Going forward with PSIRF – overcoming the challenges

Judy Walker

Work to prepare for transition to working within the Patient Safety Incident Response Framework (PSIRF) in the Autumn of 2023 is well underway by healthcare providers across England. Written for all those involved in implementing PSIRF, this article describes some of the reasons behind the challenges being faced and suggests three principles to help navigate through this complex process and offers practical ideas to help.

We are in a "liminal space" with the introduction of the Patient Safety Incident Response Framework (PSIRF) currently and some healthcare providers are finding it quite challenging. The term "Liminality" is derived from the Latin "Limen" which means threshold and refers to the boundary between the old and new ways of doing things. In physical form, we experience liminality every day as we cross the threshold from the street to our home or take the lift from the ground floor to the 10th floor ward. Some of the time, we like this in-between space, like when travelling on a train and are free of the requirement to be busy or be responsible. At other times, the uncertainty in these liminal spaces and the change of state entailed as we move across the threshold is uncomfortable.

There are also psychological liminal spaces, like the time between leaving university and getting our first job, or between pregnancy and birth, and how people feel in these liminal states and get across them will be different.

We are in a liminal space with the introduction of PSIRF currently and it can be experienced as being quite uncomfortable. Our minds like things to be regular and consistent — they crave and create predictability. Evolution has trained us to avoid anything where we don't 100% know the outcome and, as a result, when people find themselves in liminal states, it's often accompanied by feelings of anxiety. The organisational context for PSIRF is very likely to add to this anxiety as the existing reporting protocols, governance structures and meetings continue to run as before and demand attention until re-negotiated.

Therein lies the paradox of liminal space. On the one hand, when you're in it, there is a chance that you will feel uncomfortable. But it's also because of these transitions that organisations and people have a chance to grow and evolve into something new and better. We believe that the potential for significant improvement given by PSIRF for more compassionate, considered, and proportionate responses to patient safety incidents is worth the journey, but we don't yet know it for certain.

Factors contributing to the discomfort of this liminal phase

1. The freedom to choose

The PSIRF sets the scene for a move to more local decision making and responsibility about how to learn. Except for some specific remaining categories (such as 'never events'), there are no longer "thresholds" for which incidents must be investigated. The onus will be on healthcare providers to identify for themselves whether risks are already being appropriately managed and whether, or not, to undertake at Patient Safety Incident Investigation (PSII). Organisations may choose to investigate incidents that would not previously have met the criteria for mandatory investigation. This local decision making and freedom from central direction is logical, as it ensures healthcare providers can respond to their own risks and concerns. Yet with this freedom comes the responsibility to choose and there are no obvious right answers. There are different ways of fulfilling duty of candour requirements, involving families and patients in the learning process and a variety of Learning Response Tools (LRTs) to choose from. In a context like healthcare, where "knowing" and relying on experts, is so highly valued, not being definite and certain can be quite uncomfortable.

2. Attachment to the ways things are

Having invested so much time and energy into managing risk and improving patient safety, we are naturally likely to feel some attachment to continuing to do it with the current processes in place. One patient safety facilitator being trained as an After Action Review Conductor looked completely aghast at the idea that the responsibility for bringing about change would rest with those attending the AAR, not with the facilitator. Our investigators, governance leads, and risk managers really care about doing their jobs well, and undertaking investigations, writing reports, and ensuring actions have been completed are one of the ways in which they demonstrate that they are doing their jobs well.

There is a perception that if we can count how many Serious Incident Investigations are underway in a Trust and can see that the actions arising because of the investigation are moving from red to orange and green on the spreadsheet, then patient safety is improving. These tools tell us something is happening, and we are quite attached to this form of reassurance especially at the most senior levels where accountability lies.

But the PSIRF asks us to refocus our efforts to improve patient safety at the other end of the process. Not on the analysis and reporting but on the learning and improvement side of the equation, using some different tools that do not lead to action points to track on a spreadsheet. Instead, approaches like After Action Review (AAR) devolve responsibility for learning after patient safety events to those who provide the care and treatment. The evidence is very clear that expertly facilitated AARs do indeed lead to improvements in patient safety. (Renshaw et al 2020)

3. Making learning work

This liminal space has been brought about by the need to significantly increase the quality and impact of the learning that takes place after patient safety events. Some of the challenges being experienced reflect the difficulty of this undertaking. If it was easy, the Safety Incident Framework (SIF) would not have needed to be changed.

