HSJ PATIENT SAFETY CONGRESS

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Turning PSIRF theory into practice – learning from frontline NHS safety leaders

HSJ congress panel, September 2024

Catherine Okonkwo, Irum Rela, Deborah Dover, Annie Hunningher

Chair: Murray Anderson Wallace

#HSJpatientsafety

Catherine Okonkwo

Patient Safety Partner
NHS North East London

"To err is human, but to cover up is unforgivable, and to fail to learn is inexcusable."

— Sir Liam Donaldson, former Chief Medical Officer for England

What is PSIRF?

1. Shift from Serious Incidents to PSIRF
2. Focus on proactive learning
3. Cultural change

What is a PSP?

The Framework for Involving Patients in Patient Safety sets out how NHS organisations should involve Patient Safety Partners in patient safety.

- Shaping recruitment processes and sitting on recruitment panels
- Supporting the development of organisational strategies and policies
- Co-hosting engagement events and workshops
- Undertaking safety audits and assessments
- Involvement in safety improvement projects and co-producing change initiatives

PSIRF + PSP = Success!

1. Bringing the patient voice into PSIRF
2. Improving transparency and trust
3. Co-production in action

What are some practical strategies that can be employed?

1. Do you know your PSP?
2. Foster a safety culture
3. Data. Data. Data!
4. Incorporate PSP's in the process
5. Provide training and support (maybe even KPI's)
6. Everyones responsibility

Final thoughts...

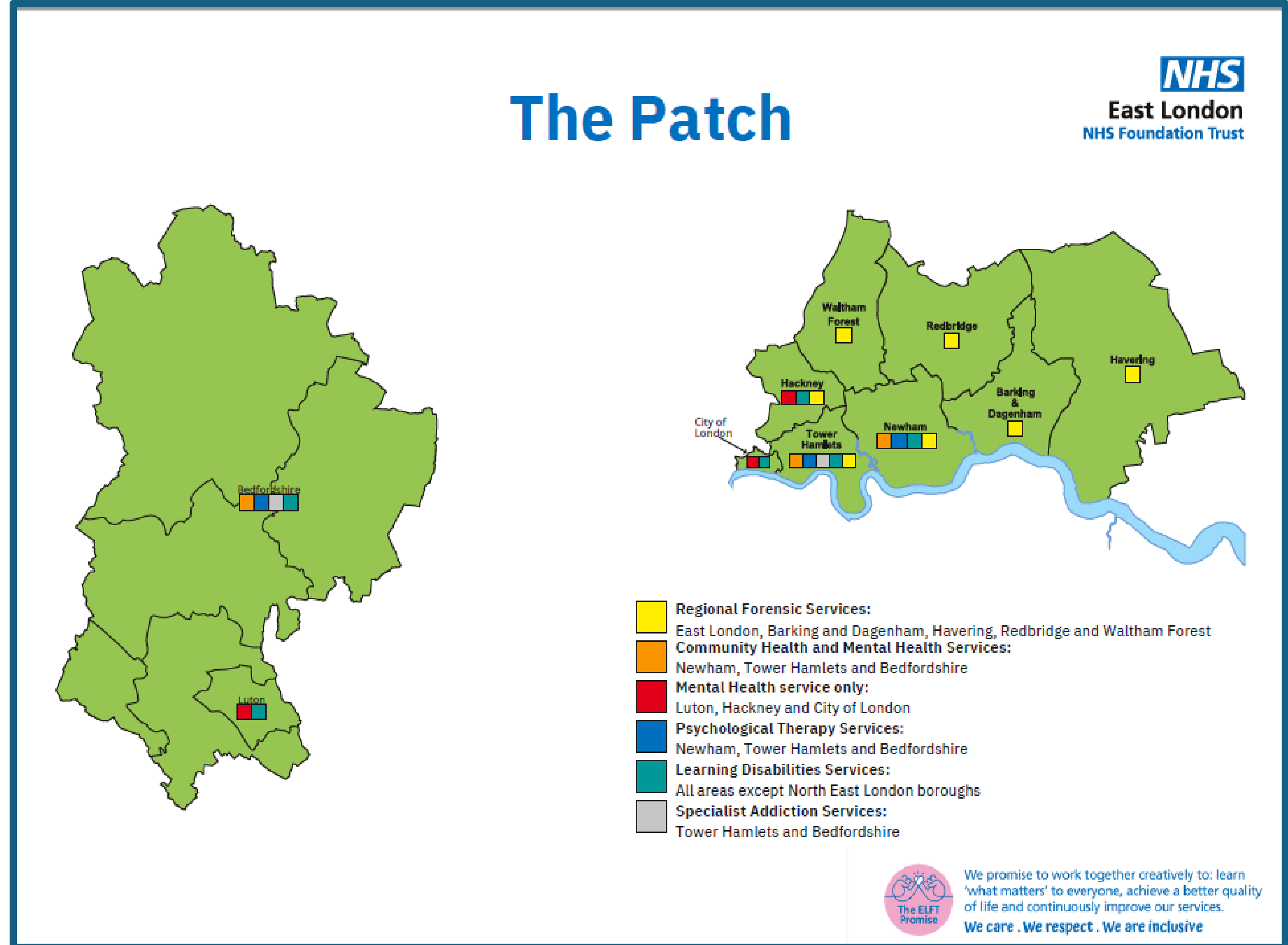
Patient safety is not a department, a person, or a process—it's a commitment.

