Independent Healthcare Providers Network

IHPN Patient Safety Incident Response Framework Conference

28 June 2023

Event supported by

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Chair's welcome

Dawn Hodgkins, Director of Regulation, IHPN

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Opening Remarks

Tracey Herlihey, Head of Patient Safety Incident Response Policy at NHS England

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Speaking Up & Just Culture

Dr Katie Grant, Risk Prevention Medico Legal Lead, The Medical Protection Society

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Selected references for Medical Protection talk IHPN PSIRF study day

- Fostering a global Speaking Up movement (cognitiveinstitute.org)

- Alan Frankel and Michael Leonard
- https://www.health.org.uk/sites/default/files/HowCanLeadersInfluenceASafetyCulture.pdf

- Alan Frankel
- A Framework for Safe, Reliable, and Effective Care | IHI - Institute for Healthcare Improvement

- Safety Culture Ladder described by Patrick Hudson, Delft Uni, Netherlands
- A number of interesting resources here:
- Moving up the culture ladder by Professor Patrick Hudson | Safe Work Australia

- Swati Gaur et al., J Am Med Dir Assoc. 2022 Feb; 23(2): 241–246.

- Integrating Principles of Safety Culture and Just Culture Into Nursing Homes: Lessons From the Pandemic
- Tasker A, Jones J, Brake S
- How effectively has a Just Culture been adopted? A qualitative study to analyse the attitudes and behaviours of clinicians and managers to clinical incident management within an NHS Hospital Trust and identify enablers and barriers to achieving a Just Cu… | BMJ Open Quality
- Being fair 2 - NHS Resolution
- Schwappach DL, Gehring K. Trade-offs between voice and silence: a qualitative exploration of oncology staff's decisions to speak up about safety concerns. BMC Health Serv Res. 2014 Jul 14;14:303
- Schwappach D, Richard A. Speak up-related climate and its association with healthcare workers' speaking up and withholding voice behaviours: a cross-sectional survey in Switzerland. BMJ Qual Saf. 2018 Oct;27(10):827-835. doi: 10.1136/bmjqs-2017-007388. Epub 2018 Mar 23
- Maxfield, D., Grenny, J., McMillan, R., Patterson, K., & Switzler, A.

- Silence Kills: The Seven Crucial Conversations for Healthcare. | PSNet (ahrq.gov)
- The Silent Treatment: Why Safety Tools and Checklists Aren't Enough - Patient Safety & Quality Healthcare (psqh.com)
- Barzallo Salazar MJ, Minkoff H, Bayya J, Gillett B, Onoriode H, Weedon J, Altshuler L, Fisher N. Influence of surgeon behaviour on trainee willingness to speak up: a randomized controlled trial. J Am Coll Surg. 2014 Nov; 219(5):1001-7
- Katz D, Blasius K, Isaak R*, et al.* Exposure to incivility hinders clinical performance in a simulated operative crisis
  - *BMJ Quality & Safety* 2019;**28:**750-757.

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How Quality Improvement fits in to the new PSIRF framework

Deborah Widdowson, Assistant Director of QI and Midlands Regional Patient Safety Specialist

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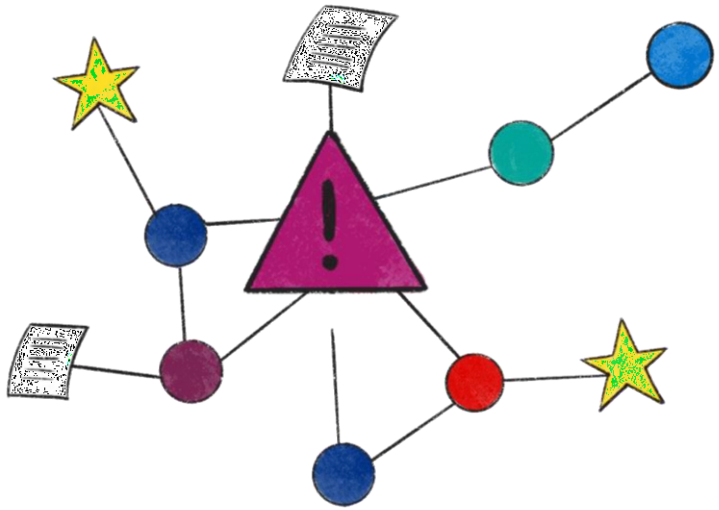
NHS England Midlands



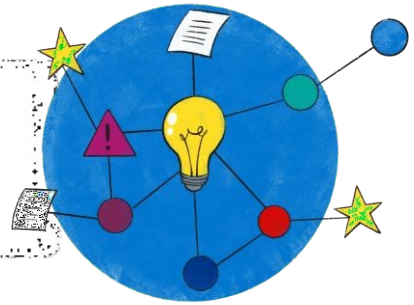
PSIRF: bridging the gap between patient safety and quality improvement

Debbie Widdowson, Assistant Director of Quality & Improvement

Achieving effective learning and improvement

COMPASSIONATE ENGAGEMENT & 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

SUPPORTIVE OVERSIGHT FOCUSED ON STRENGTHENING RESPONSE SYSTEM FUNCTIONING AND IMPROVEMENT

PSIRF is a Social Movement

- PSIRF is NOT an investigation framework
- Serious Incidents no longer feature
- PSIRF sets out a new approach to achieving effective learning and improvement following patient safety incidents
- It embeds patient safety incident response within a wider system of improvement
- Supports a significant shift in safety culture
- Prompts a move away from a reactive and bureaucratic approach to safety to a more proactive approach
- Testing and revision has been a formal part of the development cycle

Bridging the Gap

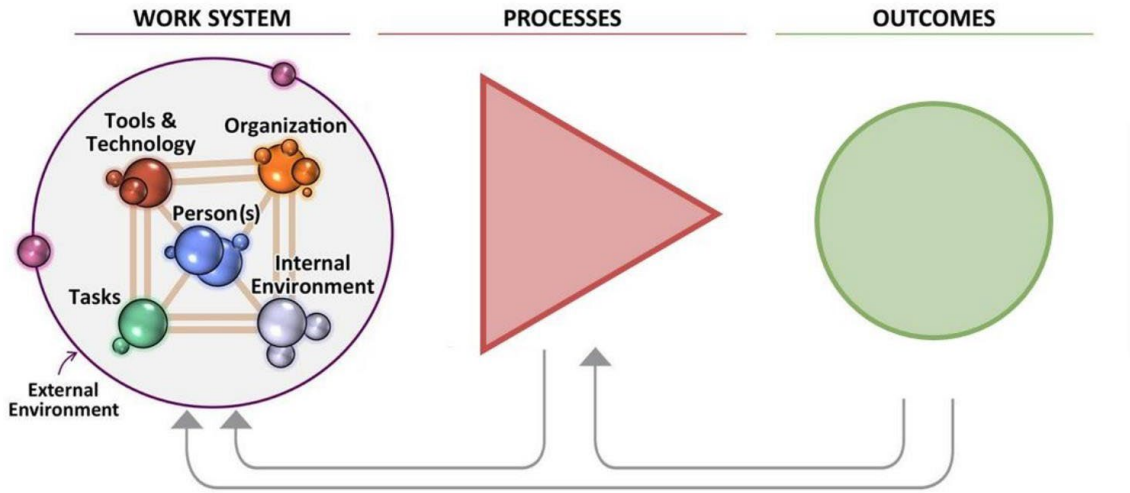
- PSIRF is an opportunity to bring greater alignment between quality improvement and patient safety
- Using insight gathered from patient safety incident response in a more integrated way across organisations.
- Less individual actions and more quality
- Working together and sharing common goals
- Breaking down barriers and removing silo working
- Learning responses can be part of the planning work for quality improvement

Using a Systems-based Approach

Looking at the components of a system and understanding their interdependencies and how those interdependencies may contribute to patient safety.

Patient safety is an emergent property of the healthcare system, it comes from interactions and not from a single component

A system-based approach will identify where changes need to be made and then monitored within the system to improve patient safety.



Balancing Response & Improvement

NHS England Midlands

- PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement.
- Organisations can explore patient safety incidents relevant to their context and populations, rather than only those that meet a certain threshold.
- Some events require a specific type of policy or regulatory response.
- PSIRF sets no further national rules or thresholds to determine what method of response should be used
- Organisations are now able to **balance effort between learning through responding to incidents or exploring issues and improvement work.**

Patient safety incident response activity

	Learning to inform improvement	Improvement based on learning	Assessment to determine required response
Circumstances in which to apply activity type	Contributory factors are not well understood and local improvement work is minimal, a learning response may be required to fully understand the context and underlying factors that influenced the outcome.	Where a safety issue or incident type is well understood and resources are better directed at improvement rather than repeat investigation.	For issues or incidents where it is not clear whether a learning response is required
Possible methods	Patient safety incident investigation, Swarm Huddle, After Action Review	Thematic reviews, horizon scanning	Structured judgement reviews, case note reviews

Safety Improvement Plans

- Safety improvement plans bring together findings from various responses to patient safety incidents and issues.
- They can take different forms:
  - Organisation-wide plans summarising improvement work
  - Individual plans focusing on a specific service, pathway, or location
  - Outputs from learning responses to single incidents where there are underlying, interlinked system issues
  - A plan to tackle broad areas for improvement (ie overarching system issues)
- Decide which approach is best suited to the data you have, and insight gained.
- The key is to demonstrate why a specific safety improvement plan approach is the right one based on available data.
- There are no thresholds for when a safety improvement plan should be developed. It must be based on knowledge gained through the learning response process and other relevant data.

If you'd like to find out more, visit:www.england.nhs.uk/patient-safety/incident-response-framework

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Shared learning: Bevan Brittan & West Suffolk NHS Foundation Trust Early Adopter Site

Hannah Taylor, Partner, Bevan Brittan
Lucy Winstanley, Head of Patient Safety and Quality, Patient Safety Specialist, West Suffolk NHS Foundation Trust
Megan Pontin, Patient Safety Incident Investigator, West Suffolk NHS Foundation Trust

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Bevan Brittan & West Suffolk NHS Foundation Trust - Early Adopter Site Shared learning

Hannah Taylor, Partner, Bevan Brittan
Megan Pontin, patient safety incident investigator
Lucy Winstanley, head of patient safety and quality

Putting you first

Bevan Brittan

QUESTION

Introduction

- PSIRF pilot launched in 2019 by NHSE in conjunction with the NHS Patient Safety Strategy
- Delayed by the COVID pandemic response and relaunched in 2020

- WSFT - Acute and integrated health provider for adult and children in West Suffolk
- Part of regional network with integrated care system and other organisations in the East
- Early adopter of PSIRF since 1st February 2021
- Now live with our third year of PSIRF and our third Patient Safety Incident Response Plan (PSIRP)

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Objectives of PSIRF

NHS West Suffolk NHS Foundation Trust

What these mean to our organisation

Improved use of resource

- Team structure – introduction of PSI
- Able to focus resource differently

Broadened approach to learning

- Opportunity to use systems-thinking and move away from root causes
- Different tools for proportionate response

Improved experience for those affected

- Putting patients at the centre of the investigation
- Ensure good mechanisms for staff support

Strengthened governance and oversight

- Develop new processes
- Accountability sits with organisation
- Responsible for quality and outcomes

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Introducing PSIRF – Challenges and changes

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QUESTION

Change from Serious Incident Framework (SIF) to PSIRF

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SIF

- The priorities for more in depth investigation were set at national level
- Root cause analysis (RCA) methodology used
- Decision about the level of investigation (serious incident RCA or local RCA) usually based on level of harm-actual or potential
- 60 day timeframe
- Oversight by commissioners

PSIRF

- The proportionate learning response/investigation is agreed at local level (with some national requirements)
- Decision about which incidents should be considered for patient safety incident investigation (PSII) is based on incidents which look to present the greatest risk to our patients and which will provide the greatest opportunity for learning
- A local plan is required - the organisation's Patient Safety Incident Response Plan (PSIRP)
- We review our PSIRP each year
- No set timeframe
- PSIIs reported on STEIS. Systems and processes for governance are managed locally.

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Developing our Year 1 PSIRP

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Ensure incidents for local PSII are narrowly defined

NHSE recommend -

3-6 narrowly defined PSII are recommended to identify common underlying factors

Select incidents for local patient safety incident investigation based on the:

- actual and potential impact of the incident's outcome (harm to people, service quality, public confidence, products, funds,
- likelihood of recurrence (including scale, scope and spread)
- potential for new learning and improvement in terms of:
    - knowledge and understanding of the deep-seated underlying factors
    - opportunity to influence efficiency and effectiveness
    - opportunity to influence wider system improvement

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Developing our PSIRP each year – the document

Patient safety risks identified through the following sources:

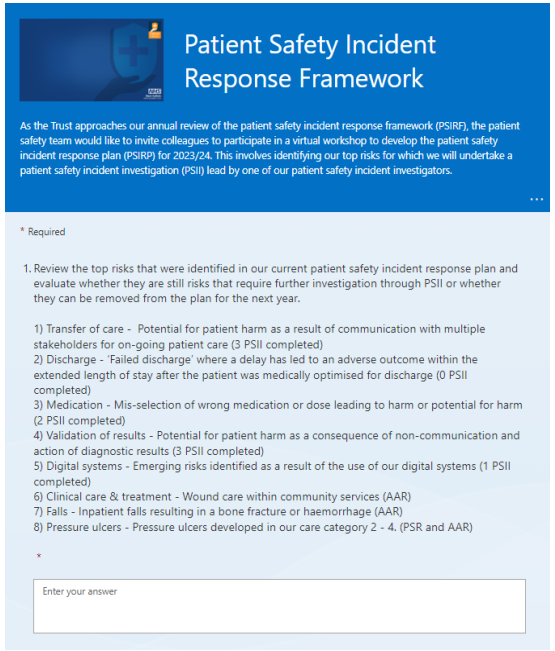
- Analysis of three years of Datix incident data for PSIRP year 1(2018-20), then yearly
- Detailed thematic analysis of Datix incident data
- Key themes from complaints/PALS/claims/inquests
- Key themes from specialist safety and quality committees (e.g. deteriorating patient, falls and pressure ulcers)
- Output of stakeholder event discussions

Collaborative workshops

NHS West Suffolk NHS Foundation Trust

To define patient safety risks and responses for the yearly PSIRP, the following were involved:

- Trust wide workshops
- Divisional representation
- Quality and safety partners
- Review of patient safety metrics
- In future aim to incorporate wider patient perspective into future planning through introduction of patient safety partners



Patient Safety Incident Response Framework

As the Trust approaches our annual review of the patient safety incident response framework (PSIRF), the patient safety team would like to invite colleagues to participate in a virtual workshop to develop the patient safety incident response plan (PSIRP) for 2023/24. This involves identifying our top risks for which we will undertake a patient safety incident investigation (PSII) lead by one of our patient safety incident investigators.

