Patient Safety Incident Response Framework (PSIRF)

Author:	David Kennett, Governance & Risk Manager
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Contents page

1 Introduction

In March 2020, NHS England (NHSE) published The Patient Safety Incident Response Framework (PSIRF). The PSIRF is a key part of the patient safety strategy (NHSE 2019) and supports the NHS to improve its understanding of safety by drawing insight and learning from patient safety incidents.

The PSIRF replaces the serious incident framework (2015) and makes no distinction between 'patient safety incidents' and 'serious incidents' and their associated thresholds no longer exist under PSIRF.

PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement (NHSE, 2022).

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.

Application of the Patient Safety Incident Response Framework (PSIRF) principles is mandatory for all health services contracted under the NHS Standard Contract. This includes all aspects of NHS-funded healthcare provided by organisations that are not NHS trusts or foundation trusts, including some services delivered by primary care and NHS funded care delivered by independent organisations.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. As a practice/provider, we have a low threshold for capturing and collating events where the absence of a response may lead to risk to patients and members of the public.

This patient safety incident response plan sets out how City Way Health Clinic intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is a fluid document that may change with emerging themes and trends. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. We will continue to learn from the patient safety incidents reported by colleagues, patients, and their families as part of our work thereby continually improving the quality and the safety of the care we provide.

This plan is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across City Way Health Clinic. All areas of service within this practice/ provider are covered by this plan including NHS, corporate and private service lines.

This plan will assist us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

- Refocusing our PSIIs towards a systems approach in line with the PSIRF and the identification of connected causatory factors and systems issues.
- Focusing and addressing these factors to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

- Transferring the emphasis so that we have high quality PSIIs so that it increases our stakeholder's (patients, families, and colleagues) confidence in the improvement of patient safety through learning from incidents.
- Demonstrating the added value of the above approach.
- Ensuring our plan reflects the needs and actions required within the national framework.

We will continue to develop the planning aspects of this PSIRP with the assistance and approval of our integrated care board.

The aim of this approach is to continually improve. As such this document will be reviewed annually and endorsed by the senior leadership team at City Way Health Clinic.

City Way Health has a low volume of impact Patient Safety Incidents. This is due to the nature of our operation and the clinical interventions we deliver. The key themes or our Patient Safety Incidents are related to the treatment they receive while under the care of the clinic's practitioners.

City Way Health will review this plan after 6 and 12 months, then annually thereafter. If there is a change to the plan, City Way Health will notify the ICB.

