PATIENT SAFETY INCIDENT RESPONSE IN GP PRACTICES

Introduction

The **Patient Safety Incident Response (PSIR) Framework** replaces the Serious Untoward Incidents (SUI) process, promoting a just culture for reporting patient safety incidents of all severities. It emphasises learning from incidents to prevent future harm through systematic investigation and safety improvements.

The PSIR Framework was introduced specifically to replace the SUI process and establish a more comprehensive approach to patient safety incident response. Here's why:

- **Broader Scope**: The PSIR Framework applies to a wider range of patient safety incidents (PSIs) compared to the SUI process, which primarily focused on serious incidents. The PSIR Framework encourages reporting and learning from all types of PSIs, even near misses, to identify potential risks and prevent future harm.
- **System-Based Approach**: The PSIR Framework emphasises a system-based approach to incident investigation, focusing on understanding contributing factors within the healthcare system. This differs from the SUI process, which may have placed more emphasis on individual accountability.
- **Just Culture**: The PSIR Framework promotes a just culture environment where staff feel safe to report incidents. This can improve incident reporting rates compared to the SUI process, which may have discouraged reporting due to fear of blame.

While the specific details of replacing the SUI process may vary depending on your local healthcare organisation, the PSIR Framework provides a new national standard for PSIs within the NHS.

Our Responsibilities

- **Reporting Patient Safety Incidents**: All staff are encouraged to report PSIs, near misses, and potential safety hazards through our designated PSIR reporting channels – utilising existing channels within individual GP Practices and where relating to PCN staff or projects via Network Manager to be reviewed by the Strategic Leadership Board (and discussion/outcome recorded in the minutes of the meeting of that group)
- **A 'Just Culture'**: We are committed to maintaining a safe and supportive environment where staff feel comfortable reporting PSIs without fear of blame.
- **Proportionate Response**: The severity and complexity of the PSI will determine the level of investigation required.
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- **Confidentiality**: We maintain confidentiality throughout the PSIR process, except as required by law.

Policy Statement

This policy outlines the approach of Burmantofts, Harehills and Richmond Hill PCN to responding to patient safety incidents in accordance with NHS England's **Patient Safety Incident Response Framework (PSIRF).**

The PSIRF promotes a just culture, systematic learning from incidents, and continuous improvement in patient safety.

Burmantofts, Harehills and Richmond Hill PCN is committed to providing safe and high-quality care to all our patients. We believe that open and honest reporting of PSIs is essential for identifying and addressing potential risks within our practice. This policy establishes a framework for responding to PSIs in a way that prioritises:

- **Compassionate engagement**: Involving those affected by the incident in a respectful and supportive manner.
- **System-based approach**: Recognising that PSIs often result from system failures, not individual shortcomings.
- **Proportionate response**: Tailoring the response to the severity of the incident and the potential for learning.
- **Continuous improvement**: Using the learnings from incidents to improve patient safety within the practice.

Definitions

- **Patient Safety Incident:** Any unintended or unexpected event (including near misses) that could have, or did, lead to harm for one or more patient's receiving healthcare.
- **Just Culture:** An environment where staff feel safe to report incidents and contribute to safety improvements, without fear of blame.
- **Learning Response:** A structured investigation or analysis of a PSI to identify contributing factors and potential improvements.
- **Safety Action:** A specific and measurable action taken to prevent similar incidents from occurring in the future.

Core Principles

This policy is guided by the following core principles:

Principle	Description
Just Culture	We will create a safe and supportive environment for staff to report incidents without fear of blame. Focus on learning and improvement from incidents.
System-Based Approach	We will recognise that patient safety is an emergent property of the healthcare system and that incidents often result from system failures, not individual shortcomings. Our focus will be on identifying and addressing system-wide factors that contribute to patient safety incidents.
Proportionate Response	We will tailor the response to the severity of the incident and the potential for learning (as not all incidents will require a full-scale investigation).
Compassionate Engagement	We will involve those affected by the incident in a respectful and supportive manner. This includes patients, families, and staff.
Continuous Improvement	We will use the learnings from incidents to continuously improve patient safety within the practice, as well as improving our safety culture and identify opportunities to prevent future incidents.

Components

While the specific stages may vary slightly depending on the implementation, the PSIR Framework generally involves the following components.