Irum Rela

Patient Safety Partner
East London NHS Foundation Trust

ELFT context

- NHS provider of mental health, community health and primary care services
- Boroughs within North East London + Luton and Bedfordshire (population of 2 million)
- Diverse boroughs
- CQC 'Outstanding' Trust known for Quality Improvement and coproduction



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- Significant experience as a patient (+ iatrogenic harm)
- Experience working frontline and in service development/leadership
- Passionate about improving services, healthcare geek, NHS supporter

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Fascinating, meaningful, challenging, emotive

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Engage, coordinate, collaborate, advocate, review/critique

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How are service users and carers involved in safety work?

- Sexual safety
- Medicines safety
- Quality Improvement projects
- Post-incident learning responses*
- Project work e.g. CCTV policy review

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Reflections on PSIRF

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What if we put this much work into responding to PALS/ complaints and informal + formal patient/carer + staff feedback? Could we 'learn lessons' **earlier**?

Challenge of learning and improving on a **large scale** (trustwide? NHS wide?)

Dr Deborah Dover

Director of Patient Safety
East London NHS Foundation Trust

The Patch

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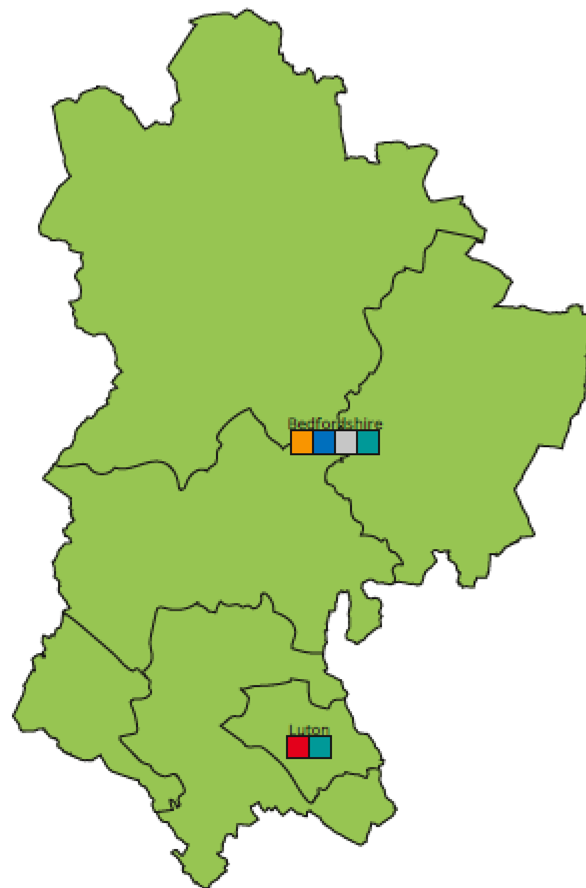

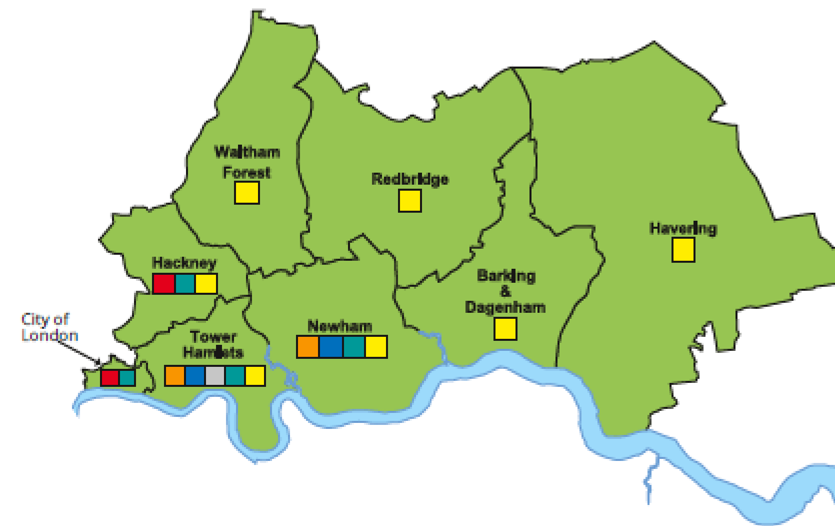

Regional Forensic Services:
East London, Barking and Dagenham, Havering, Redbridge and Waltham Forest

Community Health and Mental Health Services:
Newham, Tower Hamlets and Bedfordshire