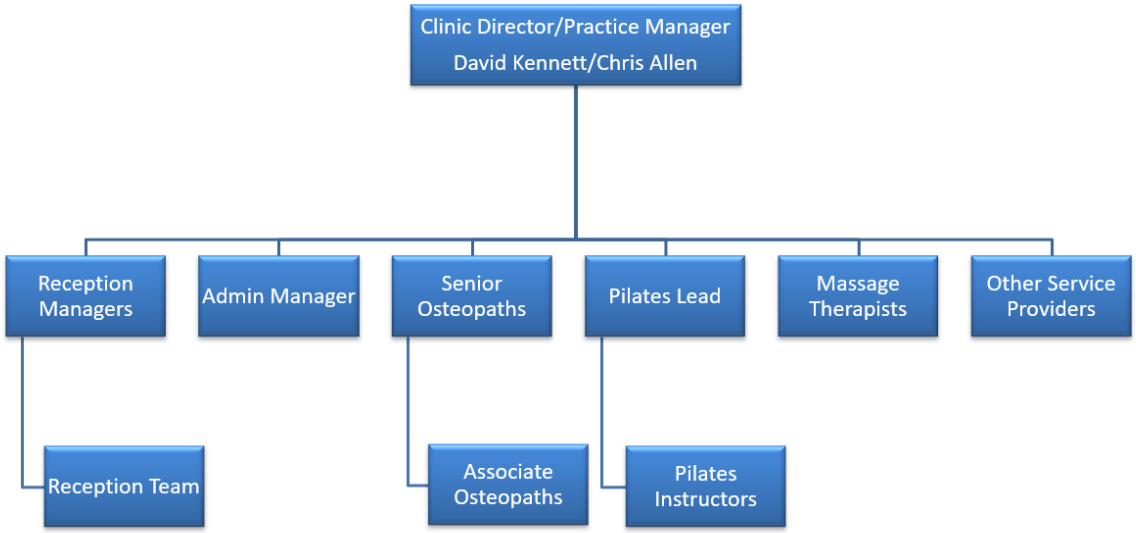
2 Our Services

City Way Health Clinic provides musculoskeletal (MSK) treatment and management for patients attending either privately or via the Kent & Medway's ICB MSK Physiotherapy contract.

Service we provide include:-

- Osteopathy
- Acupuncture (Dry Needling)
- Shockwave Therapy
- Pilates
- Adjunct Therapies including Massage and Nutritional Advice

Organisation Structure -



To deliver our services efficiently we use the CRM platform, Jane App. As an organisation City Way Health Clinic is committed to delivering the highest standards of patient care, continual professional development of our practitioner and wide team and the provision of learning opportunities is at the heart of what we do.

Internal Stakeholders

The list of internal stakeholders for City Way Health Clinic who are key to decision making are the Senior Leadership Team (accountable for Governance, Safeguarding, People Team, Health and Safety, and operational management). They work closely with the Reception and Administration Managers.

External Stakeholders

Depending on the incident to be investigated, the external stake holder may vary dependent on their subject matter expertise.

This may include patient groups, and patient and public representative organisations, for example:

- General Osteopathic Council
- Institute of Osteopathy
- Kent & Medway Integrated Care Board
- Medway Physical Activity Alliance

3 Defining our Patient Safety Profile

The patient safety issues most pertinent to our organisation are those associated with their treatment. We have looked at all our records for the last 2 years and found that there were no issues identified within that framework. However, we are committed to the ongoing improvement and if any issues were to arise we will update the plan accordingly.

We regularly engage and collaborate with our external stakeholders who publicise common themes which we should consider for our patient safety incident profile for all services mentioned in Section 2 of this document

Responses to any patient safety investigation under this plan follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components i.e. equipment, processes etc and not from a single component alone. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error' are stated as the root cause of an incident.

There is no remit within patient safety investigations to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes exist for the purpose of investigating the following:

- Complaints management,;
- claims handling,;
- human resources investigations into employment concerns,
- professional standards investigations,
- coronial inquests; and,
- criminal investigations.

The principle aims of each of these responses differ from those of patient safety responses and are outside the scope of this plan. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

This plan replaces City Way Health Clinic's Serious Incident Plan. This plan supports the requirements of the PSIRF and sets out this City Way Health approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a coordinated and data-driven response to patient safety incidents. It embeds the concept of a patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This plan supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- 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 responses to patient safety incidents and safety issues.
- supportive oversight focused on strengthening response system functioning and improvement.

The plan applies to City Way Health Clinic and all its employees and must be adhered to by all those who work for the organisation.

This plan is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across City Way Health Clinic.

4 Defining our Patient Safety Improvement Profile

City Way Health Clinic believes that continuous quality improvement is integral to quality care and patient safety, it is never the intention for things to go wrong or have unintended consequences but we must acknowledge that we are humans working in complex systems and things can go wrong unintentionally. As such, City Way Health Clinic has continuously reviewed and enhanced its governance processes to ensure it learns from patient safety incidents.

This feeds into our quality improvement activity and the Clinical governance framework. We will also continue to draw on guidance and feedback from national and regional level NHS bodies, regulators, commissioners, partner providers and other key stakeholders to identify, define and refine the quality improvement work that must be undertaken.

In line with the national PSII standards the following resources have been identified to enable delivery of the potential investigation programmes, that is:

- National priorities:
  - Never Events
  - Learning from deaths – related incidents
  - Unexpected incidents which signify an extreme level of risk for the patients, families and carers, staff, and organisations, and where potential for learning and improvement is so great (within or across a healthcare service/ pathway) that they warrant the use of additional resources to mount a comprehensive PSII response.
- Identified local priorities
- Excluding incident types that are already part of an active improvement plan that is monitored to determine efficacy and for which incremental improvement can be demonstrated.

