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PATIENT SAFETY INCIDENT REPORTING FRAMEWORK (PSIRF)

Serious Incident Reporting – What is PSIRF and how have early adopters found the transition to this new incident reporting framework?

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BDO

Introduction

What is PSIRF? An Executive Summary and added background context

INTRODUCTION

What is PSIRF?

The Patient Safety Incident Response Framework (PSIRF) provides the NHS with guidance on how to respond to patient safety incidents – with no distinction between incidents and 'serious incidents' – for the purpose of learning. The PSIRF supercedes the Serious Incident Framework 2015 (SIF 2015), and provides guidance on how to respond to patient safety incidents, placing emphasis on appropriate investigations, trust-wide learning, proportionate responses, and systems-based change.

The PSIRF uses the principles and practices endorsed by The NHS Patient Safety Strategy to support the creation of systems that are underpinned by a patient safety culture, and aims to deliver sustainable safety improvements and equity of care. A patient safety incident is investigated or reviewed under this framework to understand the circumstances that led to it, for the purpose of whole system learning and improvement.

Why is this important?

All providers of healthcare services in England under the auspices of the NHS are required to provide a Quality Account and publish it by the end of June each year. The requirements for this were amended during 2020 – 2022 due to the Covid-19 pandemic. In normal circumstances, Trusts are required to obtain assurance from its external auditors on the Quality Account, however, for many, this requirement was suspended over this period. PSIRF falls under the remit of the Quality Account, and now that reporting of the Quality Account has resumed, Trusts want assurance that they have successfully transitioned to this new model of incident reporting and are adopting its values. As some of our clients were early adopters of this new reporting framework, we are in the unique position to highlight their successes, share their learning, and make evidence-based recommendations to our audit clients who are just now beginning this process of transition. We hope that our insights and clinical expertise will add value to our audit offering, improving the staff experience of PSIRF to the benefit of all patients.

INTRODUCTION

Our Briefing Note

This paper outlines:

- Background to the introduction of PSIRF and how it differs from the SIF 2015
- Key themes that we have seen in our PSIRF reviews of early adopters in the NHS sector
- PSIRF factors Audit and/or Quality Committees should consider, and good practice observed at other organisations. These are divided into three key areas:
  - Organisation and governance
  - Stakeholder Engagement and Culture
  - Report emphasis

It should be recognised that case study examples provided here are illustrative and should not be taken as comprehensive. Inclusion of an example is also not an expression of opinion over the actual effectiveness of these measures. Users of this document should also be aware that effective Serious Incident frameworks should be sufficiently context-specific and achieved through appropriate stakeholder engagement.

Suggested action for the Audit and/or Quality Committee

- Read this document and consider whether there are any risks and issues relevant to the Committee's responsibilities
- Consider whether any internal audit work or other assurance is necessary in this area
- Consider referring this paper to the Board

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EXECUTIVE SUMMARY

Of the Trusts we work with, all have a dedicated PSIRF team who are responsible for the development, implementation and monitoring of the PSIRF. Most have developed a rigorous, and nationally recognised, Patient Safety Incident Response Plan that incorporates national and local guidelines to good effect, and ensures an appropriate investigating method is correctly determined for every serious incident. One Trust's' Patient Safety Incident Response Process ensures that human factors analysis and systems-based learning are at the heart of all investigations, and easy-to-read, internal process mapping allows the whole clinical body to participate in learning from incidents and embed change.

Effective governance has also proven to be vital for those Trusts who have successfully transitioned to PSIRF. Knowledge and experience in patient safety issues at a Board Level is essential to embed the principles of the PSIRF into day-to-day decision making.

Stakeholder engagement at all levels is essential, with senior buy-in at an early stage an indicator for success and cultural shift from blame to learning.

Our comparison of reports read under the old and new frameworks highlighted the overall change in emphasis of incident reporting, from one of determining root cause and apportioning blame, to that of analysis, learning and improvement. Although there is still some space to improve further, the Trusts we work with have embraced the opportunity to investigate patient safety incidents differently and adopt the guiding principles of the PSIRF.

The Trusts we reviewed have taken great strides in their handling of patient safety incidents under the PSIRF, demonstrating a wider commitment to learning and improvement. This should, in time, allow Trusts to reap the rewards of a culture, and reporting framework, that values learning and improvement over cause and blame.