Mental Health service only:
Luton, Hackney and City of London

Psychological Therapy Services:
Newham, Tower Hamlets and Bedfordshire

Learning Disabilities Services:
All areas except North East London boroughs

Specialist Addiction Services:
Tower Hamlets and Bedfordshire

Beyond Harm - What Safety Means to Our Service Users

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in relation to care plan
adherence to policies
supervisopn
right treatment
monitoring
out of danger
feeling heard
physical safety
lack of appointment
smooth transitions
professionalism
transparency
continuity
supervision
peer led
understanding
good health
feeling safe
care
patience
trust
building maintenance
listening
support
compassion
openness
hygiene
safe
equality
medication
follow up
staff capabilities
confidence
free of danger
right diagnosis
emotional wellbeing
feeling safe and secure
freedom
getting the support i nee
care and compassion
continued covid care

ELFT Safety Plan

NHS
East London
NHS Foundation Trust

Mission

To continuously improve safety for our service users, our staff and for our local communities

No Safety without Equity

- Culture, leadership and governance
- Continuous Learning, Insight & Improvement
- Involvement of patients, carers and families
- Workforce Safety and well-being
- Safer Communities

.uk

After Action Review

- Facilitated group discussion focussed on learning
- Close to frontline, and soon after event.
- Captures multiples perspectives
- In-group learning + onward sharing

What was supposed to happen?

What actually happened?

What can we learn?

Why were there differences?

Who does what as a result?

Description and scope of the Action Under Review

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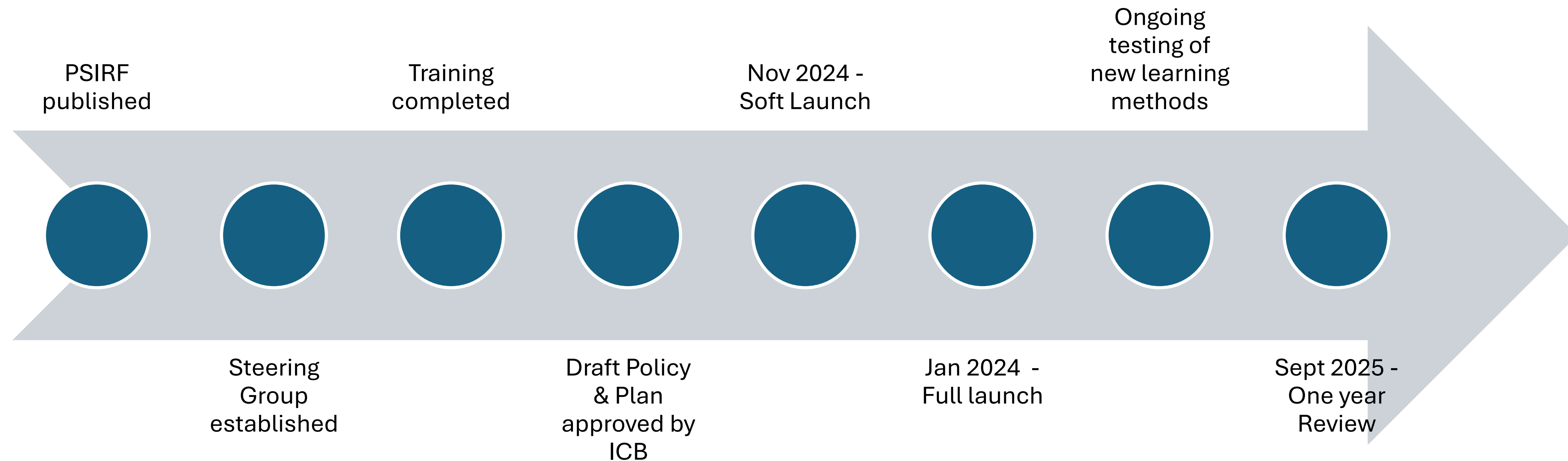

We care
We respect
We are inclusive

What Actually Happened

NHS East London NHS Foundation Trust

STRENGTHS

- ✓ Training & coaching
- ✓ Collective leadership & board support
- ✓ Decision-making and Oversight
- ✓ Improvement Programmes
  - ✓ In-patient Safety
  - ✓ Safety Culture
  - ✓ SU and carer
  - ✓ Staff Support
- ✓ New learning methods & thematic approach
- ✓ PSIRF beyond incidents
- ✓ Internal Safety system & system contacts
- ✓ Measuring what matters

CHALLENGES

- Pace
- Capacity & confidence to shift to thematic & improvement focus
- Local leadership, central support
- Designing suitable learning methods
- System analysis
- Thematic intelligence
- Evaluation

We care
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REALITY

EXPECTATIONS

Reflections, learning and take-homes

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NHS Foundation Trust

All models are wrong,
but some are useful.

George E. P. Box

We care
We respect
We are inclusive

PURPOSE

Ask about the
#ELFTPromise

IF YOU WANT TO GO FAST,
GO ALONE.

IF YOU WANT TO GO FAR,
GO TOGETHER.