Investigation stages

Below is an outline of the various stages of the investigation process and the resource required for each PSII. The exact resources will depend on the specific incident.

1. Plan the investigation
2. Gather and map the information (WHAT happened)
3. Identify problems (HOW it happened and variations from what was expected to happen)
4. Analyse contributory and causal factor (WHY these key problems arise)
5. Write investigation report – with clarity, openness and in full consultation with patient/ family and staff.
6. Develop recommendations and action plan.

The Learn from Patient Safety Events (LFPSE) service is a national NHS system for the recording and analysis of patient safety events that occur in healthcare. This can be researched and used as reference when investigating any incident.

Safeguarding

Safeguarding requires consideration throughout all patient safety events. Whilst there are some specific incidents that will follow the specialty nursing pathway for review, others may require safeguarding input or referrals.

The Mental Capacity Act (MCA, 2005) also requires specific consideration throughout all patient safety events. An individual's capacity to consent or ability to make an informed decision relating to care/treatment may influence their level of involvement in learning responses.

The role of both safeguarding and MCA will be reviewed by the City Way Health Clinic's safeguarding lead.

Infection Prevention and Control (IPC)

Our organisation has established a Local IPC Review Plan that is in accordance with the national PSIRF methodology.

We ensure the availability of qualified IPC professionals and the necessary tools by allocating adequate staffing and resources to facilitate effective IPC communication and governance.

Medicines Optimisation

Medicines Safety is committed to the avoidance of harmful events and has an established culture of learning from patient safety incidents.

Medicines are integral to patient care and the learning from patient safety events is a core function for all organisations delivering healthcare services.

Healthcare professionals delivering the medication safety agenda in their organisation require an understanding of national plan, frameworks and legislation. Embedded in all learning response pathways will be the inclusion of subject specialists informing the review process and identifying improvement strategies. In instances where medicines safety incidents are identified, our investigation process will involve collaboration, and any insights derived from these investigations will be disseminated throughout the organisation to facilitate collective learning and improve our practices.

5 Our Patient Safety Incident Response Plan: National Requirements

Due to the nature of our business currently it is unlikely that City Way Health Clinic will be involved in any Patient Safety incidents as outlined in the national priorities.

The table below outlines how we intend to respond, by patient safety incident type.

	National priority	Response/Action Required	Lead for response / actions required
1	Incidents that meet the criteria set in the **Never Events list 2018**	Locally led PSII	Organisation involved (City Way Health Clinic) Create local/organisational actions and share learning through the Clinical Quality and Assurance Board
2	Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	Locally led PSII	Organisation involved (City Way Health Clinic) Create local/organisational actions and share learning through the Clinical Quality and Assurance Board
3	Death of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally led PSII (or other response) may be required alongside the LeDeR review	Respond to recommendations as required from LeDeR. Create local/organisational actions and share learning through the Quality and Governance Assurance Board
4	Deaths of patients where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally led PSII	Organisation involved (City Way Health Clinic) Create local/organisational actions and share learning through the Clinical Quality and Assurance Board
5	Safeguarding incidents in which: Babies, children and young people are on a child protection plan; looked after plan or a victim of wilful	Refer to local authority safeguarding lead. Healthcare providers must contribute towards domestic independent inquiries, joint targeted	Respond to recommendations as required from safeguarding boards Create local/organisational actions and share learning through the Clinical Quality and

	neglect or domestic abuse/ violence. Adults (over 18 years old) are in receipt of care and support needs by their Local Authority The incident relates to FGM, Prevent (radicalisation to terrorism; modern slavery & human trafficking or domestic abuse/violence.	area inspections, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards	Assurance Board
6	Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation team for consideration for an independent PSII Locally led PSII may be required with mental health provider	As decided by the RIIT
7	Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Health Authority (SpHA) criteria when in place.	Refer to HSIB (or MSpHA when in place) for independent PSII if accepted.	As decided by HSIB
8	Incidents in NHS screening programmes.	Refer to local Screening Quality Assurance Service for consideration of locally led learning response.	As decided by local screening service Quality Assurance Board.

