Proud to be part of Somerset Integrated Care System

NHS Somerset

NHS Somerset NHS Foundation Trust

Somerset Patient Safety Incident Response Framework (PSIRF) Overarching Plan

August 2023

Our Somerset system strategic aims

To continuously Improve Patient Safety in Somerset by…

- Ensuring our people have the skills and opportunities to improve patient safety across the system.

- Improving our understanding of patient safety by drawing insights from multiple sources of patient incidents and patient experience information.

- Having an improvement programme which enables collective and sustainable change in patient safety and knowing we have made a difference.

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1. Introduction

This is an overarching PSIRF plan for the Somerset health and care system following the national publication of PSIRF in August 2022. This plan sets out our approach to PSIRF and our planned ways of working. **This plan should be read alongside the ICB PSIRF Policy.**

System partners have been working together in the spirit of PSIRF since May 2022 and following publication of the national framework in August 2022 have been rolling out our PSIRF approach through a system wide project team.

Each system partner will have their own PSIRF plan and PSIRF Policy which details how PSIRF will be fully implemented within each organisation. It is the responsibility of NHS Somerset Integrated Care Board (ICB) to review and approve each provider's PSIRF plan and policy during 2023/24 (as per the 2023/24 NHS Standard Contract). This review will take place by end of September 2023.

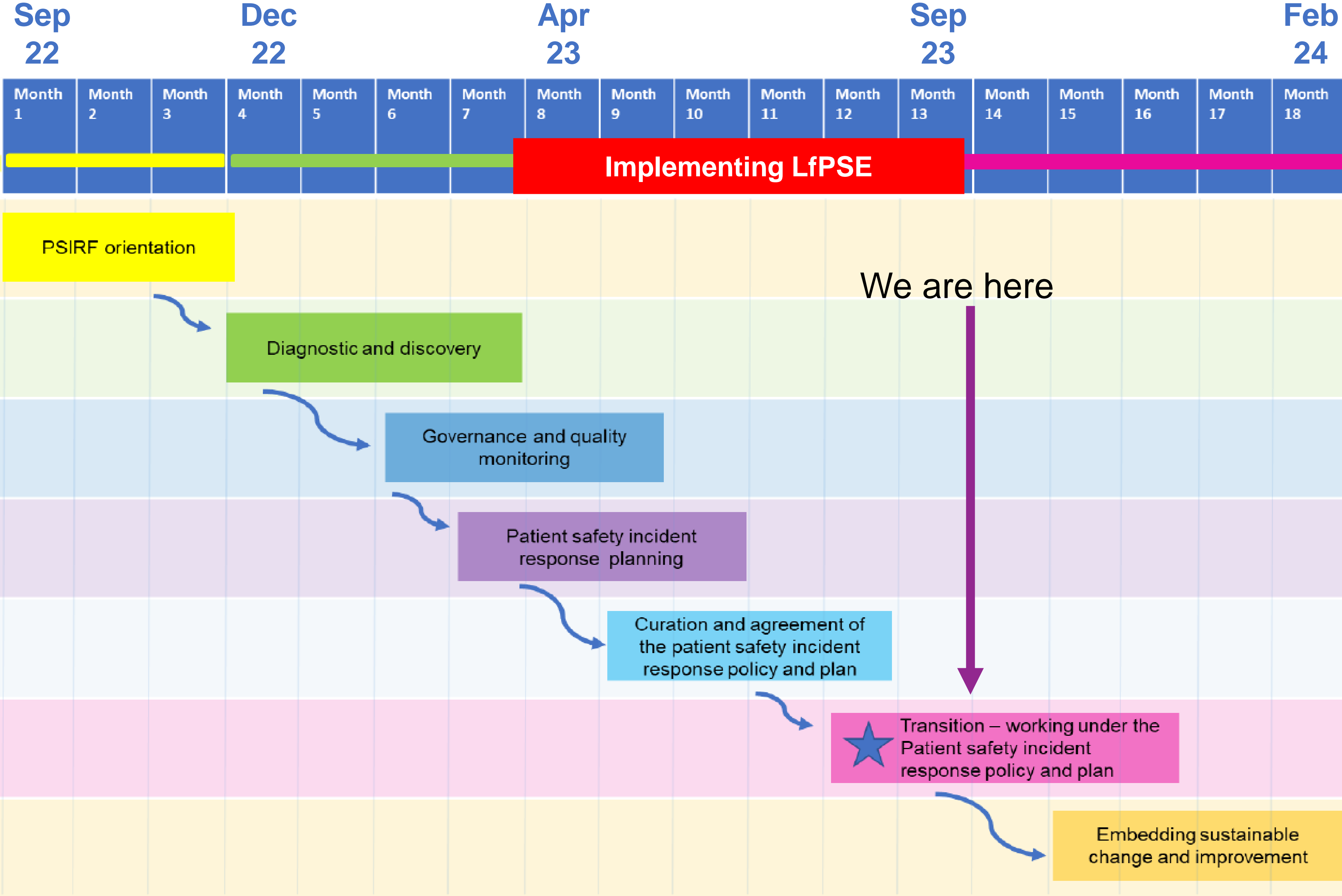
Please note that a thorough PSIRF project plan also exists which sets out the detailed steps in fully implementing PSIRF across Somerset, along with our risks and issues. This project plan is overseen by a PSIRF Project Group of patient safety leads from Somerset NHS Foundation Trust and the ICB.

