PSIRF Open Forum

Update April 2024

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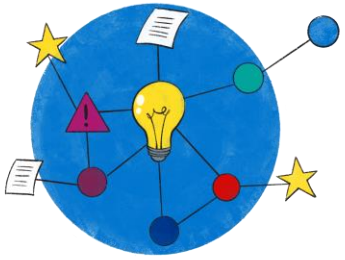
Aims of PSIRF: Better Learning, Improvement & Support

East London NHS Foundation Trust

SUPPORT & Involvement of those affected & supportive oversight



LEARNING – system approach using new methods

IMPROVEMENT focus – bringing QI and Safety work together

Ask about the #ELFTPromise

We care
We respect
We are inclusive

PSIRF National PSII Priorities

NHS East London NHS Foundation Trust

Area	Learning response recommended by NHSE
Maternity/Neonatal	N/A
Child Death	Refer to CDOP
Death of person with LD/autism	LEDER
Safeguarding Adult/Child	Refer to Designated Professional
Domestic Homicide	DHR
Screening programme	N/A
Deaths in custody/probation	Prisons and Probation Ombudsman
Mental-health related homicides	Independent PSII
Never Events	PSII
Deaths of detained patients	PSII
Deaths more than likely due to poor care (meet LfD criteria)	PSII

PSIRF Local Priorities

NHS East London NHS Foundation Trust

LOCAL SAFETY PRIORITY AREA	SUGGESTED LEARNING RESPONSES	IMPROVEMENT PLAN IN PLACE?
Staffing Shortages	Thematic Review/Observations	Recruitment and retention project will address this Trustwide.
Self-Harm and suicide attempts	AARs, Thematic Review	In place for CAMHS, needed for adult/old age
Learning from Good Practice/Everyday Work	AARs, PSII, Observations	
Clinical Care and Management	Needs narrowing down	In place for observations/engagement
Access/Delays	Thematic Review	Lots of work going on – QI/performance team led
Violence and Aggression	AARs, Thematic Review	In place for wards, needed for community
Interface Issues	System PSIIs, Round Table Review, AARs	
Communication with SU and Carers	Thematic Review	Lots of QI work, carer strategy
Staff Safety (non-violence eg sexual, racism)	Thematic Review	Working group in place for sexual safety
Pressure Ulcers	AARs, Thematic Reviews, PSII?	Established – needs linking up Trustwide?
Deteriorating Patient	PSII, AARs	? Working Group
Medication Incidents – Insulin errors	AARs, Thematic Review, Observations?	

What has stayed the same?

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Some things have stayed the same including:

- Reporting on InPhase
- Manager approval of incidents
- Local management of immediate safety cations, and risk governance review of incidents to decide on next steps.
- Duty of Candour
- Offering support to those affected by incidents
- Safety Learning Lessons Seminars & SI Committee (now renamed Patient Safety Learning Committee)
- Local Directorate Leadership Team oversight of safety actions

Prioritising Support Needs After an Incident

Focusing on vulnerable groups e.g. staff who have left or work offsite, bank staff, trainees, patient witnesses, friends and wider family.

More Time to Complete Reports - 72 Hours

Freeing up managers to support those affected by an incident and to write better quality reports - with senior oversight and sign-off of reports.

Weekly Trustwide Incident Review Panel

Involving 72 Hour Report authors/Directorate reps to strengthen decision-making, identify next steps and clarify any immediate learning

Strengthened Mortality Reviews

We have introduced a new independent Clinical Review Tool (CRT) to strengthen our learning from unexpected deaths.

Patient Safety Incident Investigations (PSII)

SIs now called PSII, focusing on fewer in-depth reviews for concerning incidents using a SEIPS (Systems Engineering Initiative for Patient Safety) methodology (work system; tools, technology, organisation, internal external environment, tasks, person) instead of Root Cause Analysis (RCA).

Developing Improvement Plans

Support directorates to work towards developing Improvement Plans in place of having individual safety actions from reviews

We have now brought in the following changes…

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New Daily Incident Review Huddle

Daily huddle where a duty director & safety reviewer consider InPhase reports and decide which learning response is most useful.

Learning from Good Care

We want to increase learning from good care and will be piloting the use of the InPhase Good Care option over the next few months.

New Safety Learning Approach

After Action Reviews as a recommended learning response for some incidents. You can read more about this here.

Measuring engagement, involvement and support of those affected – baseline data on staff survey and SU/families

Plan and Policy – working draft to align with revised incident management policy

People First

Please review your local system for supporting people affected by safety incidents and consider how this can be strengthened.

Consider those who may miss out on usual support e.g. other service users/witnesses, wider family or friends, bank staff, trainees, those who have left the Trust.

Operational

To free us up to focus on what we know is most effective, we have stopped requesting “concise” reports.

Let your authors know that they will have longer to complete 72 hour reports and the reasons behind this.

Please let your 72-hour report authors know that they will be invited to discuss their report, and support them to attend.

After Action Reviews

Make yourself familiar with After Action Review by looking at the resources and introductory videos on the intranet page.

Identify a local cohort of colleagues in your service who can facilitate AARs and support them to attend the training. You can show your interest in the training by emailing elft.psirf@nhs.net

Work with your directorate to develop a system to support, oversee and embed learning from AARs into their quality and safety forums and processes.

Upload all completed AAR summaries to InPhase, with actions logged in a similar way you are already doing for PSIIs.

Improvement

Talk in your team meetings about your safety data and actions you are already aware of that need to be implemented.

In your service, discuss and identify your safety improvement priorities for the year ahead, we can support you with this.

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Q&A