Patient Safety Incident Response Framework (PSIRF)

9 March 2023

Welcome. Thank you for joining us today.

Please do mute yourselves while joining or during presentations. (We may mute you on entry – this is not an audio fault and you can of course unmute yourself any time).

Do introduce yourself in the Chat Box by full name and organisation and please make use of it throughout for Q&A.

Hello everyone! Thank you for being a part of this group today.

Just a few things to cover before we kick off:

1. If you want to ask a question or make a comment you can use the chat box to post your questions.
2. When the presentations are is taking place, you'll be placed on mute and until we reach the question part of the meeting.
3. If something comes to mind during the discussions that is outside the questions being asked today, you may wish to use the chat function as a 'parking area' to make note
4. We will do our very best to stick to time.
5. The session will be recorded today.
6. We will be sharing the slides and the meeting note summary after the meeting.

Agenda

10.00	Welcome and Background
10.05	Jane Eades, Marie Curie
10.15	Dr Valerie Noble and Frances Hannon, St Luke's, Plymouth
10.25	Q + A for the Panel
10.30	Transfer to breakout rooms
10.50	Return to main room, next steps, AOB
11.00	Close

PSIRF

- August 2022 NHS England published its Patient Safety Incident Response Framework (PSIRF), which replaces the Serious Incidents Framework (SIF). Early adopters from 2020.
- The Patient Safety Incident Response Framework (PSIRF) – a core element of the NHS Patient Safety Strategy – establishes the NHS's approach to the development and maintenance of mechanisms for responding to patient safety incidents (PSIs) to maximise learning and improvement.
- The PSIRF is a contractual requirement and is mandatory for providers of NHS-funded care.

PSIRF

- Additionally, unlike the SIF, the PSIRF requires a degree of training to ensure that those conducting investigations – as well as those providing oversight of the process – have an adequate level of knowledge and experience to ensure that investigations lead to learning and improvement.
- The PSIRF has four key aims with regards to patient safety incidents: compassionate engagement and involvement of those affected; a system-based approach to learning; considered and proportionate responses; supportive oversight focused on strengthening response systems and improvement.

Welcome

Jane Eades

Deputy Director of Nursing and Quality
Marie Curie


Marie
Curie
Care and support
through terminal illness

Marie Curie

- *Place based structure:*
- *10 place-based regions across the UK*
- *Nursing and Quality Team*
- *1 x Deputy Director, 3 x Associate Directors, 3 x QIF/QIP, Clinical Governance Lead, 2 x Co-ordinators*

- Hospices
- *9 hospices across the UK, providing specialist palliative in patient, outpatient and specialist community care services*

- Nursing service
- *1800 nursing staff working in patients homes across the UK*
- *Rapid Response, planned overnight, multi-visit, place-based services, cross-organisational services*

Where we started

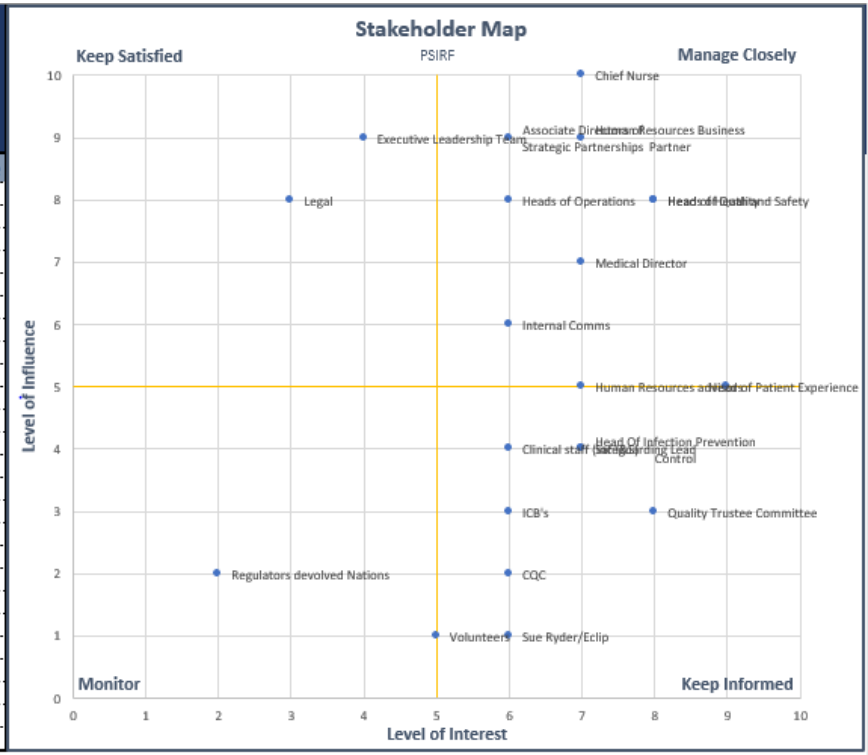
- Familiarised ourselves with the documentation
- Met with an early adopter
- Joined the Future NHS Collaboration platform
- Contacted NHS England to discuss challenges
- Undertook a SWOT and RACI
- HSIB level 2 training