Dr Annie Hunningher

Group Patient Safety Lead,
Consultant in Anaesthesia
Barts Health NHS Trust

The Context Barts Health

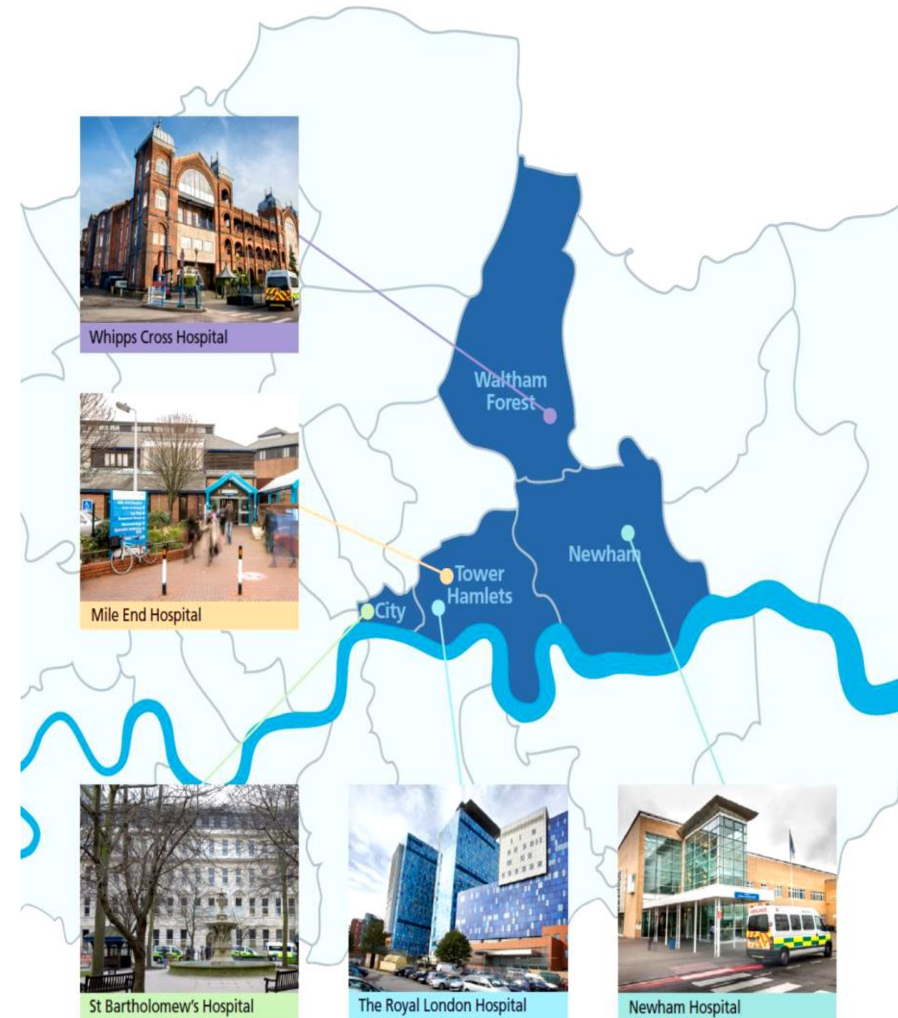
Group and Hospital Executive leadership model