6 Our Patient Safety Incident Response Plan: Local Focus

Our plan sets out how City Way Health Clinic intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change.

NHS Kent and Medway Integrated Care Board (ICB) has a responsibility to provide an oversight role under PSIRF as City Way Health Clinic's chosen lead provider for implementation and monitoring. The ICB has collaborated with City Way Health Clinic in the development of this PSIRP and will continue to collaborate with City Way Health Clinic in its maintenance and review. The PSIRP will be reviewed by City Way Health Clinic and the ICB at months 6 and 12 following official implementation of PSIRF and will then be reviewed at least annually.

Patient reported complaints and incidents are captured by our Governance Lead. Senior Leaders at all levels must enable and encourage all staff to record and share hazards, risks or incidents. Incidents can also be raised via our internal Whistleblowing process.

Engaging & involving patients, families & staff following a patient safety incident is vitally important. Our supporting processes encourage early engagement with patients and their carers, facilitated through our Governance Lead to gain their version of events, explaining the process, addressing questions they wish to be answered as part of the investigation and agreeing timescales for response.

The following principles for engaging with those affected by patient safety incidents will be upheld:

- Fully informed about what happened
- Given the opportunity to provide their perspective on what happened.
- Communicated within a way that takes account of their needs.
- Given an opportunity to raise questions about what happened and to have these answered openly and honestly.
- Helped to access counselling or therapy where needed.
- Given the opportunity to receive information from the outset on whether there will be a specific learning response and what to expect from the process.
- Signposted to where they can obtain specialist advice and/or advocacy and/or support from independent organisations regarding learning response processes.

All staff will be trained in Patient Safety Syllabus 1 and the Directors will additionally undertake Patient Safety Syllabus 2.In the future, if required, our Clinical Governance Lead will provide additional training to appropriately support patients, their families/carers, and staff, involved in a patient safety incident.

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an

effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Patient Safety Incident Response Activity

Our approach to responding to different types of incidents is set out within our Patient Safety Incident Response Plan. Application of patient safety incident response activity is triggered according to 3 key objectives:

- Learning to inform improvement - Where 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.
- Improvement based on learning - Where a safety issue or incident type is well understood (e.g. because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation.
- Assessment to determine required response - For issues or incidents where it is not clear whether a learning response is required.

Safety Improvement Plans

The type of response to a local safety event would depend on:

- the views of those affected, including clients and their families.
- Capacity available to undertake a learning response.
- Available resources to share the learning.
- What is known about the factors that lead to the incident(s).
- Whether improvement work is underway to address the identified contributory factors.
- Whether there is evidence that improvement work is having the intended effect/ benefit
- If City Way Health Clinic and it's lead ICB are satisfied, risks are being appropriately managed.

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. They can take different forms and may include:

- Creating an organization-wide safety improvement plan summarizing improvement work.
- Creating individual safety improvement plans that focus on a specific service, incident type or situation.

- Collectively reviewing output from PSII's of single incidents when it can be evidenced that there are underlying, interlinked system issues.
- Creating a safety improvement plan to tackle broad areas for improvement (i.e. overarching system issues).

City Way Health Clinic will decide upon the best approach to take as an outcome based on the available data following a PSII. This may be to follow-up a single plan or if complex be a mixture of the above.

Equality Impact Assessment Statement

During the development of the plan and processes included due regard has been given:

- To consider the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic and those who do not.
- To consider the need to reduce inequalities between patients in access to health care services and outcomes from healthcare services, as well as in securing services are provided in an integrated way, where this might reduce health inequalities.
- This document is a plan template which outlines a set of statements of principles, values, and intent in relation to the Kent and Medway Integrated Care Board (KM ICB) adoption of the Patient Safety Incident Response Framework (PSIRF).