- Stakeholder map
- Established a working group
- Met with Sue Ryder
- Joined a webinar for independent providers
- Wrote a Board Report and agreed reporting
- Risk Register

Stakeholder Map

Project Name: PSIRF

#	Stakeholder Role/Group	Individual	Internal/External	Level of Interest	Level of Influence
1	Chief Nurse	Julie Pearce	Internal	7	10
2	Medical Director	Sarah Holmes	Internal	7	7
3	Heads of Quality	N/A	Internal	8	8
4	Heads of Operations	N/A	Internal	6	8
5	ate Directors of Strategic Partne	N/A	Internal	6	9
6	Head of Heath and Safety	Claire Guise	Internal	8	8
7	Head of Patient Experience	Shirley Black	Internal	9	5
8	Safeguarding Lead	Jason Davidson	Internal	7	4
9	ead Of Infection Prevention Contr	Angela Powell	Internal	7	4
10	uman Resources Business Partne	Theresa Houghton	Internal	7	9
11	Human Resources advisors	Catherine Gilburt	Internal	7	5
12	Executive Leadership Team	N/A	Internal	4	9
13	Quality Trustee Committee	N/A	Internal	8	3
14	Legal	N/A	Internal	3	8
15	Internal Comms	Lucy Styles	Internal	6	6
16	Clinical staff (inc I&S)	N/A	Internal	6	4
17	CQC	N/A	External	6	2
18	Sue Ryder/Eclip	N/A	External	6	1
19	Volunteers	N/A	External	5	1
20	Regulators devolved Nations	N/A	External	2	2
21	ICB's	N/A	External	6	3
22	Hospice Medical Directors		Internal		
23	L&D	Geoff Speed	Internal		
24	Service User	TBC	External		
25	External Comms	Tom Robbins	Internal		