Driscoll (1994) defines learning as “A persisting change in human performance or performance potential as a result of the learner’s interaction with the environment”. This definition, out of the many available, synchronises with the PSIRF focus on the improvement side of the patient safety learning equation. Unless individual and team behaviours change, or organisational processes, structures or culture change, learning cannot be said to have taken place.

This shift in the quality of learning will only be achieved when the individuals facilitating learning have the skills and experience, they need and the structures and processes supporting them are fit-for-purpose and aligned. We know that making learning work to increase safety can be done successfully when we look at other High Reliability Organisations, but we shouldn’t underestimate the progress needed to achieve it in the healthcare provider setting.

What can help with the transition through the liminal space?

1. Keep it simple

I am working with several healthcare providers who are working to implement PSIRF and the Trust that has made the smoothest switch to using one of the recommended Learning Response Tools, After Action Review (AAR) most effectively, is the one that had just two standard responses to learning from patient safety events: Serious Incident Investigation and Root Cause Analysis. Now they have chosen to use AAR, they have removed the Root Cause Analysis option completely and replaced it with the simple AAR choice (yes or no) and changed the remit for when PSIIs will occur. This simple replacement means there is no confusion about the new approach and has been accompanied by active organisational support and formal training of AAR Conductors.

Where can you simplify your processes around PSIRF? Where can you simplify your messages? Nothing must be fixed in stone yet and it's easiest to start simple.

2. Build alignment with your stakeholders

A recurring theme for patient safety teams is centred around establishing what the reporting requirements will be going forward, to provide assurance to commissioners and ICBs and many others who have oversight responsibilities. They're also wondering how best to share learning across the healthcare system.

One of the best ways of understanding what is actually needed, as opposed to what is imagined, is through a Before Action Review (BAR). The four-question BAR model is grounded in the same principles as AAR; that when we have a psychologically safe environment, we can learn better and make significantly more progress as a group than individually. Supported by a neutral AAR Conductor, the four-question process of the BAR will enable all involved in implementing PSIRF in a location or region to make sense of the next phase of the task ahead, understand each other's contexts clearly and find an aligned path forward.

Holding BARs with the commissioners, patient groups and other stakeholders might include the following questions:

1. Expected outcomes	**2. Anticipated challenges**
• What would you like the outcome to be from PSIRF in 6/12 months' time? • What are the outcomes that are important to you and your part of the system from the implementation of PSIRF?	• Would do you anticipate will be challenging as we continue to work towards fully implementing PSIRF? • What do we need to know that we don't know yet?
3. Learning to overcome challenges	**4. Steps to success**
• What have we learned that will help us deal with these challenges? • What behaviours and actions have helped us bring about change in this region/context before? • What resources have we found helpful before?	• What will help us work effectively together? • Given what we have discussed today, what steps do we need to take to create success? • What do we need to do first? • What resources do we need to support us?

3. Learn as you go

Dave Snowden's Cynefin framework suggests that when working in a complex environment of "emergent practice" the approach should be to probe, sense and then respond. What this means is that during times of major change like this, it can be impossible to identify one "correct" solution and full understanding will only come in retrospect, but patterns will emerge to guide the way forward when steps are taken, then made sense of and responded to.

One large healthcare provider's quality and safety team met to review the PSIRF Learning Response Tools available and quickly agreed what to exclude from their toolbox. Then everyone agreed that the next editing should come after a trial period to see what approaches most frequently used, and what benefit to patients and safety were gained.

The NHS PSIRF pages and NHS Futures platform are full of resources and ideas that others have tried that you can "borrow" to try out for size in your own context. The tools needed to transition through this liminal space are already there and nothing new needs to be invented at this stage. It's the approach to implementation that will be where the work needs to be done. As Peter Senge said, "Reality is made up of circles, but we see straight lines." Regular After Action Reviews with your PSIRF implementation teams will ensure learning from the reality of these circles is identified and clarity gained about what to do next.
NHS England has put in an impressive programme of support from the centre, but it is up to individual healthcare providers to engage with people and invest the time and effort required to cross the threshold to the new and brighter world.

Please let us know if we can help you in this transition. We are world leading experts in After Action Review in healthcare settings, and NHS approved suppliers for AAR Conductor Development

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Refs

J Driscoll 1994 Reflective practice for practise Sr Nurse Jan-Feb;14(1):47-50.
P Senge 2006 The Fifth Discipline: The art and practice of the learning organization: Random House Business