- **Reporting and Triage:** Establish a clear and accessible process for staff to report patient safety incidents. Develop a process to assess the reported incident and determine the appropriate level of response.
- **Learning Response:** Conduct a structured investigation or analysis of the incident to identify contributing factors and potential improvements. This may involve interviewing staff, reviewing records, and considering system-wide factors.
- **Safety Action Development:** Based on the learning response, develop specific and measurable actions to prevent similar incidents from occurring in the future.
- **Monitoring and Evaluation:** Track the implementation of safety actions and monitor their effectiveness in improving patient safety.

Benefits of PSIR

Implementing a PSIR Framework can offer several benefits for primary care, including:

- **Improved patient safety:** By identifying and addressing system failures, the PSIR Framework can help to prevent future incidents and improve the overall safety of care provided to patients.
- **Enhanced staff engagement:** A just culture approach can foster an environment where staff feel comfortable reporting incidents and contributing to safety improvements.
- **Stronger risk management:** The PSIR Framework can help to identify and mitigate potential risks within the practice.
- **Continuous learning and improvement:** By systematically analysing incidents and implementing safety actions, the PSIR Framework can help practices to continuously learn and improve their safety culture.

Roles and Responsibilities

All Staff

All staff have a responsibility to report PSIs in accordance with this policy. Staff are also expected to participate in PSIR investigations and training as needed.

PSIR Lead: Andy Haigh Business Manager

The designated PSIR Lead is responsible for overseeing the implementation of this policy, coordinating the PSIR process, and ensuring that staff receive appropriate training.

Network Manager: Tania Swaine

The Practice Manager is responsible for providing resources and support for the implementation of this policy.

Reporting and Triage

Burmantofts, Harehills and Richmond Hill PCN has a clear and accessible process for staff to report PSIs. This may include reporting forms, a designated reporting mailbox, or a reporting hotline. All reported PSIs will be triaged by the designated PSIR Lead or a trained staff member to determine the appropriate level of response.

Proportionate Response

The level of investigation should be proportionate to the severity and complexity of the incident. Not all incidents will require a full-blown investigation.

Report a patient safety incident

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare. Reporting them supports the Practice (and NHS) to learn from mistakes and to take action to keep patients safe. Both healthcare staff and the public are encouraged to report any incidents, whether they result in harm or not, to our national services for recording patient safety events.

Primary Care Organisations such as general practice, independent dental surgeries, community pharmacies and opticians, may not have their own LRMS, but staff can record patient safety events directly to the **Learn from Patient Safety Events Service** (LFPSE), which replaces the existing National Reporting and Learning System (NRLS).

- **Report an incident to LFPSE**

Further information can be found on the **LFPSE primary care webpage**.

Stages of Investigation

Initial review and analysis
Gathering basic information about the incident and identifying any immediate safety concerns.

Detailed investigation
Conducting a more in-depth analysis to identify contributing factors and potential safety improvements. This may involve interviewing staff, reviewing records, and considering system-wide factors.

Root Cause Analysis
A structured approach to identify the underlying causes of the incident.

Learning Response

Depending on the severity and complexity of the PSI, a learning response may involve:

- Initial review and analysis: Gathering basic information about the incident and identifying any immediate safety concerns.
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- Detailed investigation: Conducting a more in-depth analysis of the incident to identify contributing factors and potential safety improvements. This may involve interviewing staff, reviewing records, and considering system-wide factors.
- Root Cause Analysis (RCA): A structured approach to identify the underlying causes of the incident.

Safety Action Development

Based on the learning response, specific and measurable safety actions will be developed to prevent similar incidents from occurring in the future. These actions may include:

- Changes to policies and procedures
- Implementation of new safety measures
- Staff education and training
- Monitoring and Evaluation

The implementation of safety actions will be tracked and monitored to assess their effectiveness in improving patient safety. This may involve reviewing data on PSIs, conducting staff surveys, and observing practice processes.

Training

All staff will receive training on the PSIR process, their role in reporting PSIs, and just culture principles. The specific training requirements will vary depending on staff roles and responsibilities.

Support from PCN

The NHS England document **Preparing to implement the Patient Safety Incident Response Framework** discusses the role of Patient Safety Collaboratives (PSCs) in supporting ICSs and PCNs during the implementation of the PSIR Framework. These PSCs are hosted by the AHSN Network and can provide resources and expertise to help PCNs develop their PSIR systems.