5 hospitals

Host organisation for the North East and South East London Pathology Partnership

One of the largest Trusts in the UK

20 000 staff



Our Vision for Safety

INSIGHT

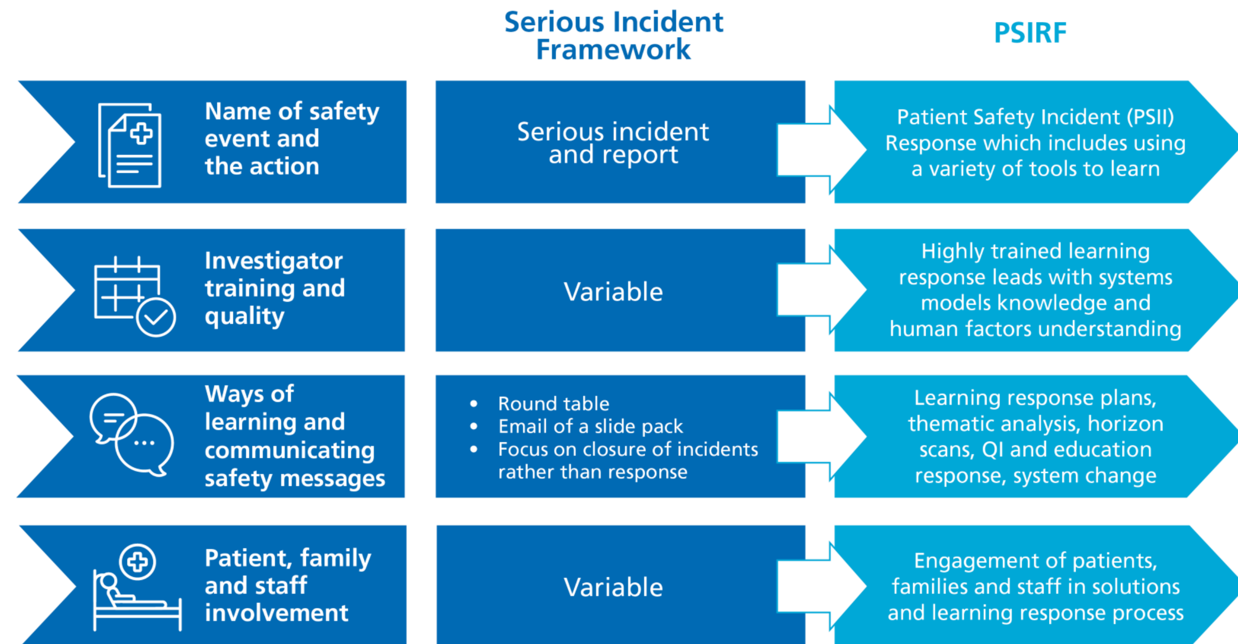
INVOLVEMENT OF OUR PATIENTS AND STAFF

IMPROVEMENT OF OUR SAFETY PRIORITIES

Achievements

- Go Live Nov 23
- Executive support
- Implementation Groups
- Creation of Learning Response resources
- Patient Safety Partners recruitment
- Patient Safety Specialists
- Review of metrics: Structure, Process and Outcome
- 3 PSIRF Group summits
- Mandatory 1-2 safety training
- External and internal safety training

What's changing slide



WeShare everything in one place...

PSIRF: resources to help and learning response templates

Under the new patient safety incident response framework (PSIRF), there is a new way of invesigating patient safety events. Alongside this, there are new resources, including teamplates, available, to help everyone respond to these events.

As this new framework has a large focus on learning, we're taking the same approach with our templates. This means that if we feel they need to be updated to help us better respond to patient safety events, we'll make those updates. We ask that you please keep an eye on this page and check in to make sure you're using the latest version of each template.

WeShare

Search WeShare

General resources

- PSIRF Swarm Huddle template.November 2023.docx 500KB
- PSIRF After Action Review template. November 2023.docx 435KB
- PSIRF MDT template.November 2023.docx 655KB
- PSIRF PSII Report template. November 2023.docx 124KB
- National Just and Restorative Culture_guide.November 2023.pdf 856KB
- National Just and Restorative Culture Checklist.November 2023.pdf 123KB

Engagement lead resources

- Engagement leads_Engaging with and supporting colleagues during a PSII.November 2023.pdf 133KB
- Engagement leads_working with families during a PSII.November 2023.pptx 277KB

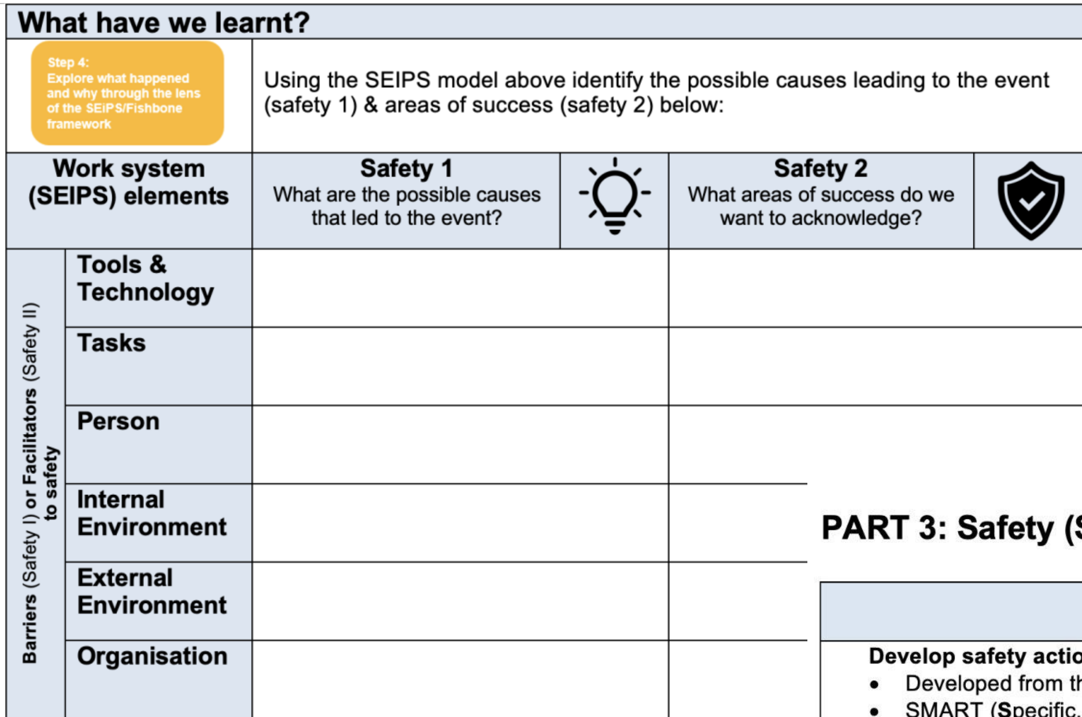
Learning response lead resources

- Learning Response Leads_Engaging and supporting staff in a PSII.November 2023.pptx 715KB