There is always an inherent risk for a Trust when implementing a new style of reporting and that is the Trust will continue to investigate and review incidents as they did before, but simply give the process a new label. To ensure this doesn't happen, not only does the new framework need to be robust, user-friendly and demonstrate an entirely different ethos to the one that went before, the framework also requires substantial buy-in from stakeholders and an organisational cultural shift. This belief and desire to change from the top down, is what is required to embed system-wide change in any organisation.

BACKGROUND

Serious Incident Framework 2015

Prior to the introduction of the PSIRF, NHS Trusts relied upon the SIF 2015 to direct their reporting of serious patient safety incidents. The SIF 2015 aimed to "describe the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again" (1). The SIF 2015 was developed in collaboration with healthcare providers, commissioners, regulatory and supervisory bodies, patients and families and their representatives, patient safety experts and independent expert advisors for investigation within healthcare. The key principles of serious incident management under the SIF 2015 included:

More explicitly defining the roles and responsibilities of those involved in the management of serious incidents;

Highlighting the importance of working in an open, honest and transparent way where patients, victims and their families are put at the centre of the process;

Promoting the principles of investigation best practice across the system; and

Focusing attention on the identification and implementation of improvements that will prevent recurrence of serious incidents, rather than simply the completion of a series of tasks.

In theory this sounded ideal, using the SIF 2015 for a focus on prevention rather than as a tool for apportioning blame. However, there was one major flaw with the SIF 2015 and that was the recognised method for conducting investigations under it: Root Cause Analysis (RCA), and its subsidiary, the Serious Incident 7 Day Report (SI7DR).

Root Cause Analysis

Root Cause Analysis (RCA) is a structured method used to analyse serious adverse events. A one-size-fits-all approach to serious incident reporting that was initially developed to analyse industrial accidents (2), RCA was the methodology employed under the SIF 2015 to investigate why and how serious incidents happened in healthcare and to assure the Trust, Clinical Commissioning Group (CCG) and the patient/family that lessons were learned, and that the incident would never happen again. The widely accepted RCA process consists of 4 stages:

1 Serious Incident Framework 2015

2 Root Cause Analysis: Why we need to change the focus. Patient Safety Learning. October 2020

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1. **Collect information** - All material facts relating to the incident gathered as soon as possible after the event. In determining what information to collect the investigator must consider the facts leading up to, as well as the incident itself;
2. **Map out the information** – Construct a timeline/chronology;
3. **Analyse the information** – Typically utilising the 5 'why's' technique (3) to reach the root of the problem;
4. **Generate a solution** – An action plan identified using SMART recommendations (4) to reduce risk.

One of the most commonly reported concerns about the RCA approach to serious incident reporting was the disproportionate focus on some of the activities associated with the first two stages of the investigation process (i.e. setting up the investigation and gathering/collating information) and not enough meaningful exploration of the activities that formed the latter stages of the review (i.e. the analysis of problems, identification of key causal or contributory factors and recommendations for change) . In one of their briefing reports from 2016, the Care Quality Commission revealed:

> *"Only 8% of the investigation reports reviewed showed evidence of a clearly structured methodology that identified the:*
>
> - *key issues to be explored and analysed*
> - *contributory factors and underlying system issues*
> - *key causal factors that led to the incident"*

In December of 2018, NHS Improvement went on to succinctly summarise the main historical problems associated with conducting RCAs under the SIF 2015 for serious incidents in the NHS:

> *"We know there are problems, for example, with how incidents are investigated and learned from. In our recent engagement to find out how we can improve the Serious Incident framework, people told us they were concerned about: providers' lack of capability and capacity to carry out good quality investigations; the tendency to use investigation for the wrong purposes; the generally poor approach to patient and family involvement; and the fact that actions to reduce risks after the completion of an investigation are too often ineffective. We know from the Care Quality Commission's review of how the NHS responds to and learns from the care provided to patients who die that too often problems with care are not identified and the bereaved, who may have concerns, are not sufficiently supported."*

3 Five whys (or 5 whys) is an iterative interrogative technique used to explore the cause-and-effect relationships underlying a particular problem. Five Whys Technique. adb.org. Asian Development Bank. February 2009.

4 SMART is a mnemonic acronym, giving criteria to guide in the setting of goals and objectives. The letters stand for Specific, Measurable, Achievable, Relevant and Time-bound. Doran, G. T. et al. "There's a S.M.A.R.T. way to write management's goals and objectives". Management Review. 1981. 70 (11): 35–36.