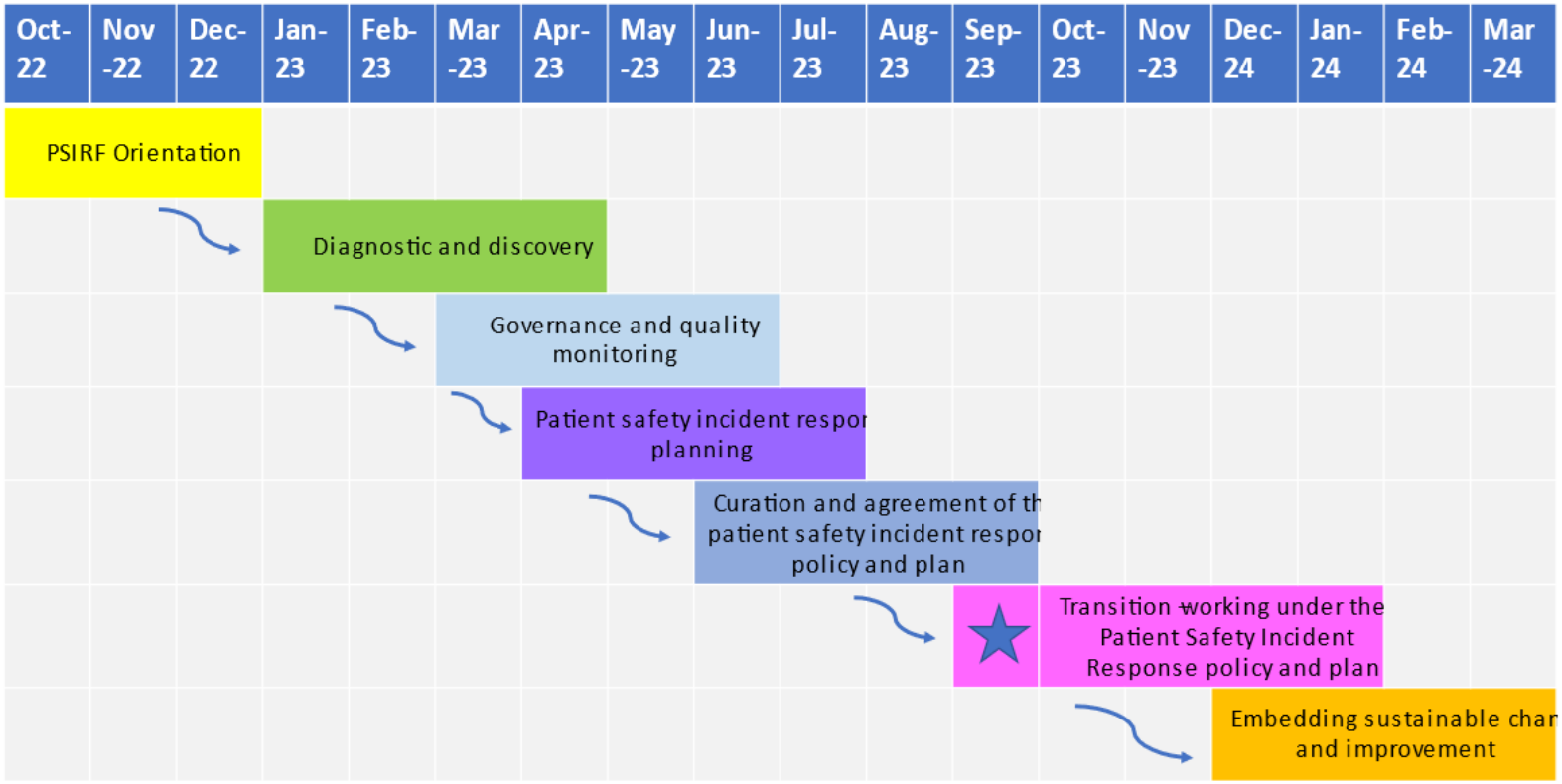
Stakeholder Map

Care and support through terminal illness

Marie Curie

Timeline

Patient Safety Incident Response Framework timeline



Challenges

- External
- Plethora of documents – difficult to navigate
- Designed for NHS Trusts – doesn't all map over to independent services
- Working across 4 UK nations – not aligned
- ICB engagement – who, how, what
- Terminology doesn't align to other external reporting e.g. charity commission

- Internal
- Aligning with HR Processes
- Aligning with organisational approach
- Less resources than NHS trusts

What do we want to keep and build on

- Keep
- Learning Panel
- Summary Learning reports
- Sentinel system and cascade
- Clinical Governance structure
- Patient question about reporting culture in patient experience questionnaires
- External Reporting processes
- Just Culture guide
- System Approach to Investigations

- Build on
- Report templates
- Triangulation (over time, staff involved, FTSU/ grievances /complaints)
- Language /culture
- Reduce suspensions
- Training (reporting, investigations, patient involvement, Interviewing techniques)
- Walkthrough methodology and SEIPS
- Reporting links for feedback from patients (add form)
- Culture of reporting in some places
- Feedback to people raising incidents
- Oversight of actions

Current and sort term work

- First:
- Mapping standards and regulatory Framework
- Understand incident profile
- Define levels of investigation and response times

- Then:
- Report templates
- Patient and Carer Engagement
- Training (Investigation training, Interview training, Reporting, Patient Engagement)
- Data
- Organisational alignment
- Policy

Questions?

Welcome

Dr Valerie Noble
Chartered Physiotherapist and Ergonomist
Moving and Handling /Ergonomics Adviser

Frances Hannon
Associate Director Quality & Patient Experience

St Luke's Hospice Plymouth

A Human Factors Systems Approach to (Patient) Safety and Supporting Learning in the Hospice Environment

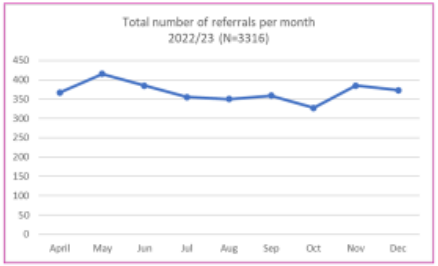
Dr Valerie Noble, St Luke's Hospice, Plymouth
vnoble@stlukes-hospice.org.uk

St Luke's Hospice Plymouth

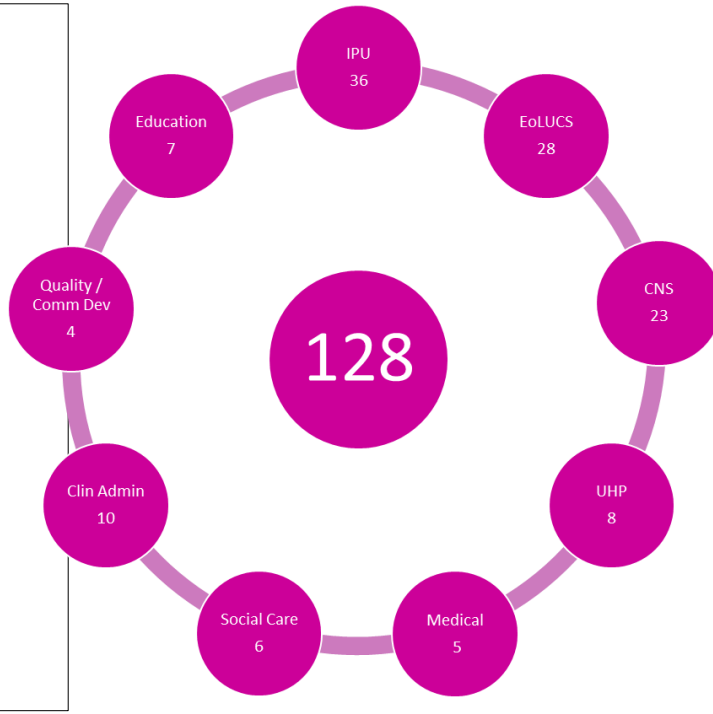
c. 2000 referrals (10/35/55)