* Required

1. Review the top risks that were identified in our current patient safety incident response plan and evaluate whether they are still risks that require further investigation through PSII or whether they can be removed from the plan for the next year.

1) Transfer of care - Potential for patient harm as a result of communication with multiple stakeholders for on-going patient care (3 PSII completed)
2) Discharge - 'Failed discharge' where a delay has led to an adverse outcome within the extended length of stay after the patient was medically optimised for discharge (0 PSII completed)
3) Medication - Mis-selection of wrong medication or dose leading to harm or potential for harm (2 PSII completed)
4) Validation of results - Potential for patient harm as a consequence of non-communication and action of diagnostic results (3 PSII completed)
5) Digital systems - Emerging risks identified as a result of the use of our digital systems (1 PSII completed)
6) Clinical care & treatment - Wound care within community services (AAR)
7) Falls - Inpatient falls resulting in a bone fracture or haemorrhage (AAR)
8) Pressure ulcers - Pressure ulcers developed in our care category 2 - 4. (PSR and AAR)

*

Enter your answer

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What to investigate?

- Use our **Patient Safety Incident Response Plan**
- The organisation must determine ‘which categories of incident are priorities locally and require an investigation’
- Nationally mandated incident categories requiring PSII: **never events, learning from deaths, referred incidents e.g. HSIB, NHSEI, LeDeR**
- There is no nationally agreed or recommended annual minimum or maximum number of PSIIs each organisation should undertake
- There are no stipulated timeframes and no requirement for external scrutiny
- We have developed working documents for specialist areas such as IPC

The EIR – emerging incident review

NHS West Suffolk NHS Foundation Trust

Four key questions

- **What is the incident?** Brief synopsis of events by clinician who has been involved or has oversight. Confirm harm grading
- **What is the most proportionate response?** Does the incident meet PSII using our plan. What would the most proportionate learning response be
- **Has Duty of Candour been achieved?** Recognise statutory DoC remains. Who would be best to do this. Would a being open conversation be more appropriate
- **What do staff need in terms of support?** Is there anything further we need to do. Has a de-brief been facilitated. Referral to well-being team

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QUESTION

Investigation tool kit

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PSII – Patient Safety Incident Investigation
Led by Patient Safety Incident Investigators who are skilled in systems based investigation

PSR – Patient safety review
A concise systems based investigation coordinated by divisional patient safety managers

PSA - Patient safety audit
A process to assess and evaluate care in a systemic way. Useful for low harm, high volume incidents

AAR – After action review
A discussion of an event that enables the individuals involved to learn for themselves what happened, what went well, what needs improvement, and the lessons learnt

Round table
Multi stake holder discussion to understand context of situation and implication for system

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QUESTION

The role of the Patient Safety Incident Investigator

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The role requires:

- Completion of Patient Safety Incident Investigations
- Liaising with local specialists/experts
- Adoption of appropriate investigation tools according to the individual incident
- Confidence to identify wider safety improvement recommendations

The benefits of the role:

- Independent from clinical/operational teams
- Dedicated time to complete Patient Safety Incident Investigations
- Improved quality of investigations
- Positive effect on the patient safety team
- Positive effect on the overall safety culture within the organisation

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QUESTION

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Patient, family/carer engagement

We fulfil Duty of Candour as part of our open engagement with our patients families/carers

The patient/family/carer voice is more clearly heard

We can be flexible with timeframes if required

Our learning about what works well during the investigation/learning response process

Enables us to work more effectively to identify what they need so that we can try to meet those needs

The patient/family/carer approves the report before it is submitted for approval

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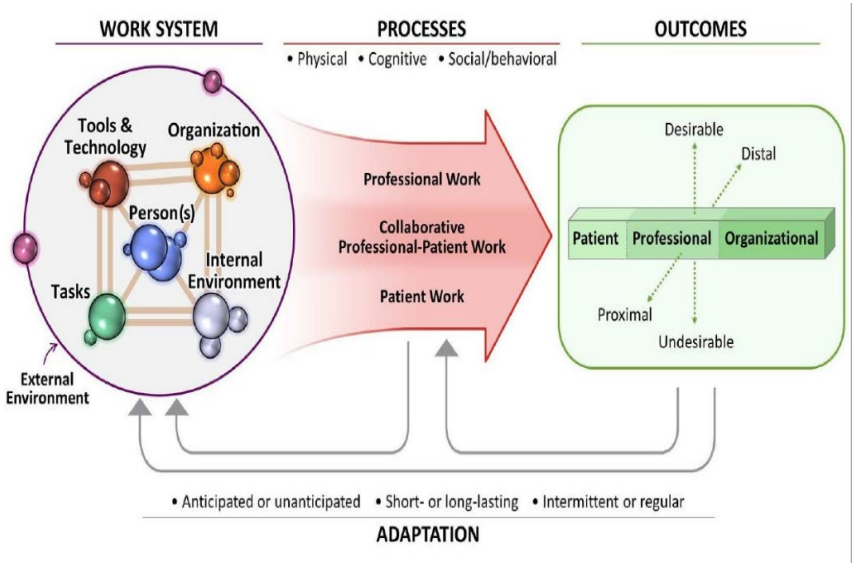
Staff engagement

Obtaining an understanding how the event came about through a human factors, systems-based investigation.



SEIPS 2.0 model taken from Holden, Carayon et al, 2013

- Conversations with those involved instead of asking for statements
- Going to the location of the incident-looking, asking, listening…
- Using appropriate tools to organise and understand the data obtained e.g. the Systems Engineering Initiative for Patient Safety (SEIPS) tool*
- All staff review and input into the draft report. It is not presented for trust approval until the participants give their approval

*Holden, R. J., Carayon, P., Gurses, A. P., Hoonakker, P., Hundt, A. S., Ozok, A. A., & Rivera-Rodriguez, A. J. (2013). SEIPS 2.0: a human factors framework for studying and improving the work of healthcare professionals and patients. Ergonomics, 56(11), 1669–1686. https://doi.org/10.1080/00140139.2013.838643

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QUESTION

Working with the coroner

NHS West Suffolk NHS Foundation Trust

- PSIRF does not change the scope of the Inquest
- We assist the Coroner with their enquiry
- Who, when, where and how?
- We proactively seek to provide reassurance about learning and preventing future deaths
- We present investigation findings which support the Coroner to make decisions regarding PFD
- We encourage dialogue with families

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QUESTION

Top tips!

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- Board engagement
- Identify resource
- Do not underestimate the importance of communications support
- Duty of candour requirements can be met within PSIRF
- Ensure you have sight of other workstreams/engagement projects/pathway reviews in progress within your organisation
- Remember that PSIRF will be a continuous evolution process

- You can find more resources on the NHS England website:
  https://www.england.nhs.uk/patient-safety/incident-response-framework/

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Thank you for listening

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Independent Healthcare Providers Network

Regulation & Assessment: PSIRF and the single assessment framework

Claire Land, Policy Manager, CQC

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PSIRF – Regulation & Assessment

- How PSIRF aligns to CQC's strategic ambitions
- Implications for the independent healthcare sector
- How PSIRF fits in to the single assessment framework and the new regulatory approach

Claire Land
Regulatory Policy Manager (Acute)

June 2023

Our role and purpose

The Care Quality Commission is the independent regulator of health and adult social care in England.

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our strategy

Our overall aim and focus is on tackling inequalities and driving improvement

Safety through learning

The importance of culture	Building expertise	Involving everybody	Regulating safety	Consistent oversight and support

“We’ll be looking for cultures that have learning and improvement at their core. In a good safety culture, it accepted that all incidents provide opportunities to learn and improve”

“We’ll expect all services to have stronger safety and learning cultures and that learning and improvement should be the primary response when anyone speaks up”

“We’ll look at how services and systems assure themselves that they have the right knowledge and expertise, and how they are investing in improving safety”

“Learning and improvement must be the primary response to all safety concerns in all types of services and local systems”

“Services that are not open to learning can’t be safe. We’ll use our powers and act quickly where improvement takes too long…where services are unable to identify systemic issues…or fail to learn lessons from widely publicised failures happening across health and care”

Preparing inspection & assessment teams for PSIRF

The Care Quality Commission's (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.

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.

Where it specifically considers PSIIs, CQC's review will consider how these meet the national patient safety incident response standards. CQC will assess, in partnership with the NHS England PSIRF team, the specific training requirements for those undertaking reviews of PSIIs.

Fortnightly calls with NHSE PSIRF leads

'Key messages' focusing on what good looks like for a provider transitioning over to PSIRF

Q&A session with NHSE colleagues

Engagement sessions with individual teams

Worming with NHSE and a small group of inspectors to map variations under PSIRF

Wider work on the StL ambitions with regards to building our internal expertise

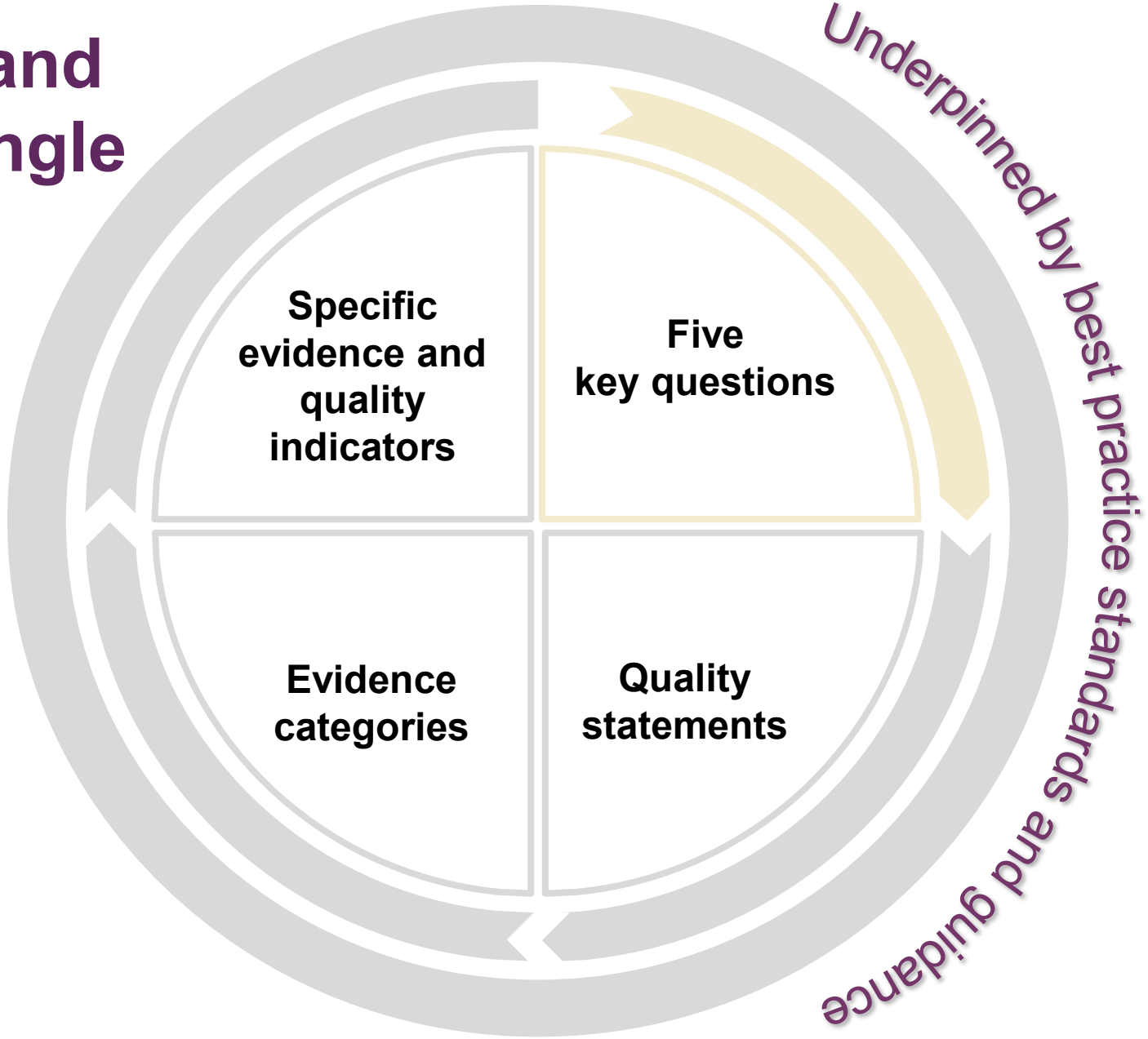
Proportionality

NHSE has started to address the proportionality challenges, which are particularly pertinent for independent healthcare providers and this will help CQC:

