Shared Services

PSIRF and what it means for Independent Providers

Heather Caddy, Partner, Browne Jacobson

Amelia Newbold, Risk Management Lead, Browne Jacobson

Flora McCabe, Head of Advocacy and Risk Management, Healthcare Senior Vice President, Lockton Companies LLP

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Browne Jacobson

Introduction

Amelia explained that we have done a lot of work over the last year or so looking at how we can support organisations in the process of transiting to the Patient Safety Incident Response Framework (PSIRF) and we were delighted to be joined by Flora McCabe, Head of Advocacy and Risk Management, Healthcare Senior Vice President at Lockton Companies LLP, to share her experience of working as a broker for independent providers.

Different organisations will be at different stages of the transition journey and independent providers are likely to experience some different issues and challenges to NHS organisations, but this session provided an opportunity for sharing of experiences across both the NHS and independent sector, both in relation to the preparation work being done to transition to PSIRF but also what changes PSIRF will bring that will impact on other processes such as inquests and claims.

Which organisations does PSIRF apply to?

PSIRF was published in August 2022 and will replace the Serious Incident Framework 2015.

It will be mandatory for all services provided under the NHS Standard Contract - this includes NHS-funded secondary care provided by independent provider organisations under the NHS Standard Contract – it effectively replaces the current contractual requirement to report SIs and manage them according to the Serious Incident Framework (SIF).

Independent providers may well be providing a range of services under different contracts e.g services commissioned by the Local Authority – these will not mandate PSIRF. However, we understand that some organisations are looking to adopt the PSIRF approach to incidents relating to these other services for consistency, and that some Local Authorities are considering using PSIRF principles for patient safety issues within their contracts.

Either way, having ongoing discussions with your commissioners will be important so that there is a shared understanding of how different incidents will be managed according to the different contracts.

Primary care providers are not required to adopt PSIRF, although they may do so if they wish.

Amelia Newbold
Risk Management Lead
+44 (0)115 908 4856
amelia.newbold@brownejacobson.com

Heather Caddy
Partner
+44 (0)3300452516
heather.caddy@brownejacobson.com

What is PSIRF? Key changes and how to prepare

Amelia Newbold, Risk Management Lead, Browne Jacobson

What is PSIRF?

PSIRF is a fundamental shift in how healthcare providers respond to patient safety incidents for learning and improvement.

PSIRF removes the classification and threshold for a 'Serious Incident' as previously set out in the SIF and the focus of incident response is on learning in contrast to SI reports which often, in practice, seek to deal with and answer a range of different questions for use in different settings, including at inquests.

PSIRF makes it clear that safety and learning should be entirely separate from other processes – *'responding proportionately to patient safety incidents under PSIRF does not form part of any HR, fitness to practice, clinical negligence, or other non-PSIRF-related process. Where those wider issues are raised, they must be managed through separate processes'* .

PSIRF involves the application of a range of system-based approaches to learning from patient safety incidents – learning responses offer "a window on the system" rather than the identification of cause(s) relating to a specific incident. There are a range of responses in addition to a Patient Safety Incident Investigation (PSII), including case review, MDT, Swarm Huddle or After Action Review.

Key changes which will impact on litigation and inquests

- If a PSII or other learning response has been undertaken this will be shared as part of the litigation process in the same way as SI reports are. However, there will be a range of different responses and documentation.
- Witness statements are no longer recommended as part of a PSII or indeed any other learning response. Statements should be collected outside the learning response process.
- Staff will continue to require support through the litigation (and or coronial process) but again, this will be separate to the learning response process.

Preparation

Organisations are expected to transition to PSIRF by Autumn 2023

Many organisations will have or will be in the process of working with stakeholders to develop a Patient Safety Incident Response policy and plan which will guide each organisation's response to patient safety incidents.

PSIRF is flexible and recognises every organisation will be different and there is no "one size fits all".

Independent providers may come across some additional challenges to those faced by NHS organisations, based on the nature of services provided and the fact these may be provided over a number of different sites in different geographical regions. As a result, risk profiles and safety priorities may differ across different sites and there may be multiple commissioners to liaise with.

Resources

You can find the note from our previous Shared Insights session on PSIRF in November 2022 here which sets out more detail about the background The Patient Safety Incident Response Framework (PSIRF) (brownejacobson.com)

That note also contains lots of resources, including an NHS England video about the changes and this link to the NHS England website– (click here) including the framework, guidance and templates.

In addition, we have prepared a **detailed checklist** to help organisations prepare for PSIRF which you can find here

Issues faced by independent providers regarding PSIRF

Flora McCabe, Head of Advocacy and Risk Management, Healthcare Senior Vice President, Lockton Companies LLP

Introduction

Flora spoke from her perspective as an insurance broker for independent providers and shared her insights into the challenges PSIRF presents for those providers and some tips for managing those.