c. 300 staff / 700 volunteers

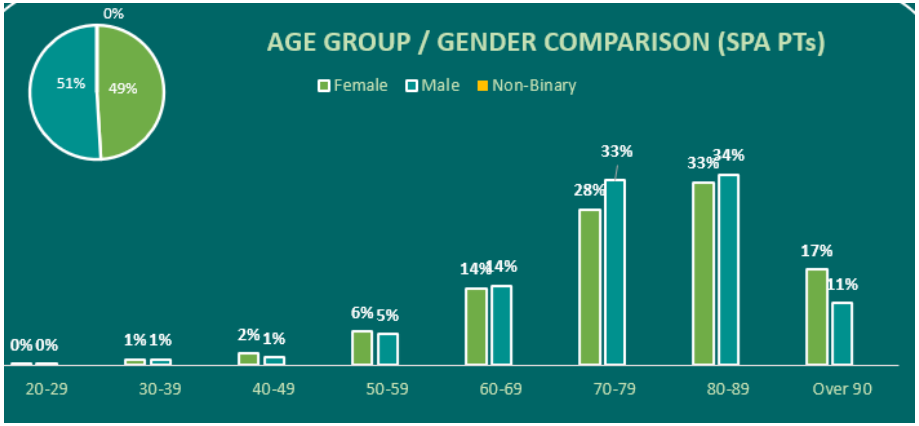
Where We Care



Team	Average referrals p/m: 22/23
UHP	114
CNS	95
EOLUCS	72
AHPs	34
IPU	29
Social Care - Clients	12
Social Care - Pts	10

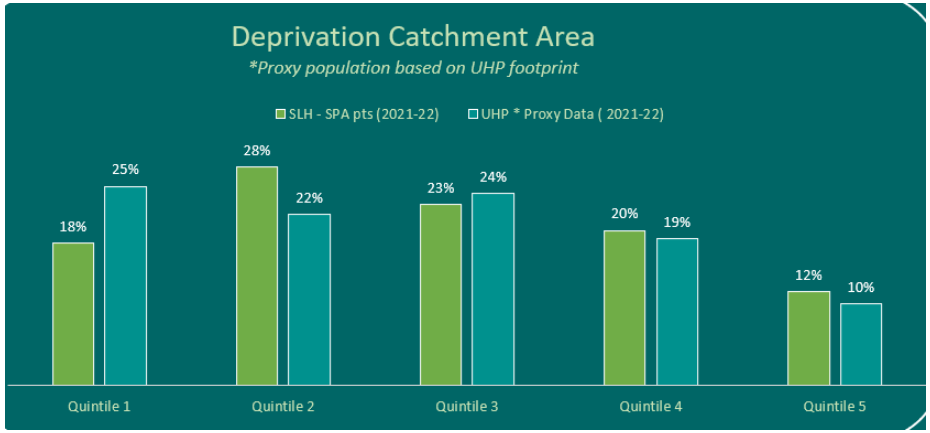


St Luke's
Hospice Plymouth

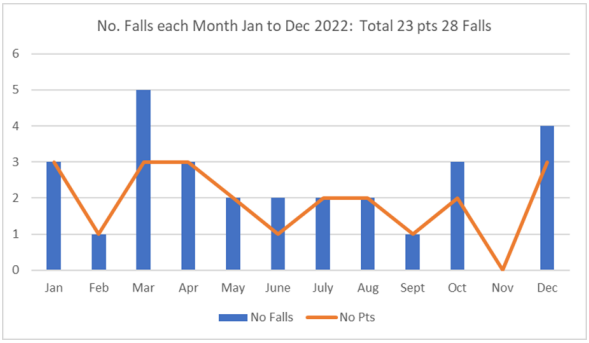


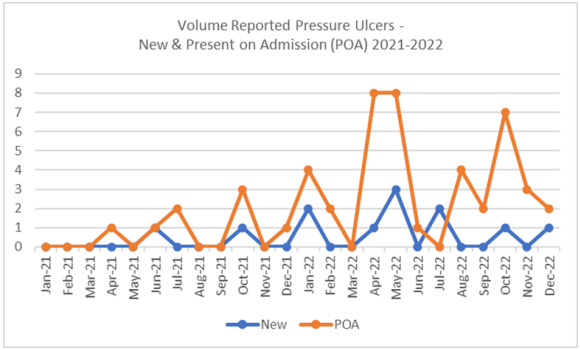
>75% pts >70 yrs
Profile of workforce >age
80% identify female