Large independents (Spire, Cygnet, Nuffield)	Smaller independents	Spot purchasing
NHSE are encouraging identification of 'lead commissioner' for PSIRF where there is agreement between relevant commissioners and provider	Key is word is proportionate; there needs to be an agreed approach for how to develop/ agree a patient safety incident response plan and policy (this might be an amendment to existing policies rather than entirely separate piece of work	Likely to be for the commissioner to check that there is an appropriate plan/policy in plan every time a patient is placed within such organisation
NHSE developing guidance principles for what it means to be a 'lead commissioner' (term to be confirmed) for PSIRF: • Some commissioners are concerned that there will be confusion re broader 'lead commissioner' role which includes much broader quality monitoring and contracting activity • Some ICB also want to ensure that the role/responsibility of the 'local' commissioner in oversight of incidents/quality concerns is not lost/replaced by 'lead commissioner' which may be geographically remote	Need to know that providers can recognise, record, and respond to patient safety incidents (in systems-based way) and use insight to inform continuous improvement	For the purposes of joining and benefiting from PSIRF networks, they could join their local/nearest network/group.
	ICBs may need to think about how to support access to expertise in systems based learning	

Evidence for compliance and how PSIRF fits into the Single Assessment Framework

- **Five key questions** - remaining at the core - aligned with “I” statements, drawn from work by Think Local Act Personal (TLAP), National voices and the Coalition for Collaborative Care on Making it Real.
- Focused on what people expect and need from their care.
- A basis for gathering structured feedback.



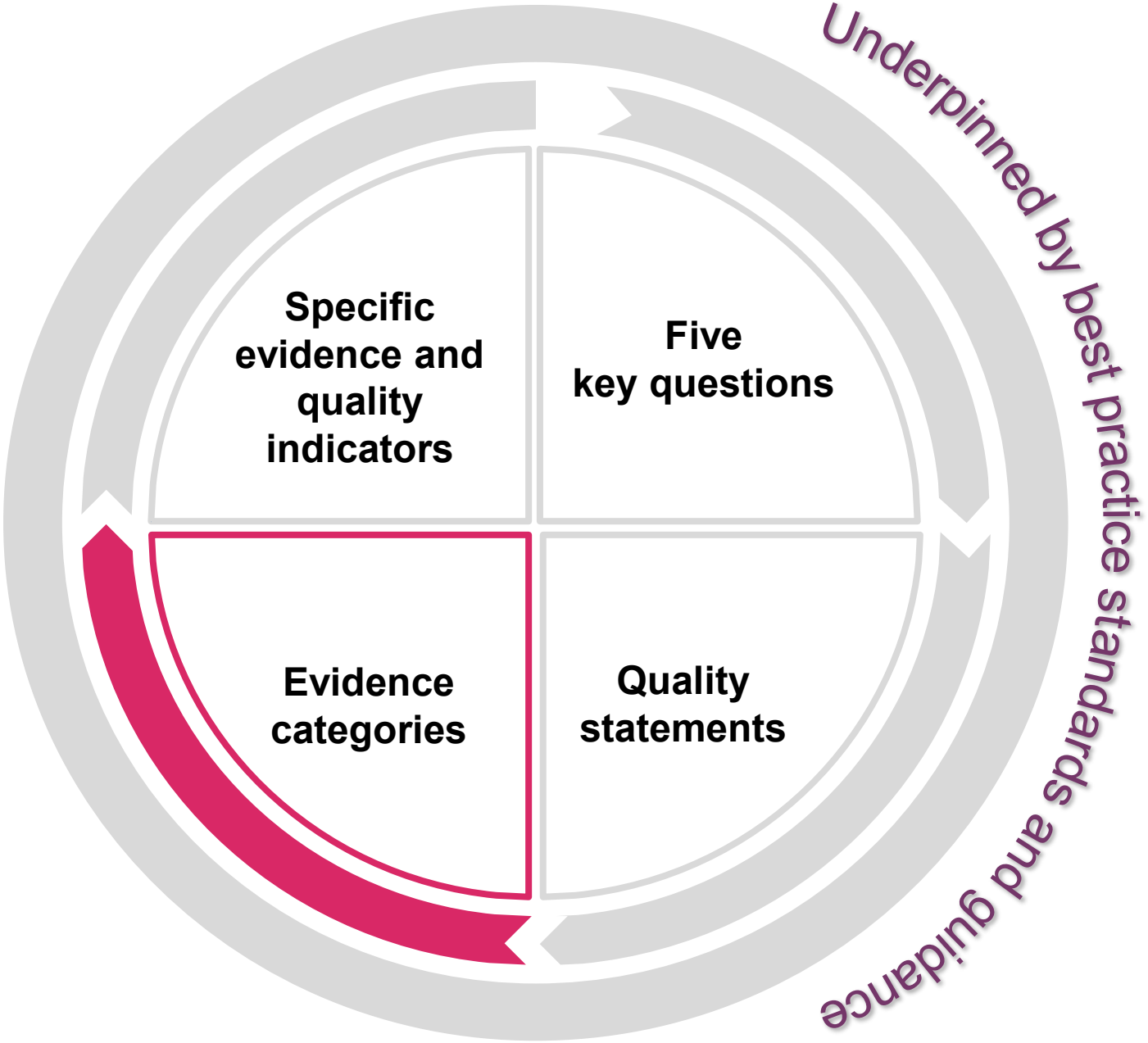
Learning culture

We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Related regulations

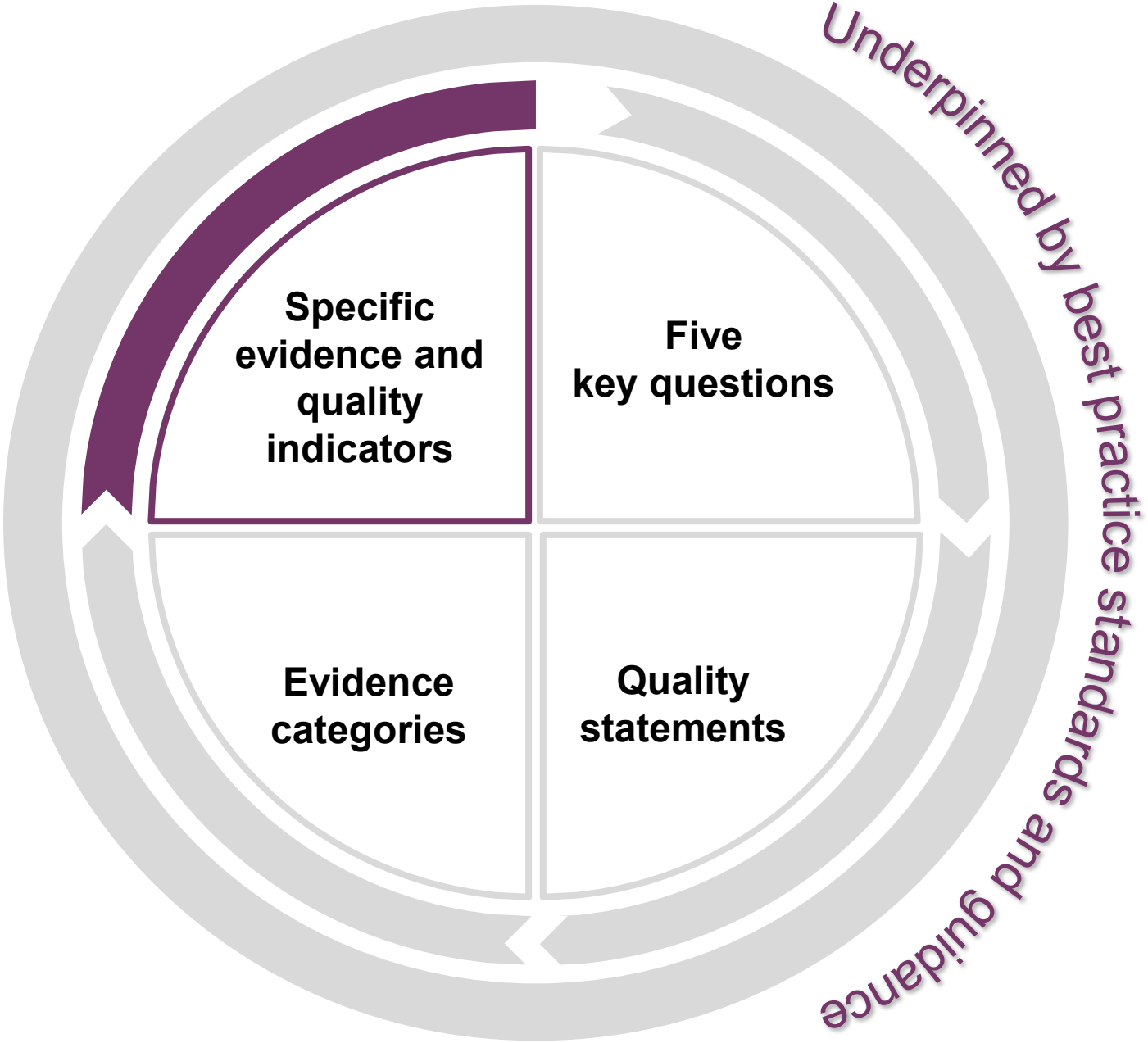
Regulation 12: Safe care and treatment
Regulation 16: Receiving and acting on complaints
Regulation 17: Good governance
Regulation 20: Duty of candour

1. People's experience
2. Feedback from staff and leaders'
3. Feedback from partners
4. Observations
5. Processes
6. Outcomes



- **Specific evidence and quality indicators** - Data and information specific to the area of work being considered

- The PSIRF and associated guidance will be (one of) the underpinning best practice standards and guidance for the Learning Culture QS



Some questions for you!

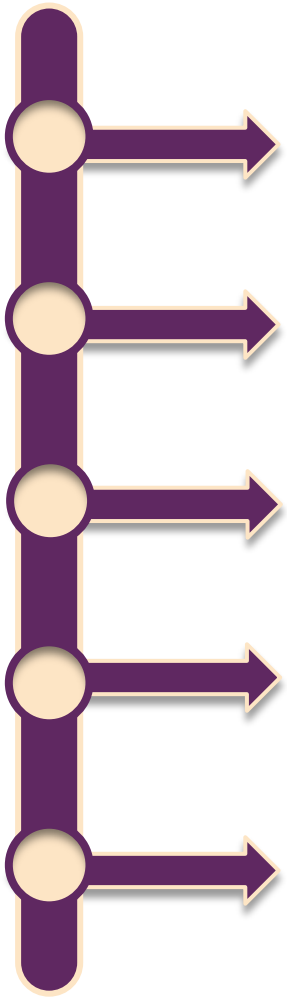
- Where you are providing a mix of NHS and non-NHS funded care, are you likely to apply PSIRF to both?

- What are your key concerns about meeting the PSI standards as you move through transition?

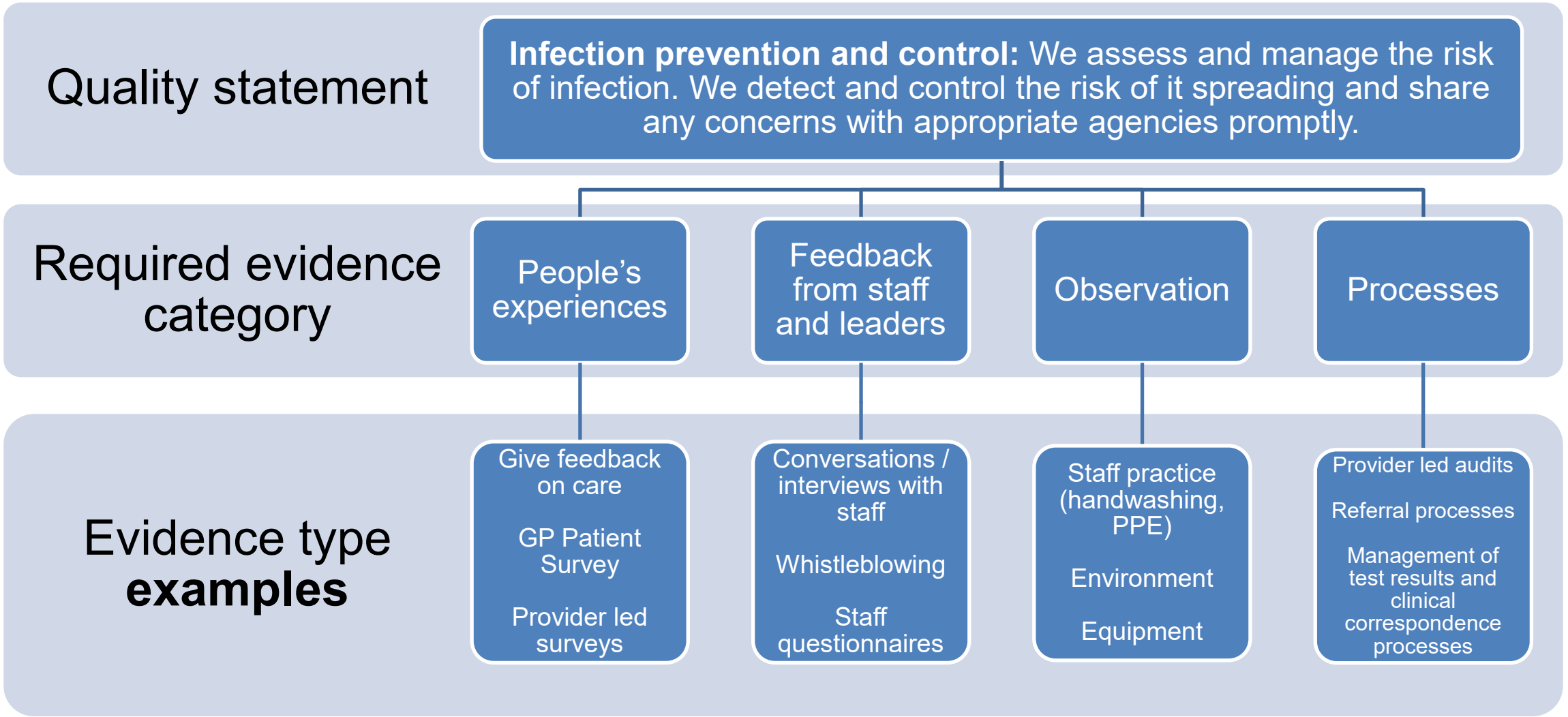
Come and have a chat during the break or claire.land@cqc.org.uk