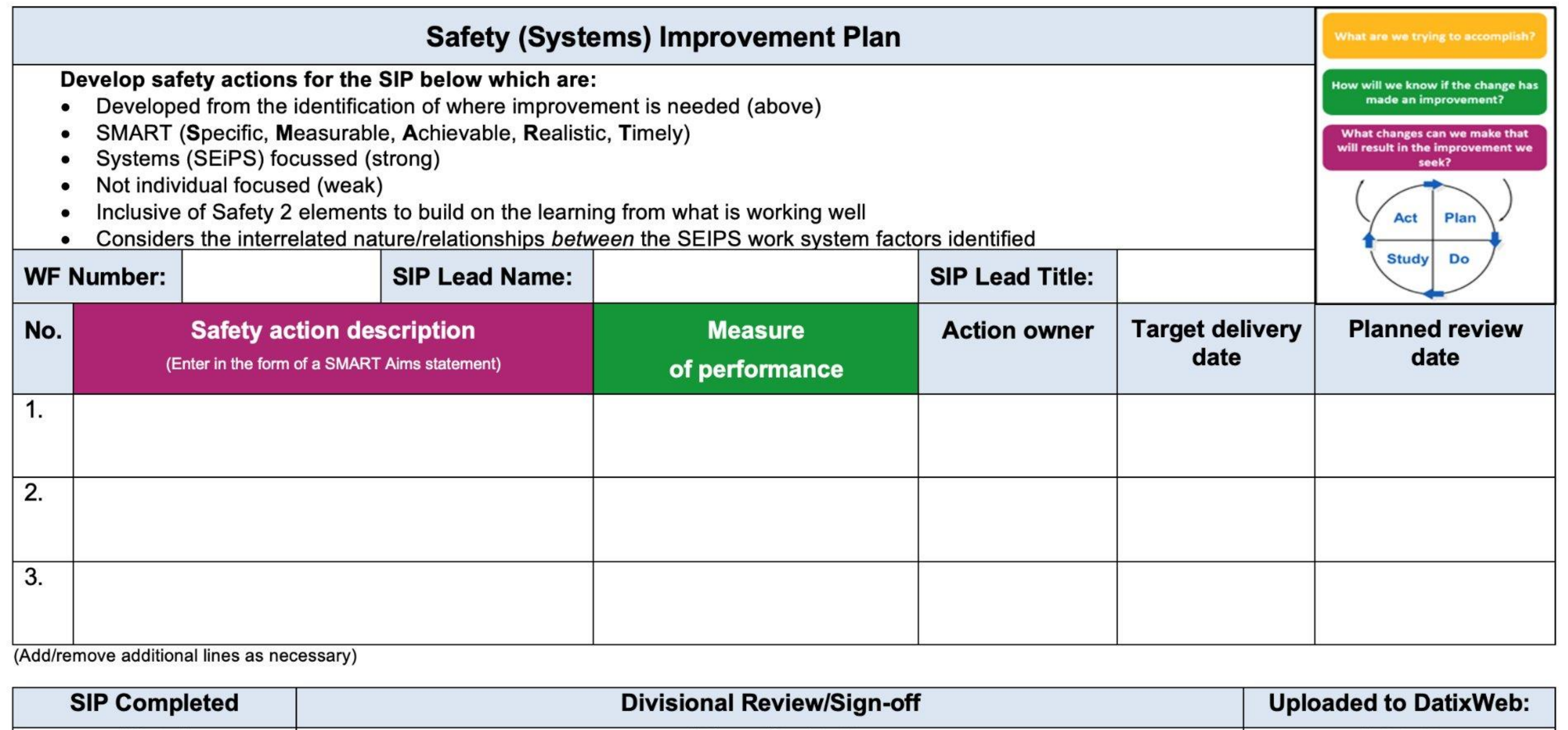
Further support on patient safety incident response framework (PSIRF)

Health Services Safety Investigations Body (HSSIB) offer courses on patient safety, including PSIRF

Find out more



What have we learnt?				
Step 4: Explore what happened and why through the lens of the SEiPS/Fishbone framework	Using the SEIPS model above identify the possible causes leading to the event (safety 1) & areas of success (safety 2) below:			
Work system (SEIPS) elements	**Safety 1** What are the possible causes that led to the event?		**Safety 2** What areas of success do we want to acknowledge?	
Barriers (Safety I) or Facilitators (Safety II) to safety	**Tools & Technology**			
	Tasks			
	Person			
	Internal Environment			
	External Environment			
	Organisation			



PART 3: Safety (Systems) Improvement Plan (SIP)

Safety (Systems) Improvement Plan					
Develop safety actions for the SIP below which are: • Developed from the identification of where improvement is needed (above) • SMART (**S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**imely) • Systems (SEiPS) focussed (strong) • Not individual focused (weak) • Inclusive of Safety 2 elements to build on the learning from what is working well • Considers the interrelated nature/relationships *between* the SEIPS work system factors identified					
WF Number:		**SIP Lead Name:**		**SIP Lead Title:**	
No.	**Safety action description** (Enter in the form of a SMART Aims statement)	**Measure of performance**	**Action owner**	**Target delivery date**	**Planned review date**
1.					
2.					
3.					

