patient safety themes such as pressure ulcers and falls, or failure to act on unexpected results. Some identified patient safety priorities where the problems are well understood may sit within a pre-existing or require a new quality improvement project.

SUPPORTIVE OVERSIGHT

Supportive oversight is based on strengthening response system functioning and improvement. Those in Oversight Lead roles must have an understanding of the fundamentals of PSIRF and have completed Engagement and Response Lead training with an additional day of training in oversight.

The Integrated Care Boards will not sign off incident responses, but exist in a supportive and collaborative role.

Curiosity is key for Oversight Leads, with frequent horizon scanning required to inform. Patient safety data are now broader and richer than before, with a variety of sources tapped to feed this intelligence. Data are not only quantitative but also qualitative, drawn from additional sources – for example, CQC reports, patient feedback, complaints, Healthwatch, equality and diversity information, and patient and staff surveys.

Those in oversight roles should use meaningful data drawn from existing data streams that are not overburdensome to collect. The patient safety data gathered by Trusts last year contributed to their published patient safety incident response plans for the next 12 to 18 months. The shift from command and control to engagement and empowerment underpins PSIRF. The Oversight Leads should operate in an open, blame-free culture, providing staff with psychological safety to raise concerns and report problems they see in patient care.

In PSIRF there will be a focus on quality improvement (QI), which requires investment. Staff need to be trained to apply the model for improvement and to use tools such as driver diagrams to develop ideas; Pareto charts to address changes that will have the greatest impact; PDSA (plan, do, study, act) to test change ideas iteratively; and process mapping to review pathways.

Change ideas should show true improvement through run and control charts with smart outcome and process metrics applied, including consideration of balancing metrics. All this must culminate in sustainability, with local ownership of QI projects and spread where appropriate.

THE FUTURE

It is important to maintain the understanding that most healthcare is delivered safely despite the complexity of both patients and the NHS system. There must be a focus on Patient Safety II that explores why things go well. PSIRFs principles arose from high-reliability organisations such as nuclear and aviation as exemplars in safety. However it's introduction into the NHS competes with the current crises of growing waiting lists, strikes, staff shortages and financial restraints.

PSIRF will require adequate investment not only in education and training, but time and championing from board to ward. PSIRF is no overnight quick fix, but a journey of systems and cultural change that should lead to improvement in patient safety and the vital rewards that could bring.

"The Oversight Leads should operate in an open, blame-free culture, providing psychological safety"

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