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In addition, and with reference to issues associated with time and pressures from the wider system, investigators have been historically asked to conduct RCAs to satisfy the needs of many stakeholders. This would often lead to a conflict of purpose when issues such as liability, professional performance and cause of death were considered in the same report.

Another issue identified by NHS Improvement at that time was that there was little training in setting appropriate actions, or a centralised place to evidence that actions had become imbedded . Indeed, there was no robust, standardised approach across the NHS to gather evidence that actions had been put in place post incident, even though the CQC can call on these actions and the evidence of these actions at any time. All this shone a major spotlight on why the SIF 2015 would never achieve ultimately what it set out to – prevent recurrence.

Serious Incident 7 Day Report

The Serious Incident 7 Day Report (SI7DR) emerged as a direct result of the COVID-19 Pandemic. At this time, trusts no longer had the resources to complete lengthy RCA documents, and so the SI7DR was born. Root cause analysis remained the primary methodology and focus, but the review was much more succinct.

In response to numerous publicly made patient safety incidents, negative press coverage, and political pressure to the SIF 2015 and its use of RCA, the NHS produced a new Patient Safety Strategy (5). This strategy included the proposal to develop a new Patient Safety Incident Response Framework (PSIRF) (6). In a huge deviation from the root cause analysis methodology of investigating patient safety-related incidents, the terminology of the Patient Safety Strategy referred to 'systems-based patient safety investigation', instead of 'root cause analysis', to reflect the new 'whole-systems' approach to safety as opposed to individualised blame. Of course, finding out what went wrong systemically is, and should always be, part of the investigators role when conducting a serious incident review; however, assuring the family and patient that the trust has put new systems in place and that they are striving for this incident to never happen again is equally, if not more important, and was vitally lacking in the SIF 2015 approach to investigation reporting.

Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) replaces the Serious Incident Framework 2015 (SIF 2015), from which it differs in the following key aspects:

5 NHS England. The NHS patient safety strategy. www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy

6 NHS England. The patient safety incident response framework. www.england.nhs.uk/patient-safety/incident-response-framework

BACKGROUND

- **Broader scope:** the PSIRF moves away from reactive and hard-to-define thresholds for 'Serious Incident' investigation and towards a proactive approach to learning from incidents. It promotes a range of proportionate safety management responses.
- **Investigation approach**: safety investigation is now tightly defined. Quality of investigation is the priority with the selection of incidents for safety investigation based on opportunity for learning and need to cover the range of incident outcomes.
- **Experience for those affected:** expectations are clearly set for informing, engaging and supporting patients, families, carers and staff involved in patient safety incidents and investigations. In accordance with a just culture (7), staff involved in incidents are treated with equity and fairness.

PSIRF is intended to be a whole system change to how trusts think and respond when an incident happens in order to prevent recurrence. Previous frameworks such as the SIF 2015 described when and how to investigate a serious incident, PSIRF instead focusses on learning and improvement. One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better (8); taking the time to conduct systems-based investigations by people that have been trained to do them.

7 "A culture in which people are not punished for actions, omissions or decisions commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated." Eurocontrol (2019) Just culture.