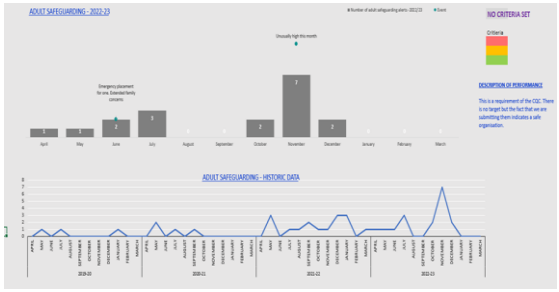
Rural, Coastal &
Urban
population

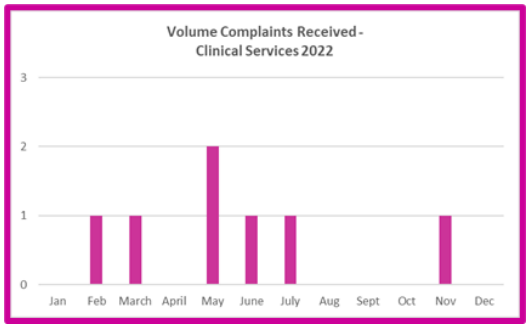


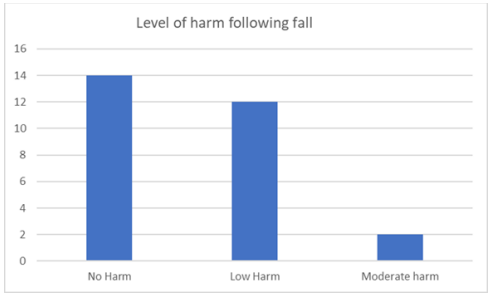
St Luke's Hospice Plymouth

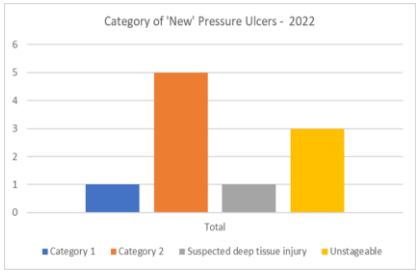












Reported Incidents:

28 patient falls, 12 acquired PUs, 14 medication, 18 safeguarding concerns raised

7 clinical complaints, >200 compliments/feedback

St Luke's
Hospice Plymouth

What PSIRF means for us?

PSIRF potential adopt a *systems approach* to pro-active design & reactive learning response to PEoL concerns across the health & social care system

Investigation summary

The investigation will:

- Seek to understand the context and contributory factors inhibiting the ability of community palliative care teams to proactively consider the holistic requirements of adult palliative patients (physical, psychological, spiritual, and social).
- Examine the ways in which patient and family expectations may differ from what is available in terms of palliative care services for adults in England.

St Luke's Hospice Plymouth

E&HF Milestones

>80%of respondents agreed that Learning Events were a helpful way to look at how incidents may occur and how to prevent them.

2013
- Bathroom
- &IPU
- layout as part
- of Falls
- Mngmt.