Changes to our regulatory approach

Multiple assessment frameworks	Single assessment framework
Ongoing monitoring and with inspections scheduled according to previous rating	Ongoing assessment of quality and risk
Evidence gathered during onsite inspection (single point in time)	Evidence gathered at multiple points in time (not just through inspection)
Judgements and ratings decisions made using ratings characteristics	Teams assign score to evidence
Narrative inspection report	Ratings updated, short narrative published



How we reach a rating - example



How we reach a rating - example

Evidence category	Score
People's experiences	1
Feedback from staff and leaders	2
Observation	2
Processes	2
Total score ÷ maximum score	**7÷16=44%**
Total quality statement score	**2**

25-38% = 1
39-62% = 2
63-87% = 3
>87% = 4

How we reach a rating - example

Quality statement	Score
Learning culture	2
Medicines optimisation	2
Safe systems, pathways and transitions	1
Infection prevention and control	2
Safeguarding	1
Involving people to manage risks	2
Safe environments	1
Safe and effective staffing	2
Total score ÷ maximum score	**13÷32=41%**
Key question rating	**Requires improvement**

25-38% = Inadequate
39-62% = Requires improvement
63-87% = Good
>87% = Outstanding

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Implementation of Patient Safety Partners – Key benefits & challenges

Melanie Whitfield, Associate Director of Patient Safety, Clinical Governance and Risk Management, Trust Patient Safety Specialist, Kingston Hospital NHS Foundation Trust

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Our Journey to Patient Involvement in Patient Safety.

Melanie Whitfield - Associate Director of Patient Safety, Clinical Governance and Risk Management. Trust Patient Safety Specialist

Inspected and rated Outstanding
CareQuality Commission

Living our values every day
CARING SAFE RESPONSIBLE VALUE EACH OTHER INSPIRING

Starting point and expectations

The NHS Patient Safety Strategy

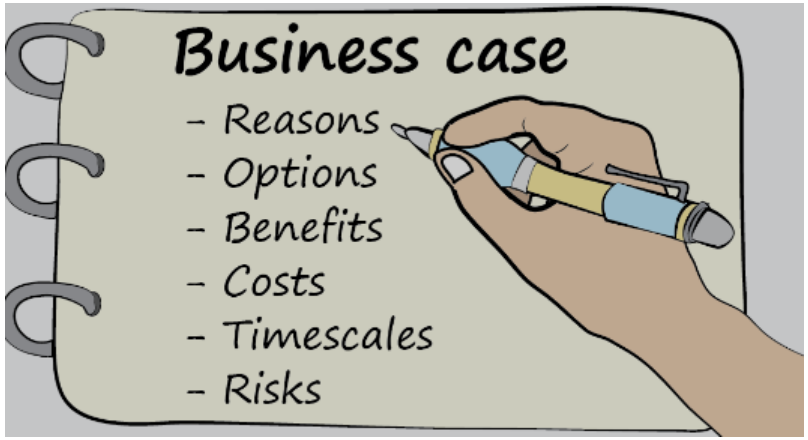
Safer culture, safer systems, safer patients

July 2019

Starting point and expectations

Patient safety partners bring powerful insight and perspectives to safety improvement.

Recruitment and selection



Recruitment and selection

- Job description
- Person Specification
- Process

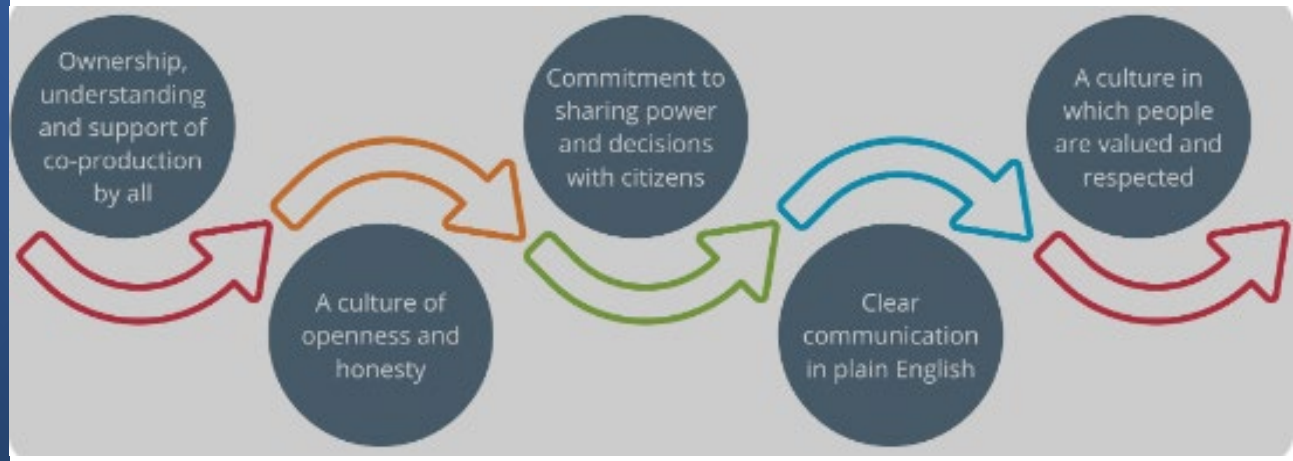
Risk and Quality Assurance
Patient Safety Partner

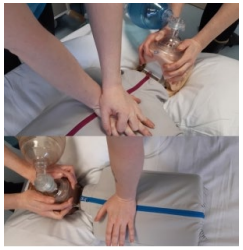
Recruitment and selection

Internal Comms

https://youtu.be/dHG08-kXBpk

Essential Roles





Patient Safety Walk Rounds

Aim

- Raise and empower the patient voice
- Critical friend
  - Speak Up
  - Listen up
  - Follow up
- Active contribution
- Robust involvement, engagement and support

Benefits

- Elevate the patient voice
- Opportunity
- Interaction
- Challenge
- Vision

How’s it going

Challenges

"I remind you, this is a private matter. We do not air our dirty laundry in public."

Challenges

- Early engagement and involvement of Boards and NED's.
- Board clarity and understanding.
- Focus and reassurance on importance of maintained confidentiality

Remember patient care and, by default, patient safety is both a product and a service.

Safety needs to be something we 'do' , not something we have.

Challenges

What supports me to participate

One-to-ones provide a regular opportunity for the PSP and their manager to discuss what the PSP has been involved in, how they are feeling, how they are performing, whether they need help with anything or are interested in getting involved in a particular area.

A copy of this form summarising one-to-one discussions will be shared with the PSP and held by their manager.

Name of PSP..... Date .....

Name of manager.....

What has been going well?

.....

What has not?

.....

What training or support do you need?

.....

Are there any other areas of patient safety work that you'd be interested in getting involved in?

.....

Outputs from conversation (including any agreed actions)

.....

PSP signature.....

Manager's signature.....

Key Nuggets

- Co-production
- Demographics
  - Take your time - Right people
- Time Required
  - Transparency of requirement
- Payment
  - Clarity
- Passion and input
- Sharing PSP's
- Elevate the patient voice
- Expert patient
- Funding/payment
- 1:1's (Team and Individual)
- Annual appraisal

Next Steps

- Grow the profile of our patient safety partners
- Increase visibility of our Patient Safety Partners
- Rolling recruitment programme
- PSP's mentoring new PSP's
- Bi-monthly walkarounds
- Collaboration with SWL PSP groups
- Collaboration with National PSP's
- PSP Newsletter update

Thank you

Questions?

Independent Healthcare Providers Network

The role of the NHSE commissioned AHSN Patient Safety Collaboratives

Wendy Stobbs, Head of Programmes,
Health Innovation Manchester AHSN

Event supported by

MPS | PARTNERSHIPS

National Patient Safety
Improvement Programmes

National
Programmes

National Patient Safety Collaboratives

Academic Health Science Networks

The role of the NHSE commissioned Academic Health Science Network Patient Safety Collaboratives

Wendy Stobbs- Head of Programmes and Patient Safety Lead for PSC at Health Innovation Manchester, National AHSN Co-Lead for System Safety

Delivered by:
*The**AHSN**Network*

Led by:
NHS England

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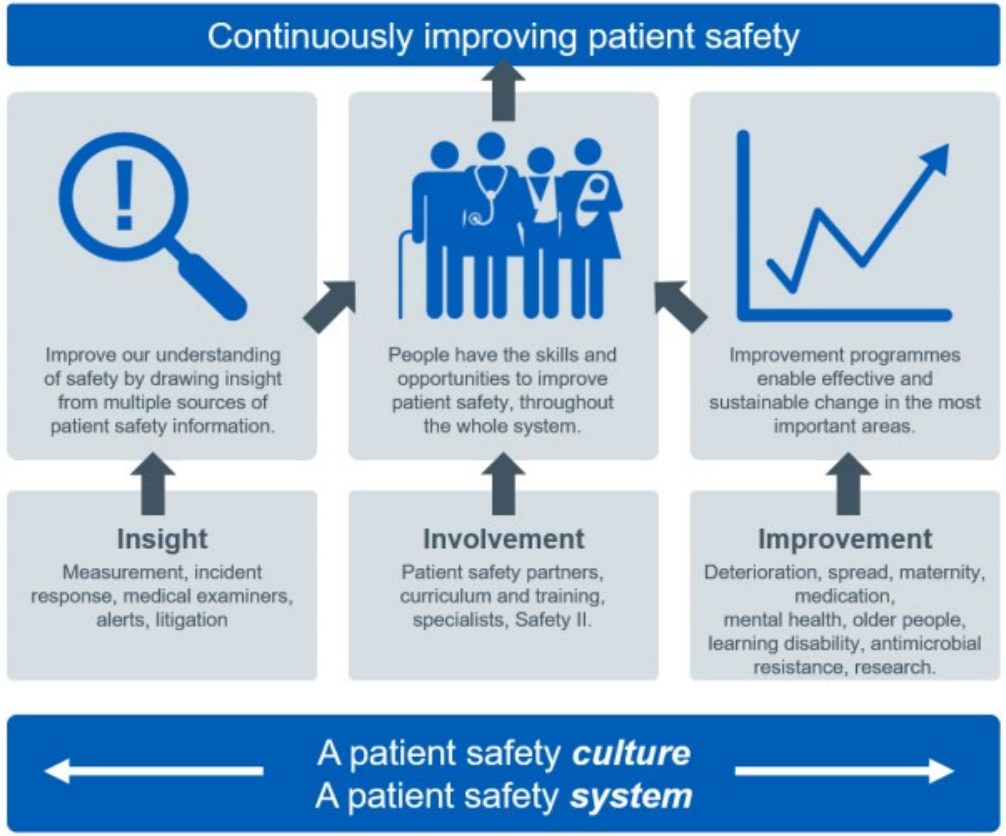
The AHSN Network

www.ahsnnetwork.com/patient-safety

Patient Safety Strategy

The NHS Patient Safety Strategy provides a structure to support ICS statutory responsibilities:

- **Patient safety culture** – encouraging engaged, visible leadership promoting openness, just culture and continuous improvement, valuing diversity and equality.
- **Patient safety systems** – governance, accountability, supporting whole systemic and systematic improvement, including primary care, intelligent use of digital.
- **Insight** – a whole organisation commitment to identifying risks, reporting incidents, understanding what contributes to safety, identifying how we normally keep our patients safe
- **Involvement** – a focus on people, giving them the skills and support they need, fundamentally involving patients and the public, recognising the need for specific expertise
- **Improvement** – identification and implementation of improvement priorities using quality improvement science to continuously reduce risks to patients.