8 North Bristol NHS Trust Patient Safety Incident Response Plan.

Key themes arising from BDO PSIRF reviews in NHS organisations

ORGANISATION AND GOVERNANCE MATTER

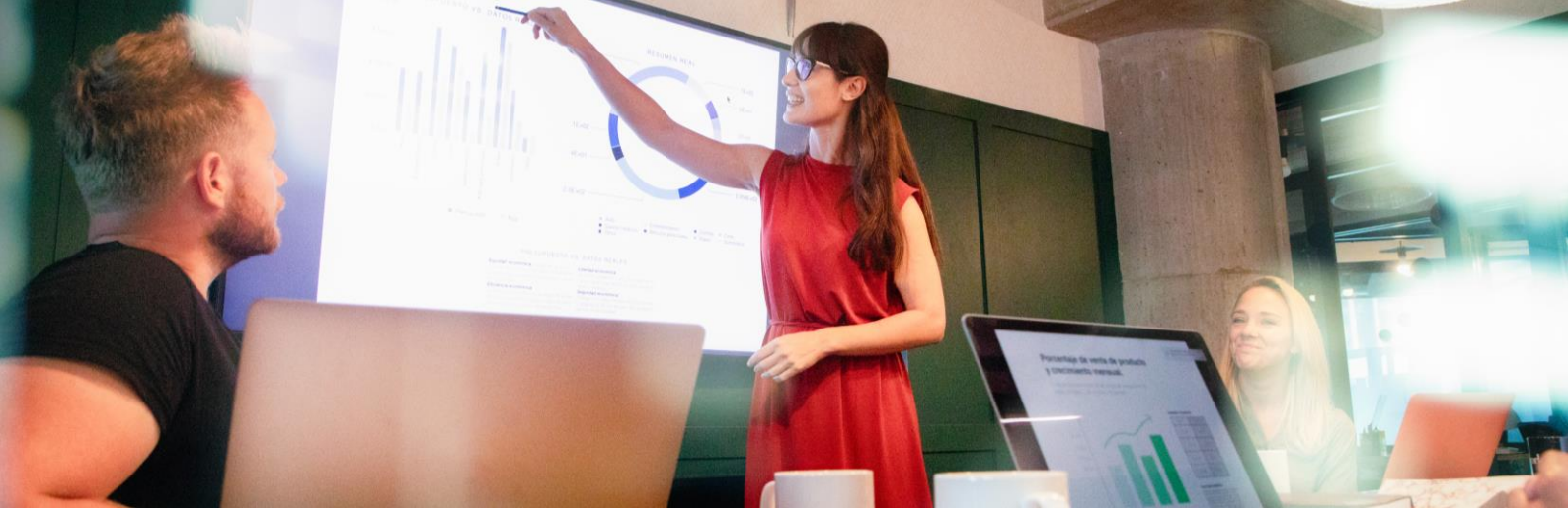
- A dedicated team responsible for the development, implementation and monitoring of the PSIRF is crucial for its successful roll out
- Sufficient oversight at Board level is important both in terms of trust-wide learning and cultural emphasis
- Training and experience in patient safety issues from C-Suite to ward is fundamental in achieving embedded change throughout an organisation
- Testing any embedded change is equally important as the change itself, and Trusts would benefit from an annual review of policy and procedure relating to PSIRF, to assure staff and families that the patient safety investigations are still achieving what they set out to; ensure lessons are learned, systems change, and serious incidents are not repeated.

STAKEHOLDER ENGAGEMENT & CULTURE

- The Trusts that have been most successful at transitioning to the PSIRF are those who have invested time and energy into finding out how best to engage with all relevant stakeholder parties
- Initial buy-in from senior stakeholders is essential to achieve top-down, whole system embedded change
- The 'Tone from the Top' drives cultural change from one of blame to one of system-wide learning and improvement.

REPORTING EMPHASIS

- The review tools developed using the PSIRF guidance allow for a reporting style geared towards analysis, patient and family inclusion, and learning from incidents
- A robust process for review tool selection is necessary for a proportionate and timely report
- The analysis and comparison of reports we undertook, under both the old and new frameworks, revealed that the Trusts we work with understand the shift in emphasis from one of cause-finding and blame to one of learning and improvement.



Organisation and Governance

ORGANISATION AND GOVERNANCE MATTER

Those Trusts that have been most successful in transitioning from the SIF 2015 to the PSIRF have two essential things in common:

- A dedicated team responsible for the development, implementation, and monitoring of the PSIRF
- Clear governance arrangements in place

The importance of a resolute team responsible for the PSIRF cannot be underestimated. The amount of work required to develop a Patient Safety Incident Response Plan (PSIRP), develop review tools suitable for a variety of patient safety incident scenarios, engage with stakeholders, initiate a training programme to ensure all those involved in undertaking reviews are sufficiently experienced, implement and review recommended actions, and report findings to various oversight committees is a large task and requires a single, unified approach in line with the values of the PSIRF.

In addition, a rigorous governance process is vital to guarantee sufficient oversight of the transition, and ensure learning is Trust-wide.

Actions and decisions made at Board/executive level define an organisation's attitude towards key issues. A strong patient safety presence at this level drives organisation-wide commitment to learning from patient safety incidents and embeds patient safety within a Trust's culture.

PSIRF presence at Board/executive level should be built on an active interest in patient safety issues but predominantly the skills and experience held by executives. This can be achieved through inclusion of patient safety requirements in succession planning and Board development.

To embed the principles of the PSIRF into day-to-day operations and decision-making organisation-wide, the Board and senior management should include patient safety as one of its key objectives.

Audit Committees should be getting regular reports on PSIRF, including information on report completion times, patient, staff and family feedback, and review selection criteria, with a nominated lead responsible for scrutiny. If not already included, PSIRF warrants a place within the clinical audit programme and should form part of the risk register. The Audit Committee Lead for PSIRF needs to work closely with both the Board and PSIRF Leadership Team to ensure a consistent message across the Trust.