2016
- Introduction
- to Clinical
- Human
- Factors –
- Mandatory
- programme

2017
- *Safety Matte… Mana…*
- *Asse… t of H… Centred Organisation*

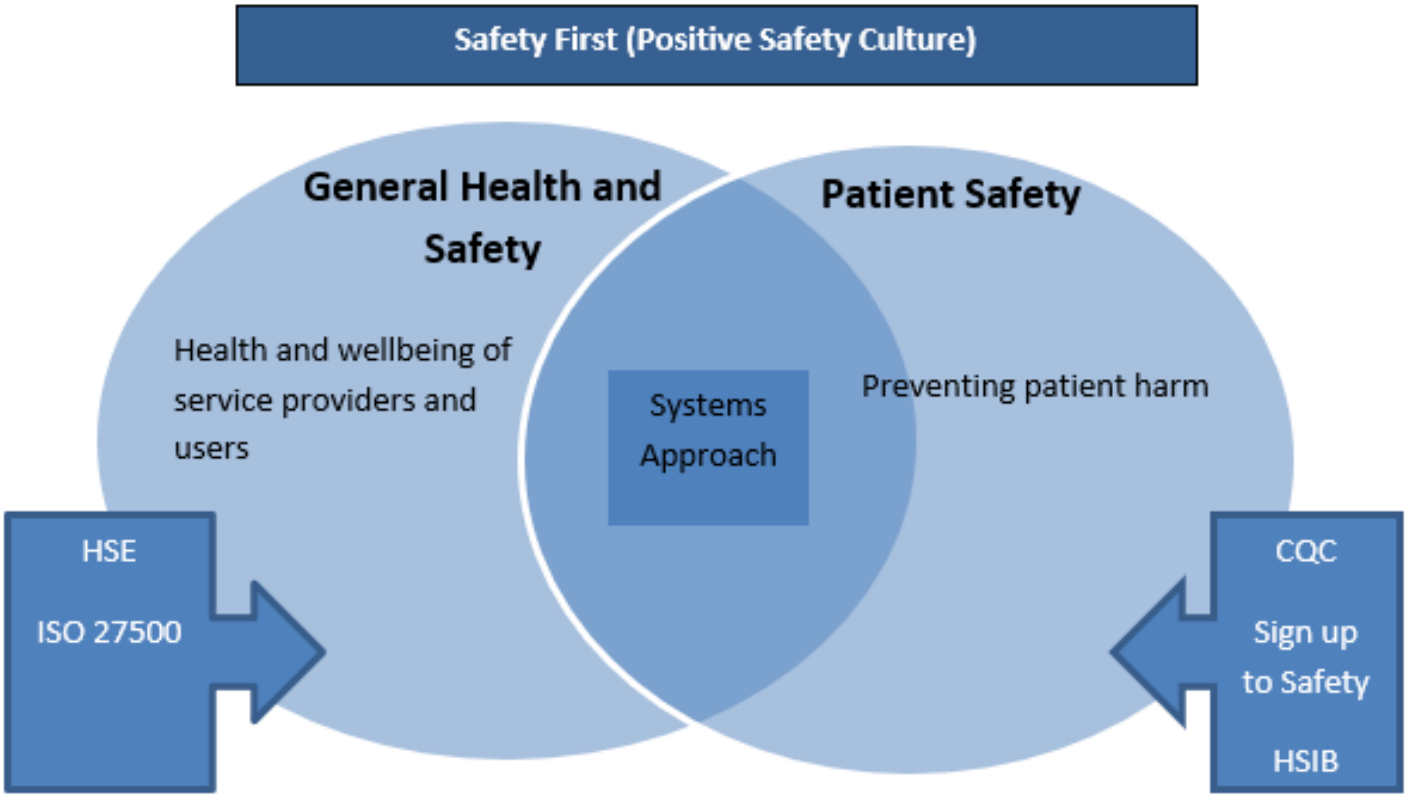
2018
- Learning Events

2019
- BEESafe

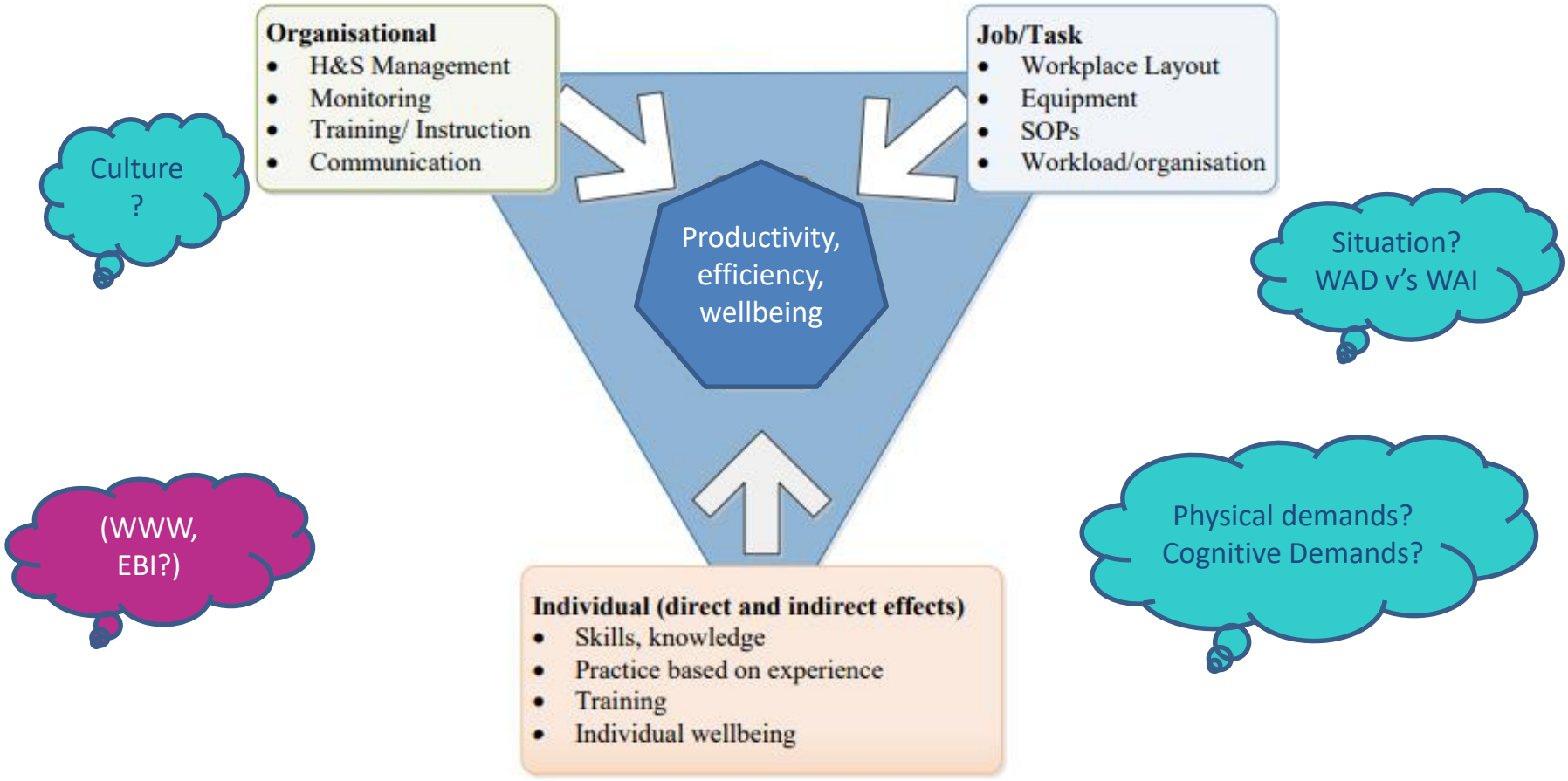
2020
- Safety
- Culture
- Survey
- Response to
- …s
- …ch,
- …oratio