Implementation – steps required

- Undertake planning exercise
  - Understand your risk profile in order to assess the proportionate response
  - Get the Executive on board e.g attending key updates, training and any regular claims meetings
  - Board needs to be fully invested and participating – increased autonomy brings increased responsibility for the decision makers
  - Systems based approach so also need support from IT and operations e.g. re document storage and considering any system failures
- Carry out thematic analysis
  - Build risk profile by looking at :
    - Previous SI investigations
    - Complaints
    - Mortality data
    - DATIX
  - Seek input from clinical and medical Directors
- Understand existing improvement plans
  - At inquest, a Coroner may focus on where there is an action plan that has not been followed
  - Diarise follow up, evidence who responsible and when carried out.
  - Confirm staff have read updates and newsletters e.g require them to click to confirm
  - Themed presentations and scenario based learning
- Consider the emotional aspects
  - Keep updated staff updated with changes to policies
  - Make the initial response to patients, families and staff warm and kind

Implementation challenges:

- More work for independent providers when identifying risk profile as data can be lacking.
- For smaller providers it can be harder to pinpoint trends due to fewer incidents.
- Might feel uncomfortable whittling it down and end up doing more patient safety investigations.
- If an independent provider has a number of locations, it can be difficult to draw those together to gather themes. Some locations may encounter specific risks that others don’t. Central governance teams and collaboration may help to overcome that particular challenge to avoid a proliferation of policies.
- Growth can be astronomical – consider how to catch up when taking over contracts on short notice

Issues faced by independent providers regarding PSIRF

Flora McCabe, Head of Advocacy and Risk Management Healthcare Senior Vice President, Lockton Companies LLP

- RCA is a well embedded process and it can be hard to change the mindset to reflect that a serious patient outcome doesn't necessarily mean a PSI is required. This may lead to nervousness that will need careful management.
- Time needed to train and shift from the previous investigation style.
- No witness statement might be seen as a positive but interviews for staff can sometimes be more daunting.
- Separate what needs investigating and what needs reporting. Ensure incidents are still being reported and monitored in terms of the outcome of the alternative ways of investigating, even where no PSI required.
- Fewer formal reports can sometimes be seen negatively by insurers.
- Key challenge – uniformity across the board.

Opportunities:

- Generally fantastic to see a focus on the learning and the shared approach to learning
- Compassionate involvement of staff
- Improves:
    - culture – move away from blame
    - staff retention
    - happier workplace
- Engagement with patients and their families demonstrates compassion.
- Learning and follow up – helps demonstrate to insurers that there is engagement with the risk profile.
- Potential for a positive impact on premiums, as showing learning assists brokers to advocate on your behalf.
- Clearer identification of trends which enables targeted training and support.
- Focus on the implementation of learning makes it easier to show progress.
- Reduces the burden on investigation leads
- Ultimately improves patient safety.

Flora McCabe
Head of Advocacy and Risk Management Healthcare
Senior Vice President
Lockton Companies LLP
0207 933 2516 / 07775429377
Flora.McCabe@lockton.com

PSIRF and Inquests

Heather Caddy, Partner, Browne Jacobson

We have prepared a **detailed checklist** which you can find here

to help with this

It is too early to determine how things are going to pan out in the coronial setting. However, NHS England and the early adopters during the pilot phase have done some events for Coroners so they are aware of the changes ahead.

Many (not all) coroners do use SI reports as a helpful starting point for preparations and so will be just as keen as organisations to ensure clarity on how the information historically presented in those reports can be presented going forward to serve the coronial process.

Recommendations

- **Early engagement** by organisations with their local Coroner specifically about PSIRF. Organisations may already have a process in place for regular meetings with their local coroners in relation to working arrangements.
- **Consider presentation of organisational learning.** The Coroner’s Statutory Duty under Regulation 28 (Prevention of Future Deaths) remains the same. It will therefore be important to consider how organisational learning can be evidenced without SI reports and the Action Plan contained within them to rely upon. Not all deaths will lead to a PSII report and other responses may not provide a sufficient level of detail. One suggestion is a standalone organisational learning statement, which can be appropriately tailored to include all relevant learning with an action plan where applicable.
- **Consider who should present the organisational learning.** Think about who is best placed to prepare those statements and whether these should be done at a local or central level.
- **Ensure learning is shared throughout the organisation**, not just at the local provider level and document how that has been done.
- **Consider presentation of causation.** PSII reports will look very different from an SI with the focus on exploring outcomes within complex systems, not root causes. They will not cover causation or cause of death and so it is unlikely they will be enough in isolation where it is anticipated there will be causative criticism. One suggestion is a separate Position Statement addressing causation.
- **Talk** to you local Coroner about what information they will need in light of the changes; this is a real opportunity to ensure that there is a mutual understanding of what is needed and what can realistically be achieved and within what timeframes to ensure a smooth and mutually beneficial transition.