CASE STUDY 1

One of the Trusts we work with has a dedicated Patient Safety Delivery Group which has overall responsibility for the transition from SIF 2015 to PSIRF:

The team have developed a Patient Safety Improvement Plan with five active workstreams. Progress made by each of the five workstreams, which includes Patient Safety and Experience, is reported to and overseen as a standing agenda item at each meeting of the Trust Board's Quality and Safety Committee.

A Safety Review Panel (SRP) and Incident Review Panel (IRP) have been created and meet on a weekly basis. The SRP reviews all incidents reported as moderate or above on Datix to review the harm grading and escalate as required. Any incidents requiring further investigation are escalated to the IRP. This has increased the timeliness of incidents being reviewed.

The team has developed monthly audits of detailed investigations to support identifying areas of best practice and improvement. The evidence for each case is assessed against the following requirements to ensure that it is sufficient:

- compassionate engagement and involvement of those affected by patient safety incidents.
- that an application of a range of system-based approaches to learning from patient safety incidents is demonstrated
- that blame language has been avoided
- 'Human Error' is considered as a symptom of a system problem
- that local rationality is considered
- the counterfactual reasoning is avoided
- that safety recommendations and actions arising are effective.

The result of each audit is reported to the Patient Safety Delivery Group and presented bi-annually to Audit Committee.

CASE STUDY 2

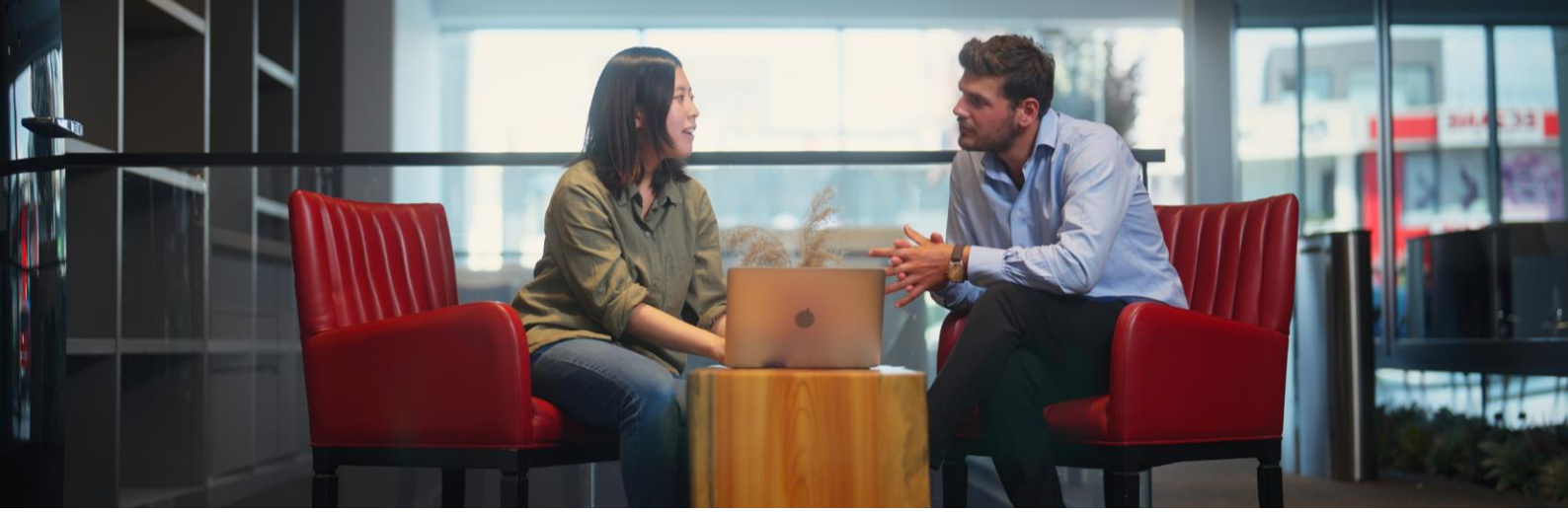
At another NHS organisation we have observed, the delivery of the PSIRF is directed internally by a Safety Investigation Assurance and Learning Group (SIALG). Improvement plans and outcomes are monitored by several governing bodies, including a Quality Oversight Group (QOG), a Quality Assurance Committee (QAC), and the Board.