1. Introduction - What is PSIRF?

It's a very different approach to patient safety incidents

- Sets out our approach to respond to patient safety incidents for the purposes of learning and improving
- A co-ordinated approach that prioritises compassionate engagement and 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 response to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement – having a just culture

2. Our High Level PSIRF Plan



2. A Somerset system wide roll out

- Since February 2023 we have met fortnightly as a PSIRF project group (ICB and Somerset NHS Foundation Trust)
- A detailed project plan is in place with shared system risks
- Met with all partners and staff groups as part of our orientation phase of PSIRF including Local Maternity Neonatal System (LMNS), local authority, VCSE, Healthwatch, independent providers and primary care
- Selected one PSIRF training provider (MedLed) for Somerset who began delivering training from 30th June and will run until November 2023
- We have begun to articulate succession planning beyond Sept/Oct 2023. This includes creation of an ICB and Provider Alumni and train the trainer model to roll our PSIRF to others

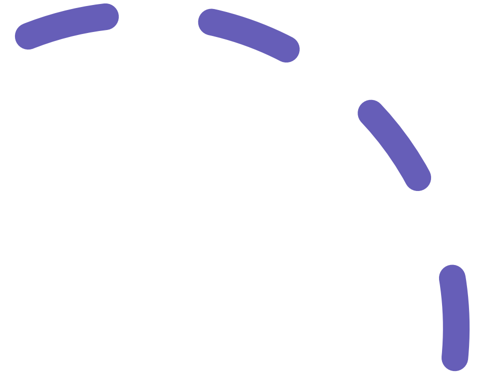
3. Our PSIRF Approach (1)

At our PSIRF workshop in May 2022, as a health and care system, we agreed some common principles in our approach to PSIRF. These can be themed into:

Approach, communication, and language

- To challenge culture in making our safety cultural change
- To feel safe to challenge
- To understand that everyone has a role in recognising patient safety because safety culture is everybody's business
- To welcome all ideas for patient safety improvement from all areas of our health and care settings
- To see, feel, and hear patient safety, be visible and use other ways to be able to raise a concern
- To have a process of top-down and bottom-up communication and joined up working with regards to patient safety. This will form part of our PSIRF communication plan
- To ensure communication throughout our geographical area
- To engage with all those in our system and get all involved
- To peer challenge and be brave in doing something different
- To update our language to focus on learning rather than investigation
- To encourage uptake of Level 1 Patient Safety Syllabus training for NHS staff

3. Our PSIRF Approach (2)



Others we are working with

- Patient Safety Partners
- Patients, families, carers (paid and unpaid)
- Primary care
- Social care
- Clinicians and care staff
- NHS England
- Academic Health Science Network
- Regulatory Bodies
- Coroner and Medical Examiner
- Family Liaison Officers
- Healthwatch
- Communities, and engagement teams, particularly when addressing health inequalities

Building on what we have available in place already

- Triangulate our patient safety information with other intelligence e.g. Patient Advice and Liaison Services, complaints, staff and patient surveys
- Build on our existing processes and patient safety improvement plans
- Identify and respond to any new opportunities for improving patient safety once we implement PSIRF