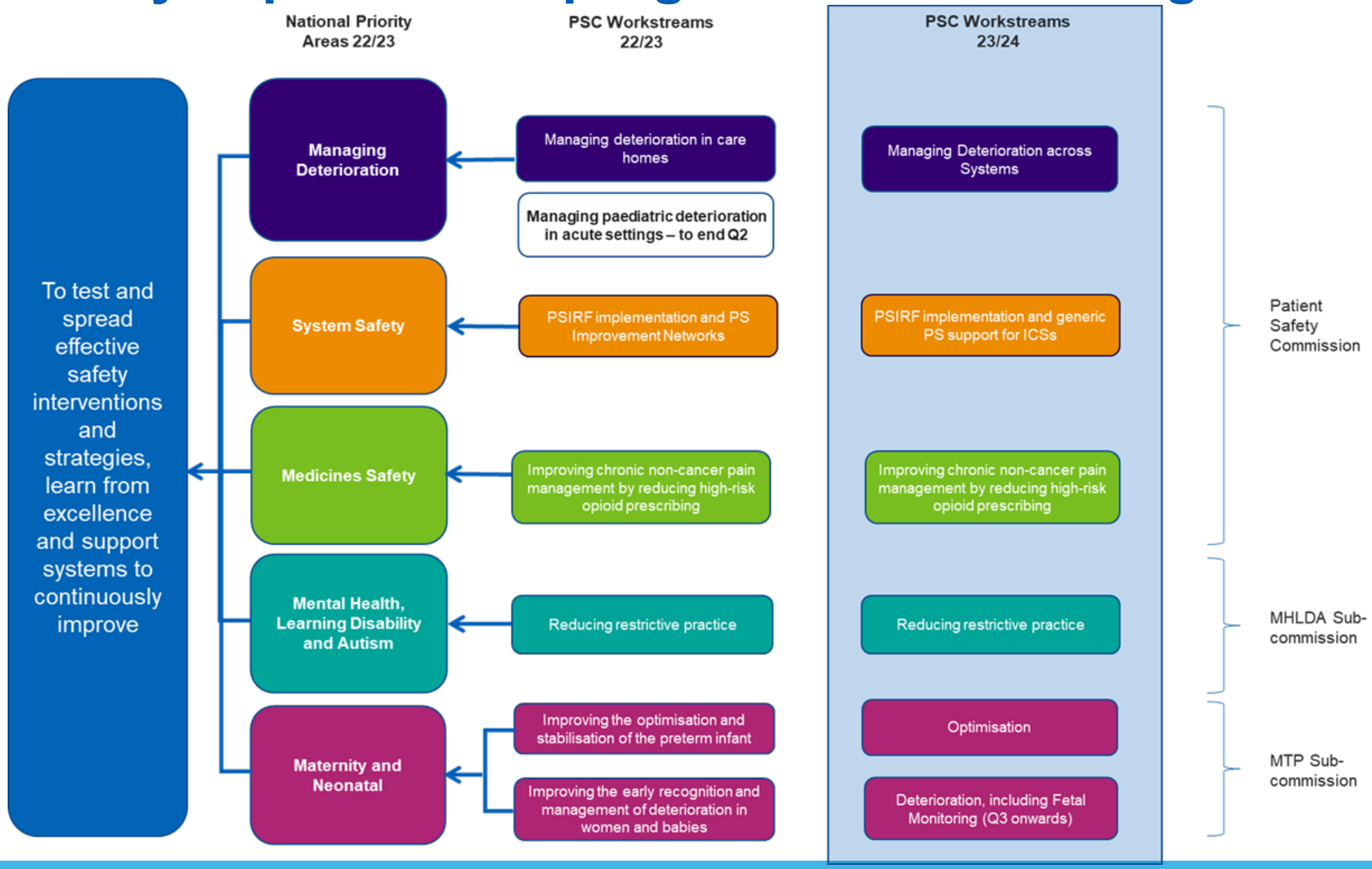
[NHS England » The NHS Patient Safety Strategy]

National Patient Safety Improvement Programmes

- Worldwide, patient safety incidents cause death and disability.
- Patient safety is about maximising the things that go right and minimising the things that go wrong for people receiving healthcare. It is integral to the NHS's definition of quality in healthcare, alongside effectiveness and patient experience.
- Programmes are commissioned by the NHS England patient safety team and delivered by the Academic Health Sciences Network through their Patient Safety Collaboratives.

'The National Patient Safety Improvement Programmes aim to support and encourage a culture of safety, continuous learning and improvement across the health and care system, helping to reduce the risk of harm and make care safer for all.'

Safety improvement programmes driver diagram



NHS patient safety improvement impact 2022-23

Managing Deterioration in Care Homes

Work with **11,621** care homes to support safe care and prevent over **57,000** emergency admissions

Patient Benefit from Medicines Safety

Saving **347** lives

Prevented **3,337** severe harms

Avoided **19,263** readmissions

Maternity and Neonatal Safety

Improving the care of premature babies has:

- Saved up to **465** lives [1 2]
- Prevented up to **385** cases of cerebral palsy [3]

Mental Health Safety

15% reduction in traumatising **restraint, seclusion** & **rapid tranquillisation** restrictive practices recorded in pilot work on 38 inpatient wards.

Working with all Mental Health Trusts in England to prevent over **19,000** restrictive practices each year

Safer Tracheostomy Care

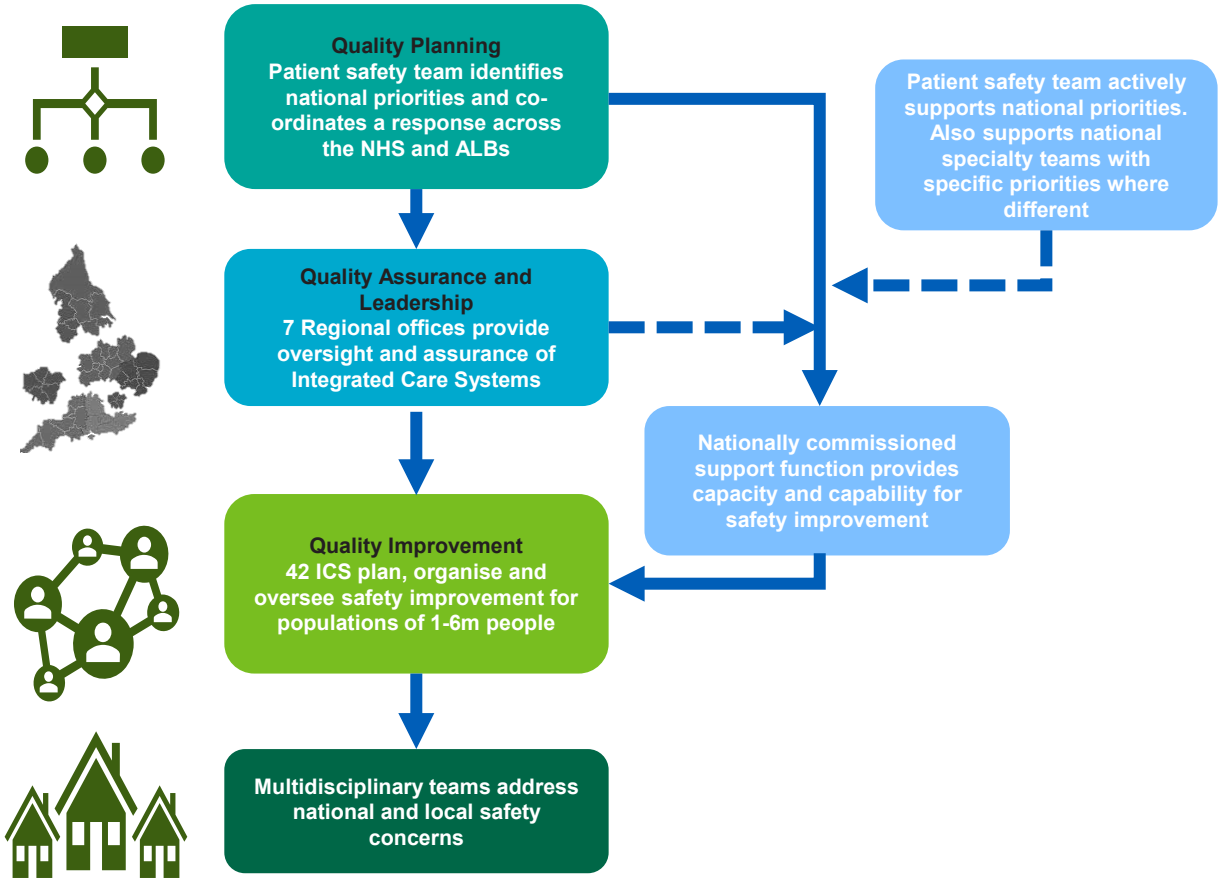
Improving tracheostomy care with an average reduction in the total hospital length of stay of **33 days per admission** needing tracheostomy, and an estimated saving of **£1.92m per hospital per year** in England

System Safety

Supporting the implementation of **Patient Safety Incident Response Framework** (PSIRF) in **all NHS provider organisations** in England.

Data correct as of 25 May 2023

Improvement Approach



Co-ordination of national safety priorities across NHS directorates and ALBs

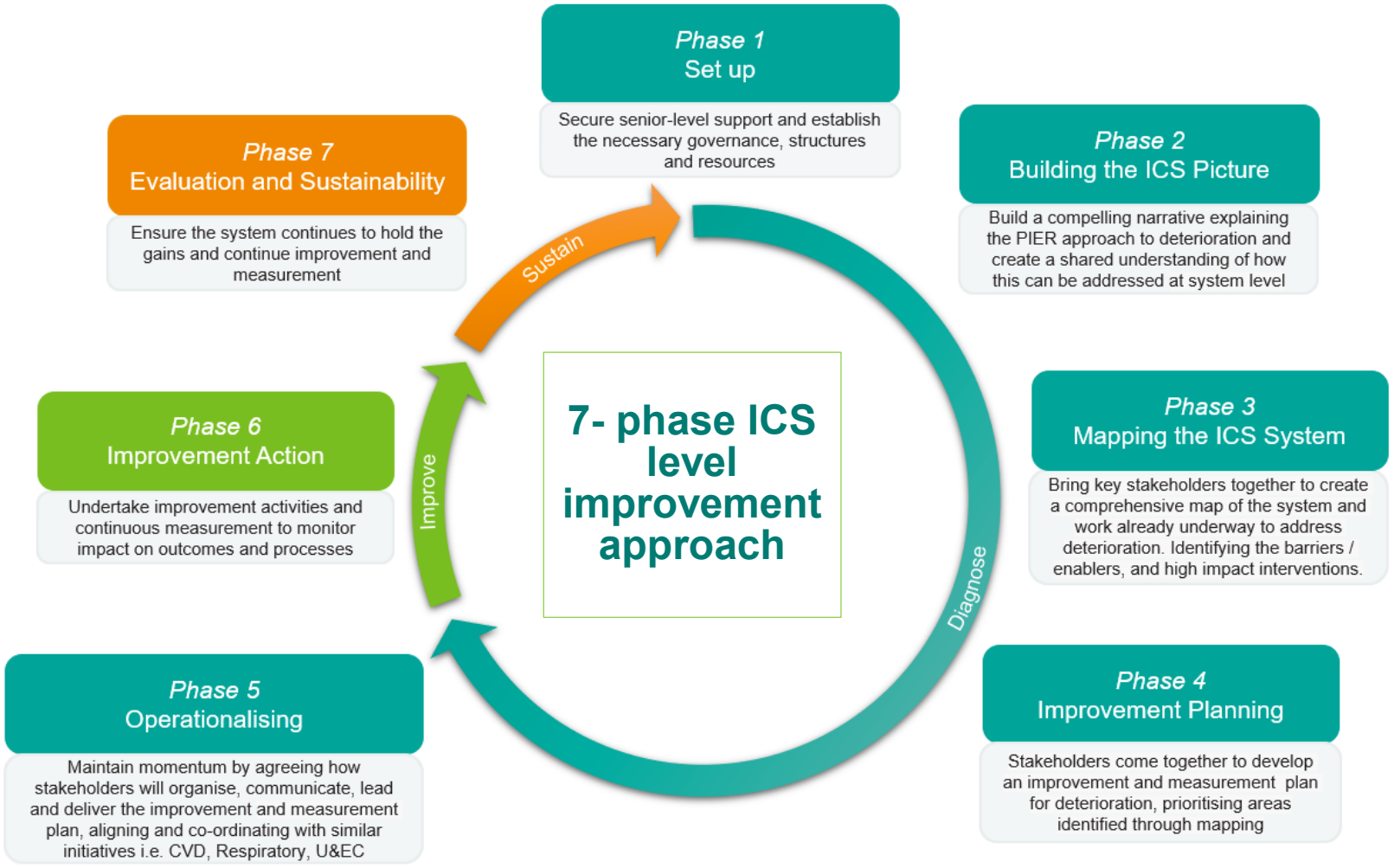
Place-based improvement, driven by ICS system quality groups, supported by the **Patient Safety Collaboratives**