The SIALG produce a Patient Safety Incident Investigation (PSII) thematic report on a quarterly basis. This report provides an overview of the themes arising from PSIIs reported during the quarter, recommendations, contributory factors, and learning and improvement actions being undertaken.

Updates on PSIIs together with themes and learning points are reported every two months to QOG, QAC and the Board. Reports to the Board include data on patient safety incidents, findings from PSIIs and implementation of improvement plans. This high degree of oversight and opportunity for learning has given the Trust confidence in the effectiveness of their transition to the PSIRF.

KEY QUESTIONS

- Is there sufficient Board and Audit Committee oversight of PSIRF?
- Does the Board and Audit Committee have sufficient skills and experience on patient safety issues?
- Does the Board have access to appropriate training and development opportunities in relation to patient safety incident reporting?
- Is improving patient safety a key objective of the organisation? Does it form part of the Risk Register or Annual Clinical Review Plan?
- How is the PSIRF considered in decision making?
- How do the PSIRF aims align with operational objectives/plans?



Stakeholder engagement and culture

STAKEHOLDER ENGAGEMENT & CULTURAL CONSIDERATIONS

Stakeholder engagement is essential to the success of the PSIRF. It can transform net-zero action from a PSIRF team operating in silo to a goal with organisational-wide buy-in.

Staff engagement can help an NHS organisation increase Board to ward ownership of PSIRF. Through greater accountability, the importance of PSIRF is elevated.

When an NHS organisation develops its approach to staff engagement, consideration should be given to the types of communication most appropriate for each stakeholder and the level of devolved responsibility permitted. Furthermore, how success of the approach will be measured should be clearly outlined and monitored regularly to ensure it is operating as intended.

A PSIRF communications plan can be used to formally outline the type of engagement that the Trust aims to undertake. It should also include measures on how the success of the plan will be evaluated.

Buy-in from senior stakeholders is essential for a Trust to achieve whole-system, embedded change. The 'tone from the top' sets the ethical climate and guiding values of an organisation which are pivotal in embedding the desired organisational culture and principles of the PSIRF.

CASE STUDY 1

At an NHS Trust we work with the PSIRF Project Lead has performed significant stakeholder engagement work, meeting with 35 staff members including the Head of the Contact Centre, Locality Managers and the Assistant Director of Operations, to ensure that the changes required to implement PSIRF are embedded within the Trust culture. This has been documented within the PSIRF Engagement Tracker and work is continuing to ensure these relationships are maintained.

CASE STUDY 2

Another Trust we work with undertook a PSIRF stakeholder mapping exercise to identify the best methods of communication to utilise for each stakeholder group to best engage with them specifically.

As such, the Trust initiated several communication mechanisms to improve stakeholder engagement with PSIRF:

- A Patient Safety Incident Response Framework campaign was launched in September 2023 which provides both staff and hospital users with information regarding what PSIRF is, what will change, what staff need to do, and how to get involved. Stalls have been set up in the main hospital foyer providing both staff and patients the opportunity to ask questions, pick up leaflets and sign up for further news.
- A digital staff engagement platform has been introduced which not only increases staff awareness of PSIRF, but acts to encourage, undertake, and track staff engagement in both mandatory and voluntary training.
- The Trust have developed an in depth 'Investigation Guide' supported by the National Institute for Health and Care Research which aims to support patient and family involvement in patient safety incident investigations.

CASE STUDY 3

A Trust we work with has recognised the need to ensure that there are support structures available for staff, patients and families involved in patient safety incidents, part of which is the fostering of a psychologically safe culture shown by Trust leaders, Trust-wide strategy and reporting systems. These beliefs are encapsulated in the Trust's wider 'Culture of Learning Project'. This Trust-wide initiative has at its heart the principles of just culture, learning and assurance, and makes use of tools such as the Just Culture Guide.

The Trust demonstrates empathy towards families in the adaptation of reports prior to their release to family members.

The Trust's involvement of family members and staff when investigating has earned the Trust's Family Liaison Response Team recognition in their dealings with families following patient safety incidents.

KEY QUESTIONS

- Are the PSIRF aims visible organisation-wide?
- Is there a staff engagement plan in place?
- Has stakeholder mapping been undertaking to understand the most appropriate communications methods for each stakeholder group?
- Is success of the staff engagement plan defined and monitored?
- Are staff properly informed and resourced to understand what they can do to contribute towards the transition to PSIRF?
- Are the responsibilities of staff clear in terms of their role in meeting the organisation's PSIRP?
- Do the current organisational structures support stakeholder engagement?
- Is there a forum to bring decisions to and get leadership support quickly?