Practices can contact Burmantofts, Harehills and Richmond Hill PCN to enquire about any support or resources they may offer for implementing the PSIR Framework.

Burmantofts, Harehills and Richmond Hill PCN may be able to connect our practices with relevant training opportunities or share best practices from other member practices.

Support from ICBs

The NHS England PSIR Framework emphasises the role of ICBs in establishing and maintaining structures for a coordinated approach to oversight of patient safety incident responses within all the services within their health and care system (https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/). This suggests that ICBs may play a role in providing resources, guidance, and support to GP practices implementing the PSIR Framework.

Practices can contact their ICB to learn more about their PSIR oversight role and how they might be able to support your GP practice. They may have resources or guidance documents available.

RESOURCES

NHS England : Patient Safety Incident Response Framework
https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

NHS England : Patient Safety Incident Response Framework and supporting guidance
https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/

NHS England : Report a patient safety incident
https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/report-patient-safety-incident/

NHS England : Learn from patient safety events (LFPSE) service
https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/learn-from-patient-safety-events-service/

NHS England : Patient Safety Incident Response Framework - Preparation guide
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-6.-PSIRF-Prep-Guide-v1-FINAL.pdf

NHS England : Guide to responding proportionately to patient safety incidents
https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf

APPENDIX 1
PATIENT SAFETY INCIDENT RESPONSE (PSIR) TRAINING REQUIREMENTS

In their Framework documentation, NHS England uses the term "training" but doesn't explicitly state if these are formal courses or knowledge principles. The core content outlined in the table (e.g., Introduction to PSIR Framework, Just Culture principles) can be delivered through various methods, including formal training courses, workshops, e-learning modules, or in-house training sessions.

For some roles, such as the designated PSIR Lead, the table references specific skills they should possess (e.g., leading investigations, Root Cause Analysis techniques). These skills are likely best acquired through dedicated training courses or workshops.

JOB ROLE	RECOMMENDED TRAINING	DELIVERY
All Staff	Introduction to PSIR Framework Understanding and reporting PSIs Just culture principles Confidentiality and information sharing	Formal courses, workshops, e-learning modules, in-house training
[Designated PSIR Lead Title (e.g., PSIR Lead, Patient Safety Officer)]	In addition to all staff training above; • Leading PSIR investigations • Root Cause Analysis (RCA) techniques • Developing and implementing safety actions • Data analysis and reporting	Formal courses, workshops
[Practice Manager Title (e.g., Practice Manager)]	In addition to all staff training above; • PSIR policy and procedures • Resource allocation for PSIR activities • Oversight of PSIR implementation	Formal courses, workshops
Clinicians	In addition to all staff training above; • Specific training on PSIs relevant to their clinical practice (e.g., medication errors, medication reconciliation)	Formal courses, workshops, e-learning modules

Please Note : ***this is a suggested framework***, Practices can adapt it to their specific needs and available resources.
Practices can also include information on specific training courses offered by your local PCN or ICB.

APPENDIX 2
PATIENT SAFETY INCIDENT RESPONSE NATIONAL & LOCAL REQUIREMENTS

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event. The Practice should complete the table below to set out their local or national mandated responses – the following formats are from the NHS England template for national and local requirements (see Resources section for link).

Patient safety incident type	Required response	Anticipated improvement route
Eg incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
Eg death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into the quality improvement strategy
Eg incident meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required and feed actions into the quality improvement strategy

APPENDIX 3 : PATIENT SAFETY INCIDENT RESPONSE (PSIR) PRACTICE REVIEW

Action Area	Practice Response
What are the main types of error and adverse event in Primary Care settings?	
What methodologies would ensure effective patient and user involvement to enhance patient safety?	
What strategies would ensure early detection of new risks before they result in a rare but catastrophic event?	
How can GP Practice cultures be safety conscious, "reporting-friendly" and free of blame?	
What methods can reduce error in particular specialist fields of medicine (eg, drug therapy)	

Action Area	Practice Response
How can equipment acquisition and management policies reduce risk?	
What automated methods of data capture could be developed to reduce reliance on human reporting?	
How can data collation, classification and analysis be enhanced to allow patterns of causation, presentation, detection, and amelioration to be elucidated?	
What are the characteristics of good leadership of clinical teams that have a good approach to performance in patient safety?	
Why does change to improve patient safety so often fail to be implemented despite widespread dissemination of strategies which have been shown to work?	