(Add/remove additional lines as necessary)

SIP Completed	Divisional Review/Sign-off	Uploaded to DatixWeb:

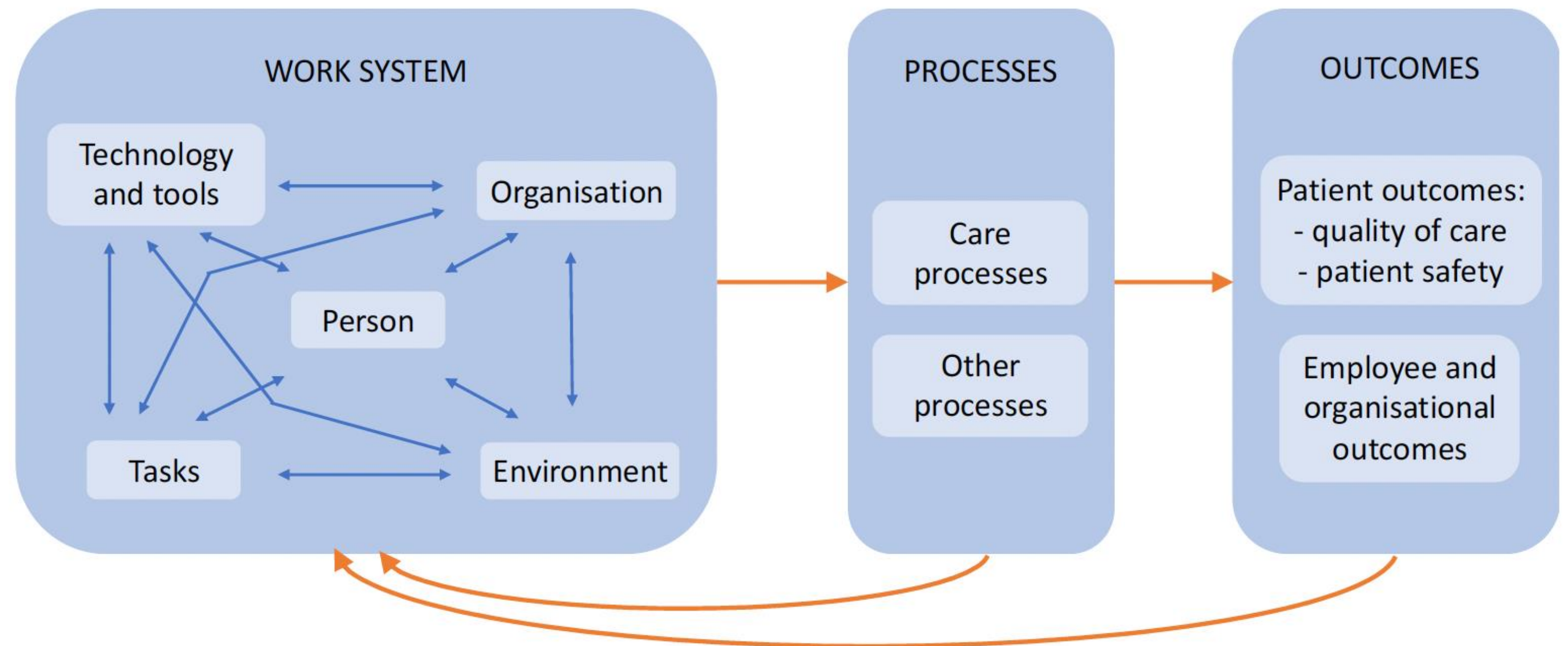
External PSIRF training

- 75 Engagement leads
- 65 Learning Response leads
- 20 Oversight leads
- AAR conductor courses
- HSSIB training

PSIRF in Practice (PIP) Course

- ✓ Over 100 staff trained at 4 trust hospitals
- ✓ Supported by leadership
- ✓ Differences between SIF and PSIRF discussed
- ✓ SWARM huddle role plays
- ✓ Co-creation of a bank of scenarios
- ✓ Live AAR practice
- ✓ PSIRF Toolkit shared
- ✓ Waiting list for the course

SEIPS model is in every tool (Systems Engineering Initiative for Patient Safety)



CANDLE

Multi-session programme providing QI safety training for trainees and trainers

- Workshop based learning
- Supported workplace-based project
- Aligned to curricula