Reporting emphasis

REPORTING EMPHASIS

Under the PSIRF, trusts have autonomy to determine how they approach patient safety investigations, using patient safety incident response plans (PSIRPs) which should be developed jointly with commissioners. This means reviews of incidents are proportionate and tailored to each different scenario as opposed to the previous root cause analysis, one-size-fits-all approach. As such the PSIRF is an umbrella for a number of reporting templates which follow direct national guidance in addition to being developed from a local perspective, incorporating local policy and best practice.

Via a documentary style review, we analysed incident reports under the old SIF 2015 framework and compared them with direct comparators under the PSIRF, to highlight any changes in investigation approach and outcomes.

The reports analysed under the PSIRF umbrella included:

- Patient Safety Incident Investigation (PSII)
- Patient Safety Incident Report (PSIR)
- Patient Safety Incident Clinical Review Tool (Clinical Review).

PSII:

The Patient Safety Incident Investigation (PSII) offers the opportunity for an in-depth study in response to key patient safety incidents. The key to PSIIs is change analysis; This involves data collection and many acute analysis phases to learn more about system-based underlying factors and their interdependencies. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for patients.

PSIR:

The Patient Safety Incident Review (PSIR) was developed with the intention of selecting the best elements of the SI7DR. It is a short but broad review, highlighting all aspects of the patients care in the 6 months prior to an incident. The PSIR reads like a story and once the report is finalised, the patients' family get a copy of the report.

Clinical Review:

The Patient Safety Clinical Review Tool (Clinical Review) was adapted by one Trust we work with from the Royal College of Psychiatrists Physical Clinical Review Template (9). As with the PSIR, it was developed to glean the best elements of the previously used SI7DR.

9. Royal College of Psychiatrists www.rcpsych.ac.uk/phyical-health/clinical-review-tool

It is much more matter of fact than the PSIR and could be potentially considered too 'cold' for a patient's family to read. The Clinical Review highlights the pivotal points in the patient journey leading up to the incident in question. It centres on specific events, which narrows the findings, and ultimately therefore narrows the learning points.

The PSIR and Clinical Review tools (and variations of, including After Action Reviews and Multi-Disciplinary Team Reviews) were the reporting templates most used to document serious incidents among the PSIRF early adopters we work with, with the more in-depth and lengthier PSII only being used in exceptional circumstances.

Regarding selecting the most appropriate reporting template for each serious incident, the Trusts we work with follow very similar approaches. All have a Clinical Review Group (in various guises), who meet on a regular basis, and a Patient Safety Incident Report Plan (PSIRP). Most have a Patient Safety Incident Response Process Map, to determine which reporting tool to utilise following every serious incident. A chronological timeline of events is established, along with the patient's medical history and any diagnoses, and this information is brought before a review group. The information is scrutinised, with the panel determining what questions need answering. These questions determine which reporting method (i.e. the PSII, PSIR or Clinical Review) should be used for each serious incident that occurs.

This approach to framework selection is robust, is in line with national guidance under the PSIRF, and is consistent with the recognised 'best practice' approach taken by other early PSIRF adopters such as North Bristol NHS Trust (10) and Cornwall Partnership NHS Foundation Trust (11).

CASE STUDY 1

A comparison of Root Cause Analysis v Patient Safety Incident Investigation

RCA summary:

- Focus on chronology
- Significant highlighting of documentation and communication errors made by staff
- Little evidence of substantial analysis having taken place to effect positive system change
- Restraints of methodology i.e. relatively limited sources of information; clinical notes; written statements; witness availability – led to conclusions that concentrated on judgements about avoidability, preventability or predictability, which should not be the purpose of a such an investigation
- Recommendations linked back to the service delivery problems found and highlighted throughout the chronological timeline of events but were vague and unplanned.
- No timescales or ownership of recommendations, or evidence of further review having taken place.
- RCAs appear concerned with what went wrong as opposed to focusing on what could be done better and how. Lessons learned and recommendations made appear to be an afterthought.

PSII summary:

- The PSII templates used followed the national standards set out in the various Trust's PSIRPs.
- PSIIs are utilised for systems improvement, they are not inquiries into the cause of death, nor to apportion blame or hold individuals or organisations to account (12).
- Approximately 80% of the full written reports were dedicated to analysis of the issues and learning from them, which demonstrates the monumental shift of emphasis that the PSIRF has allowed; going from a prominence of cause and blame to one of system-wide change and learning.