Oversight by regional teams

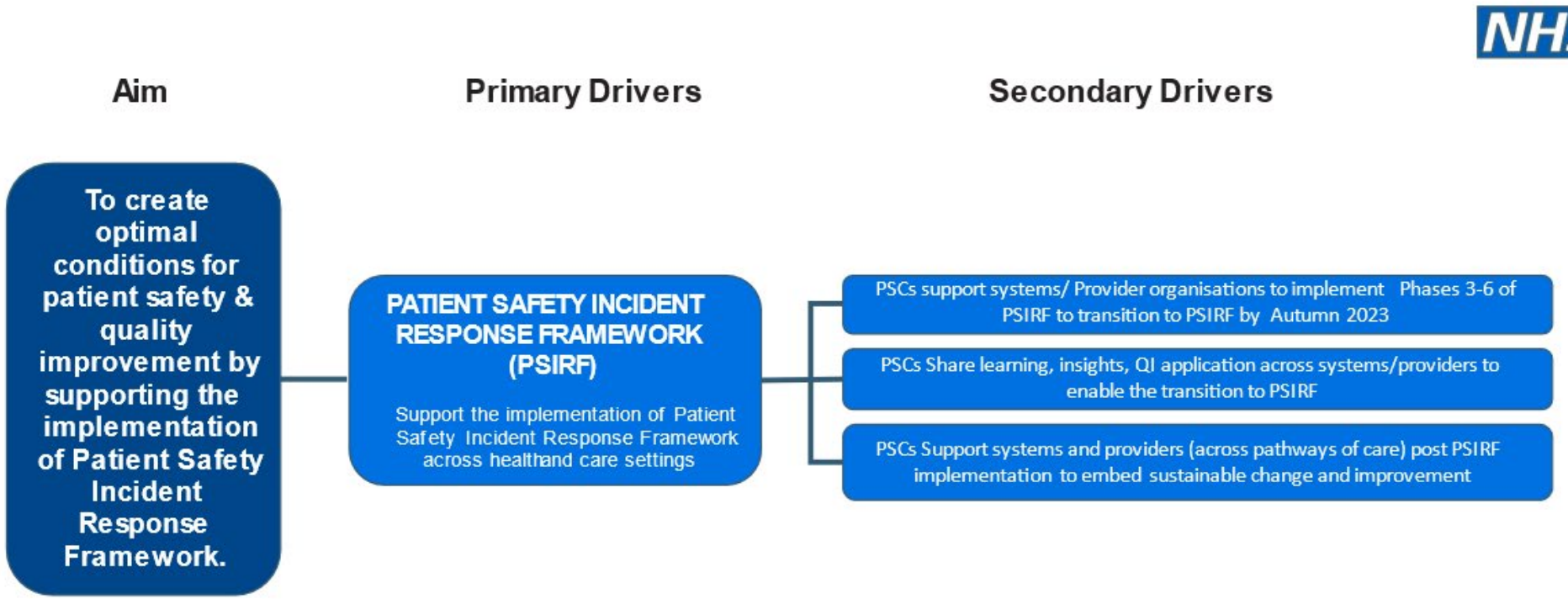
Collectively, the PSCs support ICSs across England to bring about systematic and sustainable improvement to patient safety by:

- Providing patient safety improvement expertise and coaching
- Identifying and engaging key ICS personnel who can be enabled and supported to lead patient safety improvements
- Identifying and contributing to ICS groups, committees or fora that have a remit for patient safety (for example System Quality Groups, Medicines Safety Committees)
- Supporting any mapping work across the safety priorities to identify good practice, if not already known
- Helping to build the infrastructure for patient safety improvement where it does not already exist
- Fostering a network approach to safety improvement, including key patient safety roles such as Patient Safety Specialists and Medication Safety Officers
- Advising on local measurement for improvement methods
- Advising on resource, system, flow and process mapping for improvement
- Capturing and sharing the benefits, lessons and impact of safety improvement
- Championing patient safety improvement work and the ambitions of the NHS Patient Safety Strategy

Quality Improvement Approach



Supporting System Safety



Outputs/Deliverables

- By Q1 (June 2023) PSCs to identify ICSs and providers who need focused PSIRF support and create a plan for the support that will enable the providers to transition to PSIRF by Autumn 23.

- Between Q3-Q4 (Oct 23 - Mar 24) all PSCs to use an approach (e.g coaching systems) to support systems (i.e., ICSs and providers) with ongoing PSIRF activities to embed changes and improvements.

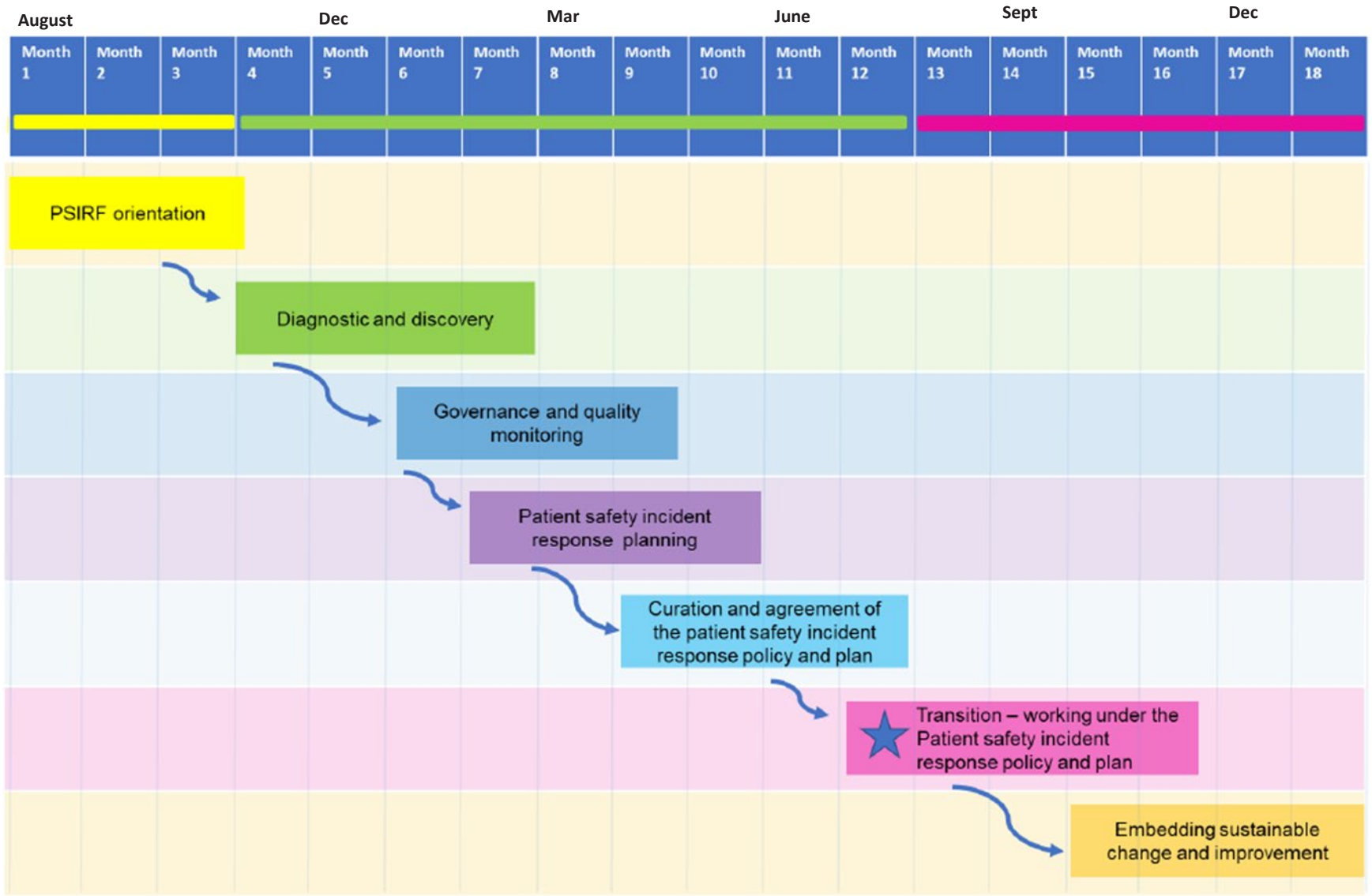
Support for the PSIRF transition- 22/23

Ambition

- Patient Safety Collaboratives supported Systems (ICSs) with the implementation and scale up of PSIRF over 2022-23.
- By March 2023 the majority of NHS providers within each ICS needed to have completed Phases 1-2 of PSIRF and commenced activities relating to subsequent phases 3-6.

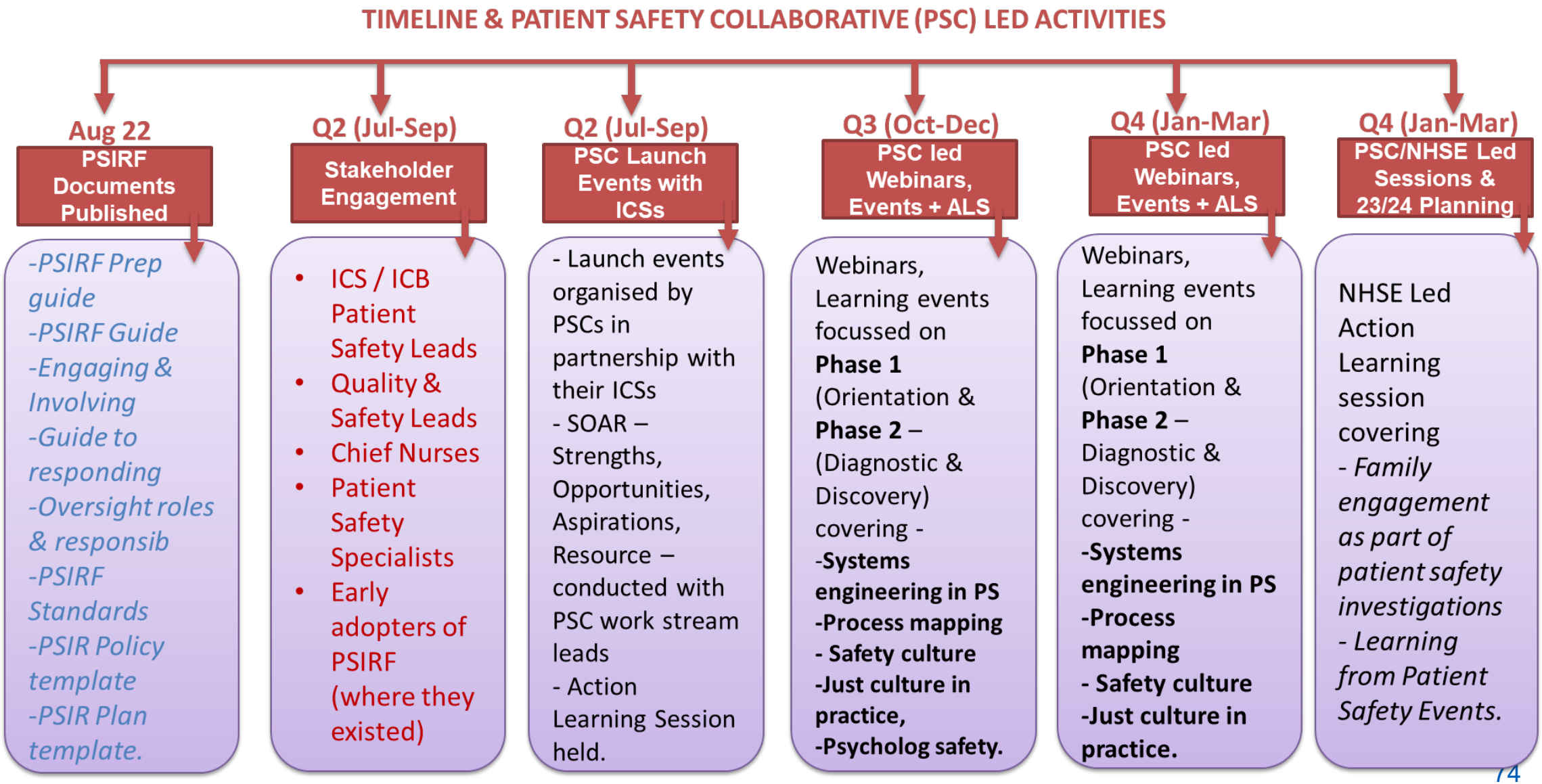
PHASE	ACTIVITY
Phase 1	PSIRF orientation / getting started
Phase 2	Diagnostic / discovery
Phase 3	Identifying measures of success, Governance and quality monitoring
Phase 4	Patient safety incident response planning
Phase 5	Curation and agreement of the Patient Safety Incident Response Plan (PSIRP)
Phase 6	Transition – working under PSIRF
Phase 7	Sustainable change and improvement

PSIRF implementation timeline



Source: PSIRF Preparation guide, NHS England. Version 1. August 2022

PSIRF – progress and input 2022/23



Case study: UCLPartners

UCLPartners Support

"UCLPartners has been instrumental in supporting and guiding the Mid Essex Integrated Board through all aspects of patient safety, with a particular focus on the PSIRF implementation.

UCLPartners expertise and leadership has been pivotal in developing and facilitating the PSIRF workstream across our ICB system and helping us guide providers in their progression whilst wrapped with an exceptional high level of support and providing a plethora of resources. UCLPartners input and support has been priceless and our working relationship is of great value."

- Karen Flitton, Patient Safety Specialist, Mid and South Essex Integrated Care Board

Case study

UCLPartners has been working closely both with our ICBs and Provider partners and with the other London PSCs to provide a comprehensive programme of support to guide and enable the implementation of PSIRF.

UCLPartners covers a diverse footprint that includes 2 NHS regions, 3 ICBs and 17 Provider NHS Trusts, therefore, in supporting PSIRF implementation, it was imperative that we did this in collaboration. This worked started pre-PSIRF publication with engagement and building relationships with ICB and Regional Patient Safety Specialists to design a programme of work tailored to the needs of those involved. This has led to a series of face to face workshops and online sessions for each of the ICSs in the UCLPartners footprint.