2021
- Systems thinking in patient safety
- …Transformation Work
- …Hybrid working
- PSIRF training

St Luke's
Hospice Plymouth



St Luke's Hospice Plymouth




Resilience
Focus of Safety II
Everyday actions and outcomes - risks as well as opportunities
Safety
Focus of Safety I
Accidents and Investigations

Beehive represents:

- Heinrichs's triangle for safety
- Triangulation of contributory factors to positive safety culture
- Collaboration – all departments working together for productivity and efficiency

St Luke's Hospice Plymouth

BEE SAFE

BEHAVIOUR AND CULTURE
EQUIPMENT AND ENVIRONMENT
EDUCATION AND TRAINING

St Luke's
Hospice Plymouth

St Luke's
Hospice Plymouth

The St Luke's People Plan includes a series of health and wellbeing ambitions that aim to create a culture of wellbeing across St Luke's, where all colleagues feel valued and well supported.

The Health and Wellbeing Strategy covers three main areas to support this aim.

BEHAVIOUR AND CULTURE

Understanding and influencing organisational systems and human behaviour is critical to developing a positive culture and healthy working environment.

It's important to think in a systemic way, understanding how our values, culture, structures and people can impact our performance.

To prioritise these, our Health and Wellbeing Strategy has an overarching focus on behaviour and culture, including the importance of:

- management and leadership (including development of a positive culture)
- work-life balance
- personal health and wellbeing

EQUIPMENT AND ENVIRONMENT

A healthy workplace is one in which all our people collaborate to continually improve the health, safety and wellbeing of us all, and by doing this, sustain the productivity of our organisation.

We want to strengthen St Luke's culture of prevention and risk management. This will minimise factors which present risk, from a physical aspect and the wider systems in which people work, while supporting healthy choices and offering resources to actively encourage healthy behaviour. This part of the Health and Wellbeing Strategy focuses on the importance of:

- physical environment
- ergonomics and human factors (organisation, job and each individual)
- work organisation (design of workplaces and shift patterns)

EDUCATION AND AWARENESS

support available at work, as well as everyone working together to create and maintain a positive culture. To support these ambitions, St Luke's will focus on:

ONE TEAM APPROACH

HEALTH AND WELLBEING STRATEGY

St Luke's Hospice Plymouth

Tools & Technology
Characteristics such as:
- Usability
- Accessibility
- Familiarity
- Level of automation
- Portability and functionality
- Maintenance (outdated, malfunctioning)

Tasks
- Specific actions within larger work processes
- Includes task attributes such as:
  - Difficulty
  - Complexity
  - Variety
  - Ambiguity
  - Sequence

Person
- Individual characteristics:
  - Psychological impacts (e.g., frustration, stress, burnout)
  - Cognitive factors (attention, memory, confusion)
  - Preferences, personal goals
  - Knowledge, competence, skills
  - Physiological factors (illness, dehydration)
  - Physical strength and needs
- Collective characteristics: team cohesiveness

