PSIRF – A significant shift in Patient Safety Incident Management and Cultural Change

Following the launch of the national Patient Safety Strategy, aimed to maximise things that go right and minimise things that go wrong, it was quickly realised that a different approach was needed to incident management. This required:

- **Greater Insight** – Improving our understanding of safety by drawing insight from multiple sources of patient safety information.
- **Greater Involvement** – People have the skills and opportunities to improve patient safety, throughout the whole system. As a Trust we have recruited three patient safety partners who will form part of our Patient Safety Incident Response Framework (PSIRF) implementation team and attend key meetings
- **Greater Improvement** – We will work to support safety improvement in priority areas such as the safety of older people, the safety of those with learning disabilities and the continuing threat of antimicrobial resistance.

The Patient Safety Incident Response Framework (PSIRF) will replace the current Serious Incident Framework (2015) as part of this new Patient Safety Strategy. The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS.

SO HOW IS THAT RELEVANT TO THE TEAM AT UHMBT?

Following on from the national ask, staff within UHMBT quickly realised the significant opportunity PSIRF presented the Trust with. Not only does PSIRF represent the chance to strengthen our work to eradicate 'weaponisation' of incident reporting, PSIRF offers a real opportunity to engage all staff from a range of backgrounds, faiths, ethnicities and diversity to contribute to the manner and form we respond to patient safety incidents (events) in a meaningful way.

Fortnightly implementation meetings enable our teams to explore different models including the idea of dedicated incident investigators with specialised training and ring-fenced time. Mechanisms ensure that human factors are present in investigations. Fundamentally, the new processes help to ensure that confirmation bias is guarded against and that the staff impacted are provided with a psychologically safe space to learn and contribute towards pragmatic system-based solutions.

UNDER THE NEW PROCESSES, FOUR KEY OBJECTIVES FOR CHANGE EXIST:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement.

RICHARD SACHS, SENIOR RESPONSIBLE OFFICER AND DIRECTOR OF GOVERNANCE EXPLAINS:

'We know that incident oversight can feel punitive, stifle our potential to learn and improve. The system can limit our ability to put the needs of people, including staff, patients, and families first. Crucially the current frameworks require an examination of all incidents that meet the serious threshold. This means that there is a lot of repetition of investigations into very similar incidents while many others, particularly those that are considered to result in lower harm that we could learn a lot from to improve patient safety, go unexamined.

PSIRF offers us an amazing opportunity to redesign how we respond to patient safety events to maximise learning and truly meet the needs of our demographic, applying the right approach to the right cases in a supportive way. With the right engagement, this is a significant opportunity to make a difference for patients, staff and each other. PSIRF represents a significant cultural shift towards systematic patient safety management and will help us to embed patient safety amongst wider systems of improvement. The Governance Team really value all contributions to this and would actively encourage you all to become involved.'

IN SUMMARY THE KEY BENEFITS ARE:

1. Reduced risk of errors in clinical care and patient safety incidents
2. Improved patient engagement, involvement and ownership for their own care
   Enhanced education and training for staff to ensure safe and reliable care
3. Increased patient satisfaction due to the implementation of NHS PSIRF standards
4. Improved staff safety and wellbeing
5. Reduced costs associated with safety initiatives.

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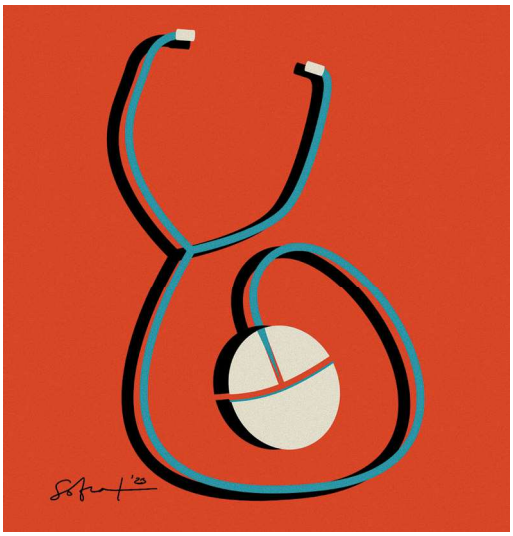

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