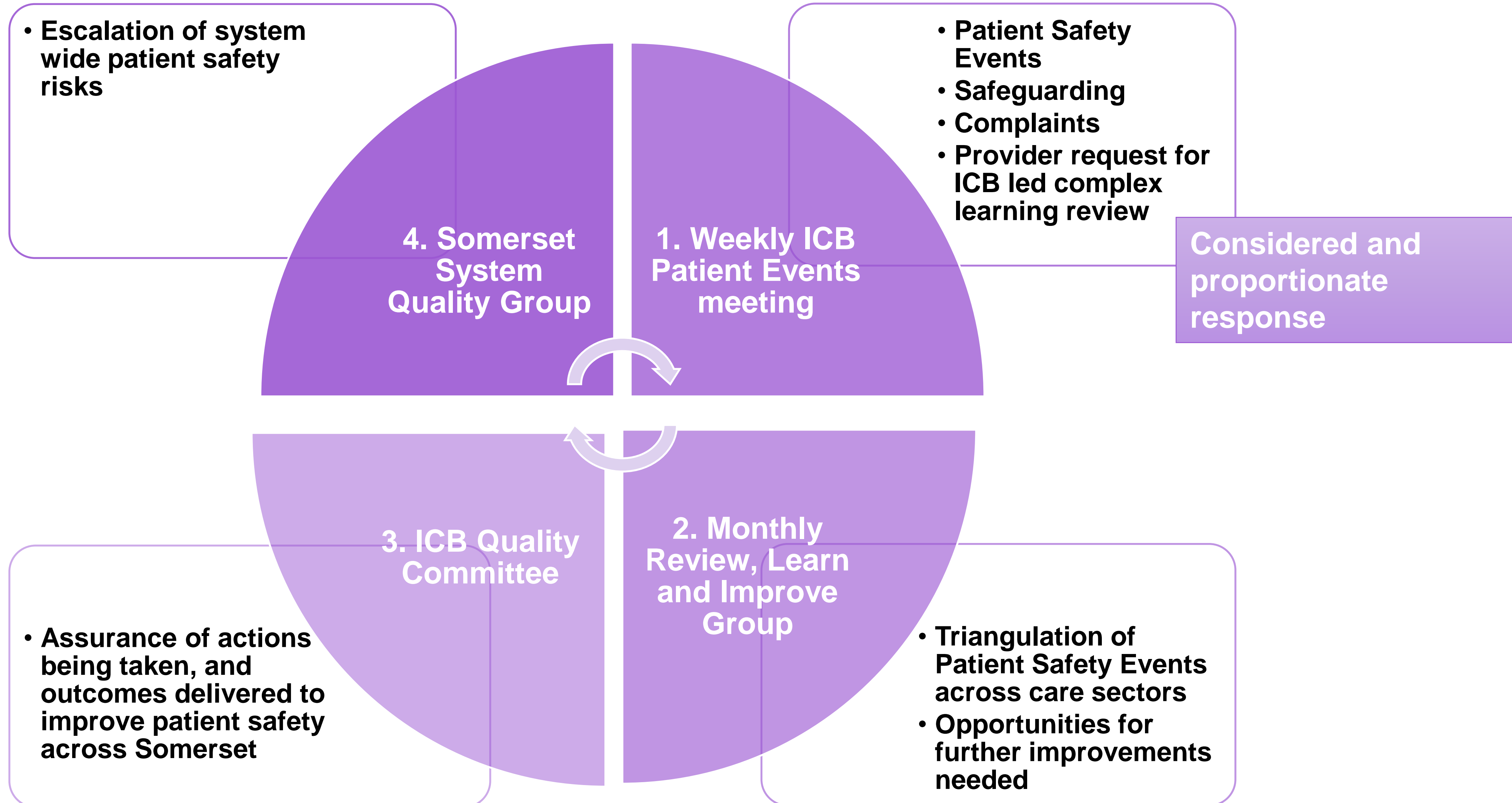
4. Ensuring our people have the skills and opportunities

As a Somerset health and care system we have agreed to using one PSIRF training provider to ensure we are being consistent in our approach and messaging on PSIRF

This PSIRF training is provided together, across sectors, which is helping us to promote the richness of conversations when working through patient safety examples

Whilst we are engaging primary care colleagues in the awareness raising of PSIRF, it is not intended for them to fully implement PSIRF by September/October 2023. As a system we want to hear of the learning from the primary care national PSIRF pilots.

5. Our PSIRF Governance Arrangements



6. Our Somerset Patient Safety themes

- Having completed (at ICB level) our Patient Safety Incident Response Planning. We have:
- Mapped all our services
- Examined all our patient safety incident records, safety, complaints, PALS, safeguarding, CHC, health professional feedback information, etc

- We now have a description of the Somerset wide patient safety issues
- From this, we have identified the following key themes/ contributory factors

1. Lack of resources (including. people, knowledge, & services) leading to delays
2. Poor communication (in a multitude of forms)
3. Patient safety in its purest form (e.g. Infection Prevention and Control, maternity, medication errors)
4. Caring for individuals with complex needs
5. Digital systems, data, record keeping & access
6. Culture

- Our next task is to agree how we intend to respond to the issues listed in our Somerset patient safety incident profile

7. Our PSIRF Aspirations

Once PSIRF is embedded across Somerset, these are the likely outcomes we will see and experience

- Increase in the proportion of time spent on improvement and a decrease in time spent on investigation of patient safety incidents
- Greater compassionate engagement and involvement of those affected by patient safety incidents
- Being learning organisations on all aspects of patient safety by implementing a 'just culture'
- Providing examples of excellence, improvement and innovation across our health and care services with regard to patient safety
- Patients and families seeing and feeling the impact of and the speed of our improvement with regard to patient safety
- Reducing harm and ensuring people feel confident and safe when in receipt of our care and support across Somerset

8. How we will know we are making a difference

As a Somerset system, we all need to experience and evidence the improvements that have taken place in response to a PSIRF review. This could take place in several ways and can include:

- Creating a patient safety culture and people being able to speak up if they feel unsafe
- Staff and patient surveys and other feedback mechanisms
- Patient and public forums
- Gathering and analysing patient, carer and staff feedback following implementation of a PSIRF improvement project
- Healthwatch projects in response to a PSIRF improvement project
- Walkthrough visits in response to PSIRF thematic reviews

Glossary

Patient Safety Syllabus – An NHS Patient Safety Syllabus training programme. The content of the training helps to deal with risks before they can cause harm and working to create a positive patient safety culture

Patient Safety Incident Investigation (PSII) - Provides a clear explanation of how an organisation's systems and processes contributed to a patient safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks and work processes involved.

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 Partner - Is someone who works with the NHS to help make care safer for patients. Roles can include:

- membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- 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