10. North Bristol NHS Trust. www.nbt.nhs.uk/about-us/our-standards/patient-safety

11. Cornwall Partnership NHS Foundation Trust. www.cornwallft.nhs.uk/patient-safety-incident-response-framework-psirf

12. NHS England Patient Safety Incident Investigation Standards. www.england.nhs.uk/wp-content/uploads/2020/08/Standards_for_PSI_Investigation.pdf

- Significant opportunity for embedding systems-based safety improvement
- Succinct and easy-to-follow change analysis used to identify care delivery problems allowed for sensible and realistic solutions.
- Shared learning and recommendations sections of the reports were prominent and robust, referring to local and national policy and giving clear guidance on how to improve and avoid further repeat occurrences.

What was clear from the PSII reports analysed was the importance placed on involving staff, carers and family in the development of it. Not once was any blame apportioned to any particular party, something that would have been an easy conclusion to jump to under the RCA methodology. Instead, the PSII approach to investigation reporting proved a safe environment for those involved in the patient's care to both ask and respond to questions, leading to opportunities for the various Trusts to improve in a number of areas, including but not limited to allocation of hospital resources; training of staff; signposting of equipment; policy adherence; governance and patient/family satisfaction.

CASE STUDY 2

A comparison of Serious Incident 7 Day Reports (SI7DR) v Patient Safety Incident Reports (PSIR)

SI7DR summary:

- Content imbalance placed emphasis on the timeline of events as opposed to analysis and learning points
- Negative/blame bias
- Limited opportunity to demonstrate whole system analysis or document positive findings
- No opportunity for patients, relatives or clinical staff to express their views or concerns
- SMART recommendations included.

Although it was clear that the SI7DR uses RCA as its guiding methodology, there was improvement in the recommendations formatting, which explains why Trusts have chosen to use this element of the SI7DR in their later adapted (PSIR) reports falling under the PSIRF framework.

PSIR summary:

- PSIR templates were developed using PSIRF guidance, but with the intention of selecting the best elements of the SI7DR
- The PSIR is a broad review covering everything that happened in the 6 months prior to an incident
- Reads like a traditional serious incident report as used in the SIF 2015, however an important difference between these two documents was the inclusion of a section which recognises the strengths of the care and service delivery, in addition to weaknesses
- Families have much more input into the content of the reports, allowing the Trusts we work with to exhibit their duty of candour (13).

13. Care Quality Commission. Duty of Candour. Regulation 20. www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

CASE STUDY 3

A comparison of Serious Incident 7 Day Report (SI7DR) v Patient Safety Incident Clinical Review (Clinical Review)

A Patient Safety Incident Clinical Review (Clinical Review) from one early adopter of the PSIRF was directly compared with the above SI7DR (from the same Trust) owing to the event similarities.

SI7DR summary:

See Case Study 2 on previous page.

Clinical Review Summary:

- The chronology of events constituted the main body of the text
- There was a good summary of explicit judgements
- Little opportunity to demonstrate significant change analysis as in the PSII
- Dedicated sections in the report for family and staff to put forward their views of the patient's care, although opportunities to reference family and carer views regularly which shows the more holistic nature of the methodology under the PSIRF.
- Learning points had a mixture of actions required for change and positive reassurance of good work observed. This set a good tone for the report and re-emphasised the PSIRF principles of learning and improvement as opposed to apportioning blame.
- The learning points, with recommendations embodied within them, were specific and clear, yet they still required timeframes, ownership, and a review section to ensure that actions are taken, embedded, and documented.

This difference in approach between the Clinical Summary and PSII highlights the importance of clear and effective selection criteria within the PSIRP to determine the best review style for the investigation in hand.

KEY QUESTIONS

- Does the Trust have a PSIRP in place?
- Do staff know how to access the PSIRP?
- Have the Trust developed a range of reporting templates in line with PSIRF guidelines, incorporating both local and national policy, which reflect the diversity of patient safety incidents seen?
- Is there a sufficient system in place to select the most appropriate review template for each patient safety scenario?
- Are Lead Investigators appropriately trained?
- Are all stakeholders (staff, patients and families) actively involved in the review process?
- Who is responsible for actioning recommendations made and reviewing their effectiveness?

FOR MORE INFORMATION:

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