Organisation
- Structures external to a person (but often put in place by people) that organise time, space, resources, and activity.
- Within institutions:
  - Work schedules/staffing
  - Workload assignment
  - Management and incentive systems
  - Organisational culture (values, commitment, transparency)
  - Training
  - Policies/procedures
  - Resource availability and recruitment
- In other settings:
  - Communication infrastructure
  - Living arrangements
  - Family roles and responsibilities
  - Work and life schedules
  - Financial and health-related resources

Internal environment
Physical environment such as characteristics of
- Ambient environment: lighting, noise, vibration, temperature
- Physical layout and available space
- Housekeeping: cluttered, organisation, cleanliness

External environment
Societal, economic, regulatory and policy factors outside an organisation

Desired Outcomes

System Performance:

Human Wellbeing:

Appreciative inquiry question:

The SEIPS model sets out desired outcomes– what are you aiming to achieve when you deliver patient care?

St Luke's Hospice Plymouth

Table A1: PSIRF training requirements

Topic	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
Systems approach to learning from patient safety Incidents	2 days/12 hours	• Introduction to complex systems, systems thinking and human factors • Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews • Safety action development, measurement, and monitoring	✓		✓
Oversight of learning from patient safety incidents	1 day/6 hours	• NHS PSIRF and associated documents • Effective oversight and supporting processes • Maintaining an open, transparent and improvement focused culture • PSII commissioning and planning			✓
Involving those affected by patient safety incidents in the learning process	1 day/6 hours	• Duty of Candour • Just culture • Being open and apologising • Effective communication • Effective involvement • Sharing findings • Signposting and support		✓	✓

St Luke's Hospice Plymouth

? For all clinical staff

Patient safety syllabus level 1: Essentials for patient safety	eLearning	• Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety and is open to learning about risk and safety	✓	✓	✓
Patient safety syllabus level 2: Access to practice	eLearning	• Introduction to systems thinking and risk expertise • Human factors • Safety culture	✓	✓	✓
Continuing professional development (CPD)	At least annually	• To stay up to date with best practice (eg through conferences, webinars, etc) • Contribute to a minimum of two learning responses	✓	✓	✓

PSIRF standards

St Luke's Hospice Plymouth

- ✓ Funding secured from HEE
- ✓ Training delivered in-house by Human Factors Practitioner
- ✓ Eleven attendees
- ✓ **Day One** – focussed on Organisational culture, developing a positive safety culture (no blame), Human factors (SEIPS headings), Safety I and Safety 11, Task Analysis, Design
- ✓ Participants conducted a 10 minute observation at their workplace to feedback on day 2
- ✓ **Day 2** – sharing of findings, Use of SEIPS model to explore an untoward event, WTTT, Performance Influencing Factors, Interviewing (TEDS PIE) Involving families, Engaging staff, further actions required
- ➢ Follow up in 2 months
- ➢ In progress – PSIRP, action plan for Patient Safety Strategy and PSIRF
- ➢ Collaboration with AHSN, ICB leads, local providers

JULIA

BREAKOUT 1 Governance

Have other hospices identified leads for learning, response and oversight?

(Oversight roles and responsibilities for team members)

JANE

BREAKOUT 2 Getting Prepared

The Plan.

What are you doing to prepare?
How do you understand your patient safety incident profile?

FRANCES and AMBER

BREAKOUT 3 Collaboration

Please discuss experiences and ideas of engaging with Integrated Care Systems/ Boards, Patient safety partners and Patient safety specialists and how they can help.

VALERIE and CANDICE

BREAKOUT 4 Training

How are hospices undertaking the patient safety training (or plan to?)

How are you planning to involve of those affected by patient safety incidents?

Have you thought of Systems Thinking?

TRAINING

A number of hospices across Yorkshire & Humber will be joining together to commission training from Facere Melius. We have negotiated a cost of £600 per hospice for 2 places for the 4 days mandatory training.

The training will be made up of a 2 day course followed be two 1 day courses, dates to be confirmed but likely to be in March/April.

Info from National Team:

An ICB in the East recently shared a document on FutureNHS relating to their sign-off process for patient safety incident response plans in their area. It has specific guidance on how they plan to work with small providers. I thought perhaps your network might find this useful.
https://future.nhs.uk/NHSps/viewdocument?docid=159279557&done=DOCCreated1&fid=37541584

Next Steps

Please identify any further areas and write in the chat. We will upload a write up to the patient safety section on the website:

https://www.hospiceuk.org/innovation-hub/clinical-care-support/quality-improvement/patient-safety

Ask A Colleague discussion platform (HUK Members only)

Hospice UK online discussion groups | Hospice UK

Thank you!

Evaluation -

1. One new thing you have learnt today?
2. What will you change as a result of attending today?

Please write in the chat……