The focus for each of these has been on the relevant PSRIF implementation phase, and included tools and techniques such as stakeholder and process mapping as well as providing time for teams to work together to progress their local implementation. The main learning from these events is that providers value the time to come together outside of the workspace as one of the main challenges has been finding the time and resources to implement PSIRF.

We have also led on the delivery of two Pan-London PSIRF webinars in collaboration with Health Innovation Network and Imperial College Health Partners, one focused on discussing orientation of PSIRF and one on Safety Culture. Both of which have been well received with over 100 attendees from across London and Essex. Our supportive and facilitative role has meant that we are able to flexible and responsive to the needs and challenges of those we work with. Challenges such the changing landscape with the ICB formation, changes in PSS and PSIRF leads within provider organisations have reinforced the need for this approach. We now have every ICB and provider trust engaged with the with the work, with overwhelmingly positive feedback for our workshops. We will work to continue building these relationships to understand local challenges so we can provide more tailored support.

Case study: North West collaboration

North West Collaboration

"The Greater Manchester PSC team have been instrumental by working in collaboration with the NHSE North West Quality & Safeguarding Teams lead. We have been working together for some time to ensure that we collectively support the implementation of PSIRF and the Patient Safety Specialists across the Region. We are making excellent progress and have formed strong relationships; I feel much more confident that we are all working together to have a successful journey in working with the systems to implement PSIRF and other key deliverables."

- Elizabeth Ratcliffe, Deputy Director of Quality, Regional Safeguarding & Investigations Lead (NHS England North West Clinical Directorate)

Case study

Health Innovation Manchester PSC have worked with the Innovation Agency PSC to convene a regional partnership to offer a consolidated PSIRF support offer across the North West region.

In the immediate period following PSIRF publication, against the backdrop of emerging ICB structures and appointments, the Health Innovation Manchester PSC team have worked as system coordinators, taking a 'helicopter view' and recognising there was an opportunity to create alignment and avoid duplication not just in the GM system but at a North West regional level. The team formed a strong relationship with the Regional Safeguarding & Investigations Lead and responded to concerns that there was a risk of fragmented support offers within the PSIRF space. The GM PSC team proactively initiated a collaborative partnership with colleagues in the Innovation Agency PSC, the NHSE North West Quality and Safeguarding Team and regional improvement organisation AQUA which mobilised quickly to begin to design a single, consolidated PSIRF support offer for NHS trusts across the North West. It is envisaged that combining the skills, expertise, credibility and influence of the 4 partner organisation, PSIRF implementation teams will have access to a comprehensive and consolidated single support offer that is standardised across 3 different ICB footprints.

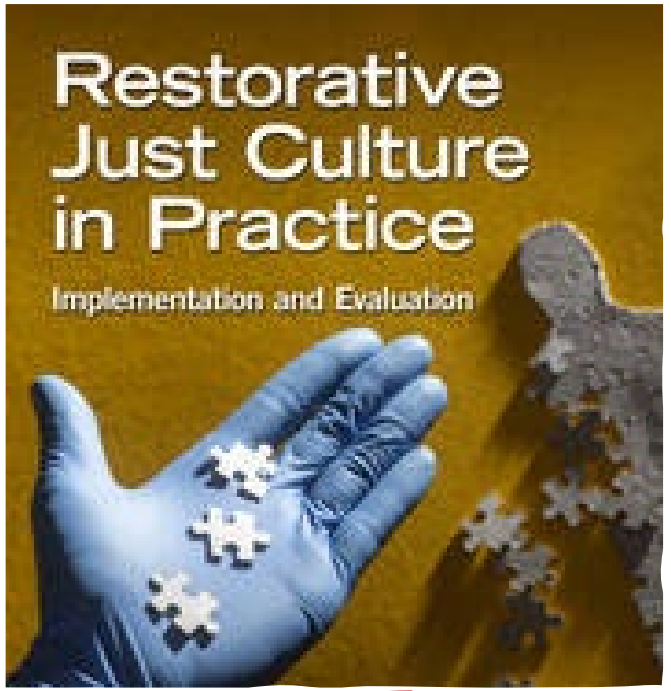
A podcast was produced by the Innovation Agency in collaboration with Health Innovation Manchester and AQUA (Advancing Quality Alliance) at a PSIRF education and learning event for ICSs and providers in December 2022.

Listen to the podcast

System Safety National Action Learning Sessions (ALS)

Topics covered at the ALS sessions focusing on PSIRF

- Safety Culture and PSIRF
  - Leadership development in healthcare
  - Just culture in practice
  - Psychological safety
  - Learning from best practice
  - Continuous learning and improvement [SWARM huddles, After Action Reviews (AARs)]
  - Team-work and Communication
  - Inclusivity, diversity to narrow health inequalities
  - Measurement for improvement
- Learning from Patient Safety Events (LFPSE)
- Engagement on Family engagement while managing Patient Safety Incidents
- SOAR (Strengths, Opportunities, Aspirations, Resources) exercise

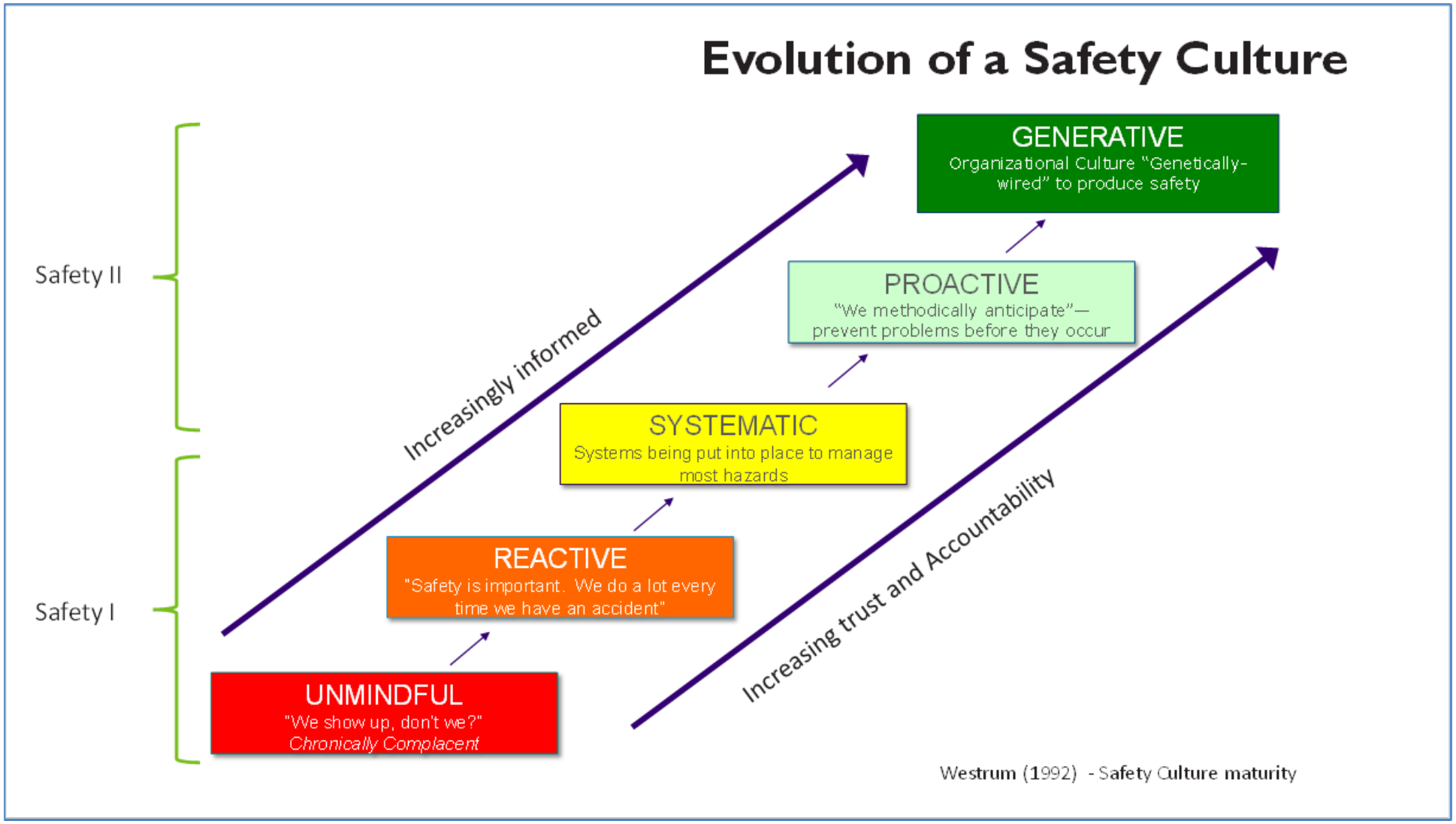


How to create psychological safety in a crisis?’

PSIRF webinar outputs from the Patient Safety Collaborative led events to support the implementation of PSIRF regionally.

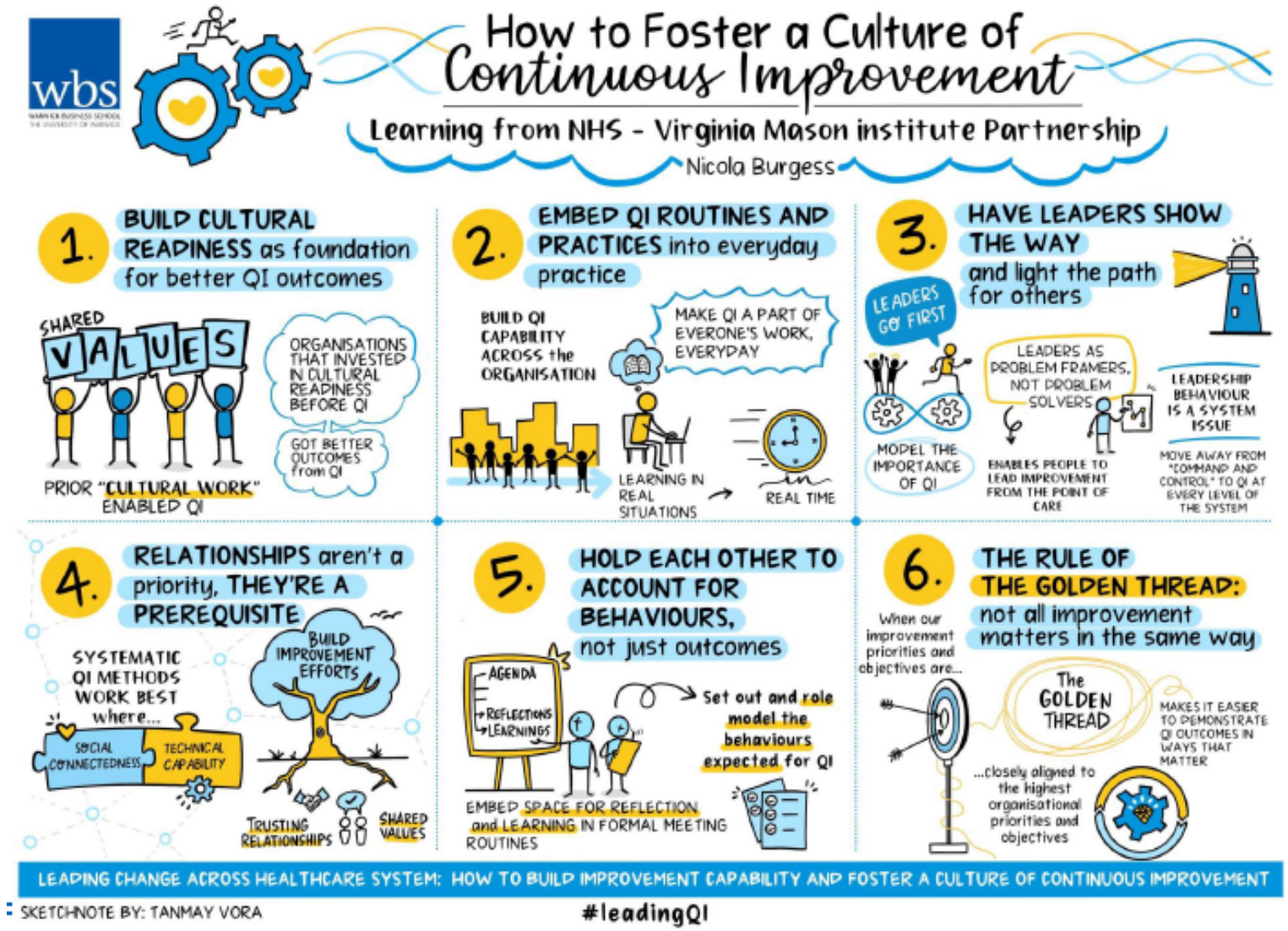
From the NW Collaborative Session in partnership with Health Innovation – Manchester, Innovation Agency – North West Coast and AQUA (Advancing Quality Alliance).

Evolution of a safety culture



From the NW Collaborative Session in partnership with Health Innovation – Manchester, Innovation Agency – North West Coast and AQUA (Advancing Quality Alliance).

How to foster a culture of continuous improvement



Source: Six key lessons from the NHS and Virginia Mason Institute Partnership. Warwick Business School. Available from: https://www.wbs.ac.uk/news/six-key-lessons-from-the-nhs-and-the-virginia-mason-institute-partnership/ 2022.

Independent Provider Support from PSCs

Generally via your ICB lead- so please contact them in relation to

- Your PSIRPlans sign offs

PSCs can support with

- Developed PSIRF resources (webinars, documents etc) and insight, but most are on FuturesNHS

More information

- Find your local Patient Safety Collaborative: www.ahsnnetwork.com/priorities/patient-safety/
- Follow us: @AHSNNetwork
- Access the FuturesNHS resources
  - Anyone can join the platform – it's easier if you have an NHS email address, but if you don't, emailing NHSps-manager@future.nhs.uk should reach the team to give access.