SAFETY TEAM TRAINING

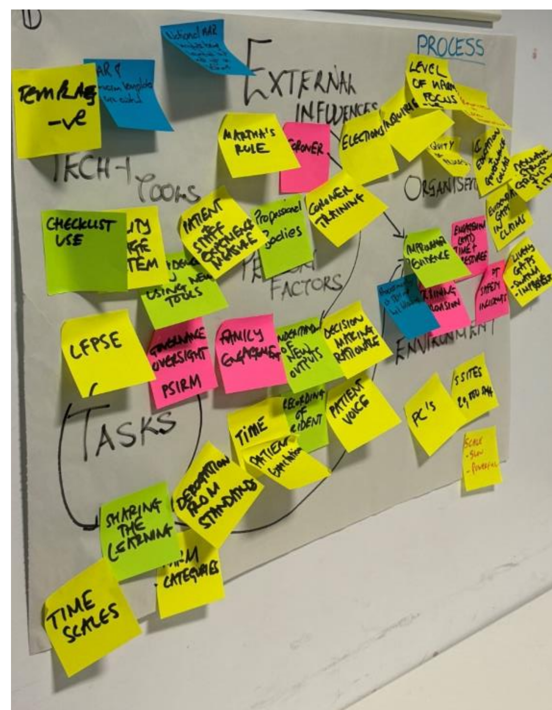
Bringing a team together to learn

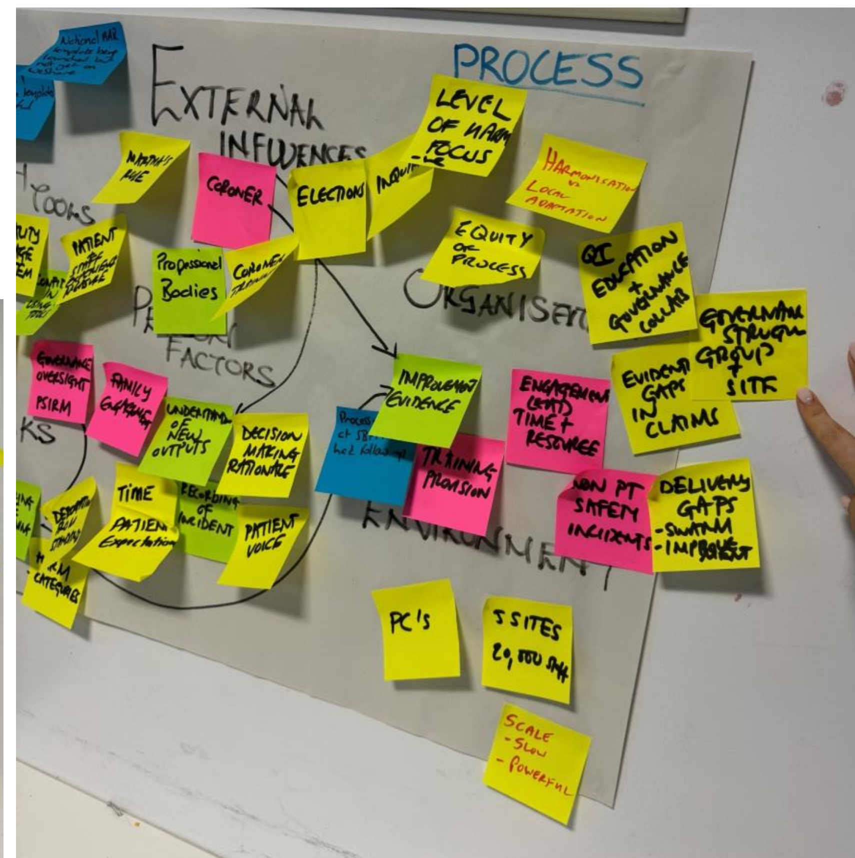
- The MDT hold the key!
- Culture eats strategy for breakfast
- NatSSIPs, Human factors

Learning Responses into Improvement work

- At macro and micro level
- Using new tools eg. SEIPs, SWIFT, IFACES
- Delivery and sustainment of improvements
- PSIRP priorities vs Evidence of Improvement

SEIPS in action





Tasks

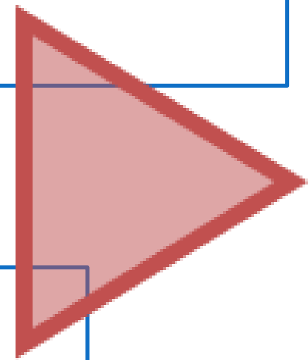
- Improvement in PSIRPs
- Quality management system
- Professionalisation of safety
- Safety communications
- Quality assessment of PSIIs

Organisation

- Policies and Procedures
- Clear PSIRPs with improvement evidence
- Board oversight and knowledge
- Safety NED on the board
- PSIRF metrics Structure, Process and Outcome
- Group benchmarking
- Roles for delivery

Internal Environment

HF design consideration



Desired Outcomes

System Performance:

✓Safe treatment

✓PSIRF is meaningful

Tools/Technology

- Qi approach
- Safety toolbox
- Linking training and QI
- Safety dashboards
- Intranet storage of PSIRF tools

Person

- Just restorative culture
- Involved patients
- Involved staff
- Psychological safety
- Safety training and opportunity ward to board
- PSPs and PSSs

External Environment

- Culture of openness and transparency
- LFPSEs and incident reporting
- Insight data/dashboard
- CQC inspections
- Coroner support
- ICB oversight

No magic wand

Need to involve, listen and remain in the reality

Will take time to EVOLVE and for culture change