Record keeping and disclosure

- Under the PSIRF Framework, there will be no requirement for staff to prepare statements or reflections for a learning response. Instead there will be a variety of different methods to gather information.
- However, any documents generated as part of the different responses to an incident are not protected by legal privilege and are disclosable as part of the inquest disclosure process.
- Different responses/types of investigation will generate different types of documentation so it is important legal teams know where to find the information they need in tight timeframes to ensure that they are able to comply with disclosure requests made by the Coroner.
- Statements required as part of an inquest process should be written specifically for that process and staff will need to be carefully supported through this process.

Discussion

How we can help

There was some discussion around a number of issues including

- **Whether any independent providers attending the session have made any proactive moves to engage their local Coroner in relation to PSIRF.** The Chief Coroner has issued a learning newsletter including information regarding PSIRF. NHS England were hoping to contribute to the coroners training scheme. Coroners who are keen to understand the PSIRF principles are asking questions.

- **The challenge of engaging with local coroners for providers with sites in multiple coronial jurisdictions.** A clear plan defining responsibilities and ensuring sufficient resources are available is helpful. From the insurers' perspective, providers should be able to demonstrate that efforts have been made to engage.

- **Implementing PSIRF in care homes, and the lack of guidance on this.** Again, ensure you have documentary evidence that questions have been asked/help has been sought.

- **Whether to formalise changes around obtaining witness statements in legal policies.** It was suggested that, as every incident is different, incidents should be dealt with on a case by case basis. One of the key things for legal teams is understanding what is being produced and where the documentation is being stored, especially with the less formal responses. Engage systems managers (e.g. IT and operations) about this.

- **How to secure engagement of Executives and the Board.** Sometimes this is reactionary i.e. following a hefty claim. Some of it follows active recommendations. Some is down to personality. Ask for accountability to be a key topic on the agenda. It is also important for Boards to foster an internal culture where issues and concerns can be raised.

How we can help

We have developed a **checklist** to help Heads of Legal and legal teams support with the transition to PSIRF here

We also offer a number of services which may be of interest:

- Deep dives of claims/inquests to assist with identifying your risk profile.

- Support and training in relation to drafting PSIIs (or SI's during the transition to PSIRF) to ensure they are clear and effectively communicate findings which are based on the evidence and linked to appropriate areas for improvement and developing safety actions

- Representation and support in relation to investigations involving patient safety incidents (inquests, regulatory investigations, police investigations)

- Training on other areas relevant to PSIRF including statement writing, disclosure and duty of candour.

You can find the note from our previous Shared Insights session on PSIRF in November 2022 here The Patient Safety Incident Response Framework (PSIRF) (brownejacobson.com)

Contact us

Lorna Hardman
Partner

+44 (0)115 976 6228
lorna.hardman
@brownejacobson.com

Simon Tait
Partner

+44 (0)115 976 6559
simon.tait
@brownejacobson.com

Damian Whitlam
Partner

+44 (0)3300452332
damian.whitlam
@brownejacobson.com

Nicola Evans
Partner

+44 (0)330 045 2962
nicola.evans
@brownejacobson.com

Amelia Newbold
Risk Management Lead

+44 (0)115 908 4856
amelia.newbold
@brownejacobson.com

Heather Caddy
Partner

+44 (0)3300452516
heather.caddy
@brownejacobson.com

Contact us

Birmingham

Browne Jacobson LLP

15th Floor
103 Colmore Row
Birmingham B3 3AG

+44 (0)370 270 6000

Exeter

Browne Jacobson LLP

1st Floor
The Mount
72 Paris Street
Exeter EX1 2JY

+44 (0)270 6000

London

Browne Jacobson LLP

15th Floor
6 Bevis Marks
London EC3A 7BA

+44 (0)270 6000

Manchester

Browne Jacobson LLP

3rd Floor
No.1 Spinningfields
1 Hardman Square
Spinningfields
Manchester M3 3EB

+44 (0)270 6000

Nottingham

Browne Jacobson LLP

Mowbray House
Castle Meadow Road
Nottingham NG2 1BJ

+44 (0)270 6000

Dublin

Browne Jacobson Ireland LLP

Viscount House
6–7 Fitzwilliam Square East
Dublin 2
D02 Y447

+353 (0)1 574 3910

brownejacobson.com
+44 (0)370 270 6000

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