National Patient Safety
Improvement Programmes

National
Programmes

Thank you, any questions?

wendy.stobbs@healthinnovationmanchester.com

Independent Healthcare Providers Network

Staff member feedback: Experience and learnings from being involved in an incident

Emma Watson, PSIRF Implementation Lead, Circle Health Group

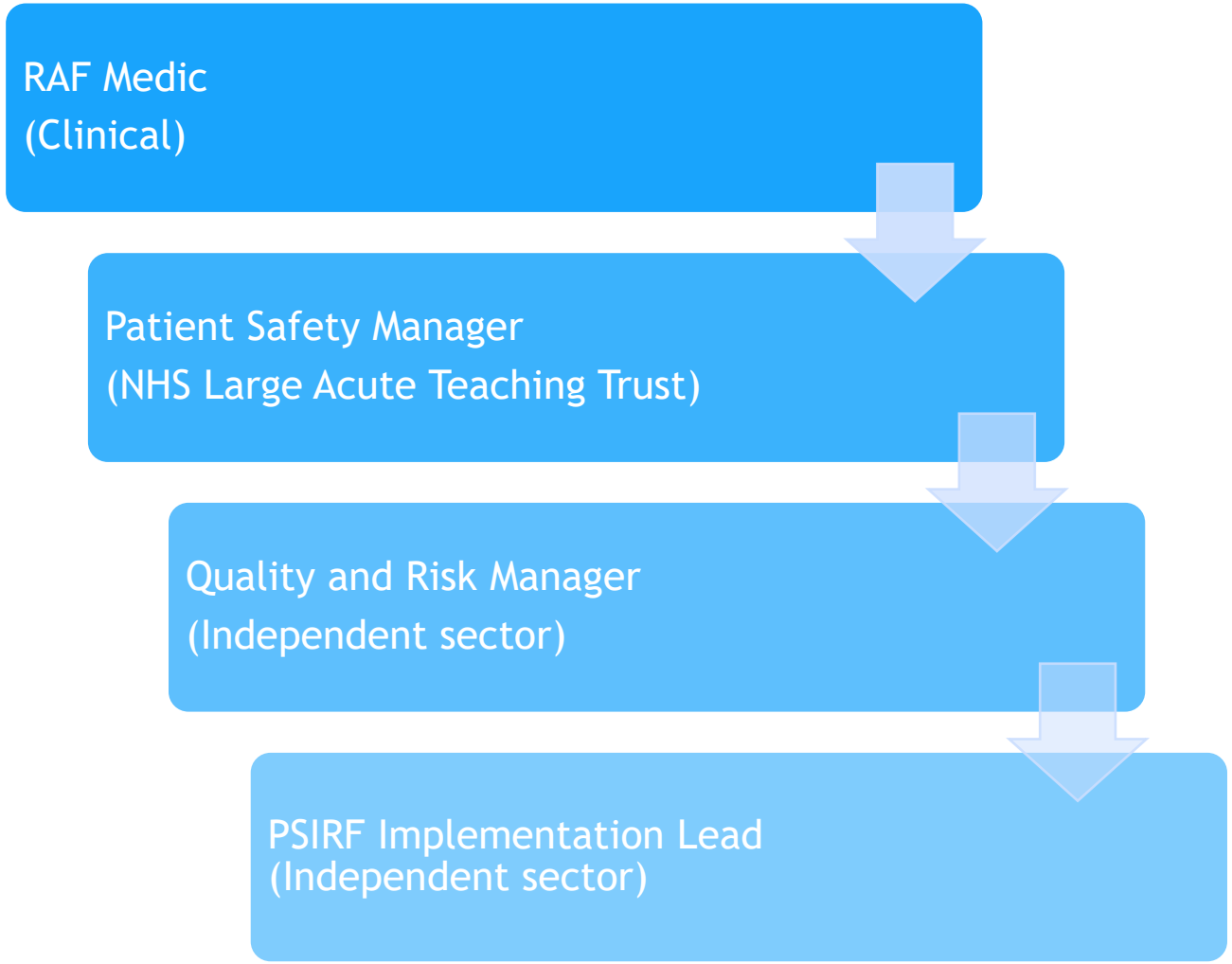
Event supported by MPS PARTNERSHIPS

IHPN Conference slides - 28 June 2023

Emma Watson – PSIRF Implementation Lead

Circle Health Group

Welcome and introduction



Setting the scene

Service description

Medium sized Private Hospital

Elective orthopaedic surgery

Surgical team made up of Experienced Practitioners

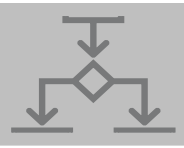
My role

Quality and Risk Manager – 2 years in post

Routinely attended Crash calls

Co-ordination of staff at scene

Scribe for incident



Operational support during incident

Circle Health Group

The Incident

Incident description

- Patient admitted for elective orthopaedic surgery, TKR.
- No notable co-morbidities, ASA 2
- Plan for Spinal anaesthesia
- Patient surgery commenced under spinal anaesthesia
- 30 minutes into surgery, patient snored and became unresponsive, cardiac monitoring showed PEA
- Full resus commenced and continued for 50 minutes
- Patient death pronounced

My role

- Attended crash call.
- With a view to commencing the scribe
- Contacted ambulance service
- Met ambulance – escort to theatre suite
- Operational support during
- Met family
- Consoled family

Circle Health Group

The Investigation

Description

- Initial engagement with Family
- Case review/Timeline
- Staff debrief
- Report writing
- Approval process

My role

- Initial Investigator
- Family Liaison
- Conducted investigation (RCA)
- When coronial process became apparent referred for external (to site) investigation
- Remained a co-author
- Gathered statements for Coronial process

Circle Health Group

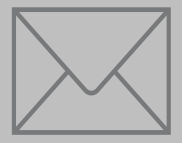
The follow up

Description

Submitted for inquest

Staff Liaison around Coroners statements

Statements collected for Coroner



Prepare to be Coroner's witness

My role

Attempted to engage with Family

To share RCA Report

Family dis-engaged

Circle Health Group

The Coroners court

Coronial process

- 2 days in Court
- Coroners witness
- Family Present
- Supported by Barrister
- Supported by ED

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Lessons Learned - too many hats

Initial contact with Family

Witness for Coroner

Early Family support

Coroners contact

Investigator

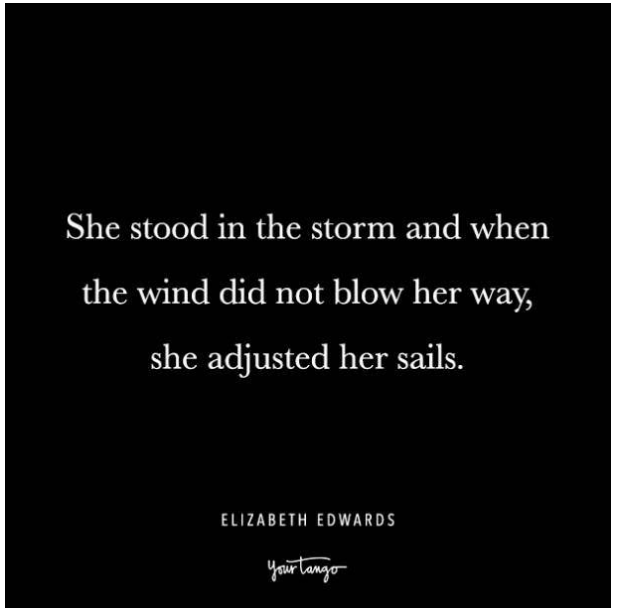
Ongoing Family Liaison

Staff Liaison

Report Author

Circle Health Group

Resilience



[Resilience-based approaches to wellbeing - 6 domains of resilience – NHS leadership academy]

Circle Health Group

The PSIRF Way forward

Patients

1. Before Contact

- Identify family contact
- Assess inclusivity needs
- Assess potential support needs
- Ensure familiarity with the incident
- Assess potential for parallel response and prepare guidance

2. Initial Contact

- Provide a clear introduction
- Offer a meaningful apology
- Identify key point of contact
- Explore support needs
- Discuss the incident
- Explain what happens next
- Schedule or discuss next contact

For-Investigation¶

- Confirm involvement preferences

3. Continued Contact

- Agree timeframe for responding to questions
- Revisit support needs
- Check for additional questions
- Share experience of the incident

For-Investigation¶

- Define/discuss terms of reference
- Agree timeframe for completion of investigation
- Revisit involvement preferences
- Discuss report preferences
- Share the draft report

4. Closing Contact

- Address questions
- Reiterate meaningful apology
- Final contact (formal end)
- Ongoing support

For-Investigation¶

- Final report
- Discuss any further investigations
- Opportunities for further involvement

Staff

Figure 1. Foundations for effective and compassionate engagement

Leadership
Managers and leaders should demonstrate their commitment to compassionate engagement and involvement in their words and actions.

Training and competencies
PSIRF sets specific expectations regarding training required for engaging and involving those affected by patient safety incidents.

Support systems
Families and staff may need to be signposted to support at any point during engagement or involvement in a learning response.

Ensuring inclusivity
Engagement and involvement must take into account individual needs. Organisations should consider this in the design and delivery of their service.

Information resources
Those affected by a patient safety incident must have clear information about the purpose of a learning response, and what to expect from the process.

Processes for seeking and acting on feedback
Organisations must assess the progression and outcome of engaging with those affected by a patient safety incident and their involvement in a learning response.

Processes for managing dissatisfaction
When the expectations of those affected are not met, families and staff must be given meaningful, truthful and clear explanations as to why this was not possible.

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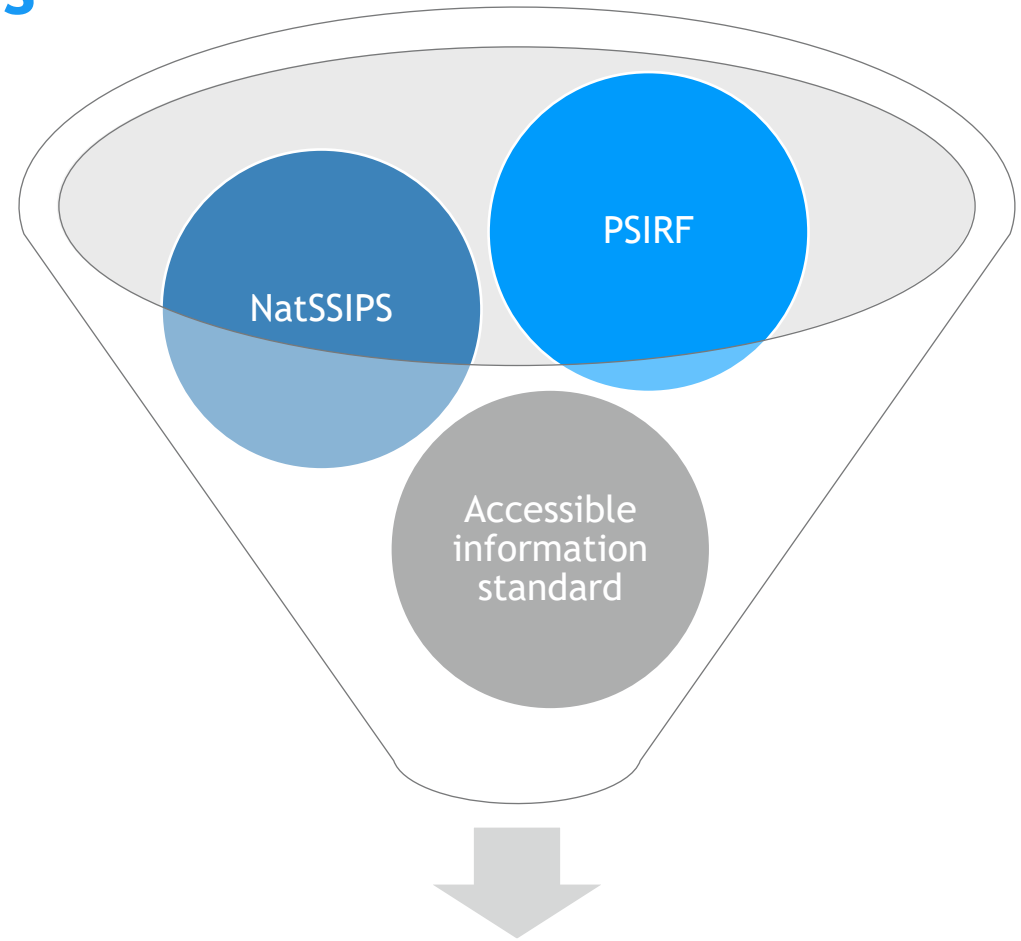
Associated projects



Engaging and involving (patients and staff)

Circle Health Group

Conclusion

Circle Health Group

Thank you

Circle Health Group

circlehealthgroup.co.uk

Independent Healthcare Providers Network

How can we improve collaboration and learnings from each other?

Dawn Hodgkins, IHPN (chair)
Dr Katie Grant, The Medical Protection Society
Deborah Widdowson, NHS England
Wendy Stobbs, Health Innovation Manchester
Emma Watson, Circle Health Group
Hannah Taylor, Bevan Brittan LLP

Event supported by
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Independent Healthcare Providers Network

Closing remarks

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