



East London
NHS Foundation Trust

Patient Safety Incident Response Framework (PSIRF)



We care
We respect
We are inclusive

Introduction

At ELFT, the safety of patients, carers and staff is very important to us. We aim to deliver high-quality care in safe environments where everyone is protected from harm.

Very sadly, sometimes things go wrong and patients experience harm. These instances are called ‘patient safety incidents’.

These incidents can highlight areas where we need to learn and improve our systems and services.

Therefore, it is crucial that we have effective processes in place to respond, which enable us to learn and improve to prevent similar incidents reoccurring.

It is also vital that we show compassion, respect and sincerity to those impacted by incidents to support their healing.

As well as the personal support we will offer to anyone affected by a safety incident, our website has information about organisations that can also provide advice and support. Go to: www.elft.nhs.uk Search ‘Safety at ELFT’



“NHS trusts want to learn why patient safety incidents happen and how they can reduce the likelihood of the same incident happening in the future. Undertaking a patient safety incident investigation is the first step in trying and find out what happened and why.”

At a national level, the NHS has recognised a need to improve processes to help us achieve this. This is where the Patient Safety Incident Response Framework (PSIRF), comes in. PSIRF guides us, as an organisation, to respond to patient safety incidents differently. Over the months ahead, we will be working towards the following aims:

Provide more support to those affected by patient safety incidents (the patient, their carers/family, and staff)

Engage with and involve those affected by patient safety incidents more meaningfully in the incident response process, as well as subsequent learning and improvement work

Maximise our learning from patient safety incidents by using new methods and a 'system lens', which recognises the multiple factors in any context which influence incidents

Develop our methods for sharing learning across the organisation, so that services can learn from each other and make improvements proactively rather than reactively

Take action, with the help of our Quality Improvement team, to continuously improve our systems and services, so that we can prevent or reduce the likelihood of similar incidents reoccurring

Improve our organisational culture, so that staff and patients have more trust in our patient safety processes. In turn, patients will receive a higher quality of care



Utilise our resources in a more efficient way, prioritising the investigation of those incidents where we can gain the most new insight and learning.

Work more collaboratively with the wider health and care system, including Integrated Care Boards who oversee our services

Patients or carers who have been affected by a significant patient safety incident can expect the following:

- A meaningful apology
- Open, honest and clear communication
- To be treated with compassion
- To have your views listened to and taken seriously
- Answers to your questions
- Sensitivity and responsiveness
- Respect for your choices and preferences
- Effort to meet any support needs arising from the incident or investigation process
- Information about external support services you may wish to access
- An invitation to feedback about your experience of being involved in a patient safety incident investigation
- An invitation to contribute to patient safety-related learning and improvement work and to share your insights
- Information about opportunities for involvement in the Trust more generally via People Participation, if applicable
- Accurate records of all interactions

Email us: elft.safetynetwork@nhs.net if you would like to be involved in this work, or contact the PALS/Complaints team: www.elft.nhs.uk



We promise to work together creatively to: learn 'what matters' to everyone, achieve a better quality of life and continuously improve our services.

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