

Meeting Title	The Board of Directors Meeting		
Date	16/11/23	Agenda item	Bo.11.23.17

Patient Safety Incident Response Framework Implementation

Presented by	Dr Ray Smith, Chief Medical Officer		
Author	Leah Richardson, Patient Safety Specialist		
Lead Director	Dr Ray Smith, Chief Medical Officer		
Purpose of the paper	The purpose of this paper is to present the Trust's Patient Safety Incident Response Plan (PSIRP) and Patient Safety Incident Response Policy to enable transition to the Patient Safety Incident Response Framework (PSIRF)		
Key control	The PSIRP and policy are key controls for the strategic objectives to provide outstanding care for patients, to be a continually learning organisation and to collaborate effectively with local and regional partners.		
Action required	For approval		
Previously discussed at/ informed by			
Previously approved at:	Academy/Group	Date	
	Quality and Patient Safety Academy	01/11/2023	
	ETM	06/11/2023	
Key Options, Issues and Risks			
Following the Publication of the national Patient Safety Incident Response Framework ¹ (PSIRF), Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) will be expected to transition from the current Serious Incident Framework to the new framework by the Autumn of 2023. The aim of this paper is to present to the Board of Directors BTHFT's Patient Safety Incident Response Plan and Patient Safety Incident Response Policy, and agree transition to the Patient Safety Incident Response Framework on 01 December 2023.			
Analysis			
The PSIRF was published by NHS England on 16 August 2022 and replaces the current Serious Incident Framework ² . From September 2022, there has been a phased period of preparation for completing the transition from the existing Serious Incident Framework to the new PSIRF.			
In order to successfully transition and be fully compliant with the NHS Standard Contract the Trust must have in place a Patient Safety Incident Response Policy and Plan. This work has included establishing the organisation's local patient safety incident profile and reviewing existing improvement work, to identify areas that will benefit most from learning responses, to maximise opportunities for improvement.			
The Governance route for approval, sign off and agreement of proposed PSIRF Plan and PSIRF Policy is detailed in figure 1.			

¹ NHS England (2022) Patient Safety Incident Response Framework. <https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-1.-PSIRF-v1-FINAL.pdf>

² NHS England (2015) Serious Incident Framework Supporting learning to prevent recurrence <https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incident-framwrk.pdf>

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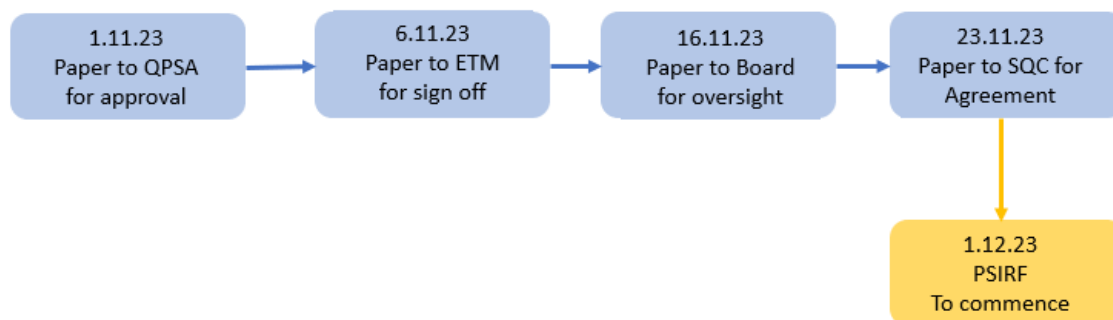


Figure 1: Governance route for approval, sign off and agreement of proposed PSIRF Plan and PSIRF Policy by 1.12.23

Recommendation

The Board of Directors are asked to:

1. Approve the Patient Safety Incident Response Plan and the Patient Safety Incident Response Policy
2. Approve the transition to PISRF on 1 December 2023

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

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Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diversity and Inclusion implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Performance Implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) <input type="checkbox"/> Risk Assessment Framework <input checked="" type="checkbox"/> Quality Governance Framework <input checked="" type="checkbox"/> Code of Governance <input type="checkbox"/> Annual Reporting Manual
Care Quality Commission Domain: Safe
Care Quality Commission Fundamental Standard: Safety
NHS Improvement Effective Use of Resources: Corporate Services, Procurement, Estates & Facilities
Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1	PURPOSE/ AIM
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The aim of this paper is to present to the Board of Directors BTHFT's Patient Safety Incident Response Plan and Patient Safety Incident Response Policy, and seek approval for transition to the Patient Safety Incident Response Framework on 01 December 2023.

2	BACKGROUND/CONTEXT
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NHS England published the PSIRF on 16 August 2022 which outlines how NHS organisations should respond to patient safety incidents for the purpose of learning and improvement. The

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PSIRF is a core element of the NHS Patient Safety Strategy³. PSIRF is a contractual requirement under the NHS Standard Contract; it is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers.

The framework will replace the current Serious Incident Framework and represents a significant shift in the way the NHS responds to patient safety incidents, centring on compassion and involving those affected; system-based approaches to learning and improvement; considered and proportionate responses; and supportive oversight.

From September 2022, there has been a phased period of preparation for all providers which BTHFT has undertaken ahead of completing the transition from the existing Serious Incident Framework.

BTHFT is required to develop and publish a Patient Safety Incident Response Policy and Plan. This includes establishing the organisation's local patient safety incident profile and reviewing existing improvement work, to identify areas that will benefit most from learning responses, to maximise opportunities for improvement.

PSIRF makes the full Board of provider organisations accountable for high quality incident responses, while integrated care boards will consider their providers' overall approach to learning and improvement, rather than each individual response.

3 PROPOSAL

A PSIRF implementation group was established and was responsible for providing strategic and operational leadership, and oversight for the implementation and delivery of PSIRF across BTHFT. The PSIRF Implementation Group chaired by Ray Smith, Chief Medical Officer, provided oversight to a number of task and finish groups to support the development of our Patient Safety Incident Response Plan (PSIRP), our Patient Safety Incident Response Policy, as well as a communication strategy, and education relating to the new approach to learning from patient safety incidents.

The Patient Safety Incident Response Plan has been developed working with Bradford District and Craven Health Care Partnership, Integrated Care Board, and other partner organisations (Bradford District Care Trust and Airedale NHS Foundation Trust) through the Patient Safety network group.

The Executive Team and the Board of Directors are asked to have final oversight, in line with the NHSE PSIRF Oversight Roles and Responsibilities Specification⁴.

³ NHS England and Improvement (2019) The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients . https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

⁴ Patient Safety Incident Response Framework supporting guidance Oversight roles and responsibilities specification (2022) <https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf>

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4	BENCHMARKING IMPLICATIONS
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None

5	RISK ASSESSMENT
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Not Applicable

6	RECOMMENDATIONS
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The Board of Directors are asked to:

1. Approve the Trusts Patient Safety Incident Response Plan and Patient Safety Incident Response Policy prior to submission for final oversight by the Executive Team and the Board of Directors.
2. Approve the transition to the PSIRF from 01 December 2023.

7	Appendices
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Appendix 1

Patient Safety Incident Response Plan

Appendix 2

Patient Safety Incident Response Policy