Change to NHS Investigations into Serious Incidents

NHS England is gearing up to implement the Patient Safety Incident Response Framework (PSIRF) gradually in Spring 2022, following multiple delays due to COVID-19. This will be replacing the Serious Incident Framework (SIF), altering the way in which serious incidents in clinical settings are investigated. Here is a summary of how the framework could affect you.

What is a serious incident?

A serious incident is defined as an unintended or unexpected incident which could have or did lead to harm for one or more patients receiving healthcare.

Examples include (but are not limited to):

- Unexpected or avoidable death (including suicide or self-inflicted death)
- Unexpected or avoidable injury that has resulted in serious harm
- Unexpected or avoidable injury that requires further treatment to prevent death or serious harm

What are the differences between SIF and PSIRF?

The SIF was created with the intention to inform the process of serious incident management, to ensure that serious incidents were correctly identified and investigated.

The PSIRF is broader in scope, aimed at supporting the development of NHS organisations, and basing improvement on the level of insight gained by investigations into serious incidents to prevent future occurrences.

The purpose of PSIRF was noted to be the assurance that investigations were strategic, preventative,

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collaborative, fair and just, credible and people-focused.

Although some incidents will qualify for a Patient Safety Incident Investigation (PSII), there will be other alternative responses viewed as being more proportionate – for example case note reviews, and 'being open' conversations. There will also be incidents where the appropriate response will be considered that no investigation is required.

Each organisation must develop a patient safety incident response plan (PSIRP) and set out how incidents will be identified and investigated. The PSIRP must be reviewed every two years.

What are the implications of these changes?

The effect of the change will result ultimately in less investigations, strategically focusing only on those where the most learning can be had from the cases at hand.

In real terms, this will result in more patients being unable to have incidents regarding their care investigated, as the focus will be on the potential for health care professionals' learning and improvement. There will as a consequence be more reliance on the use of the complaints procedures which arguably do not afford such a detailed investigation.

How does this affect you and what do you need to know?

PSIRF means that if a serious incident occurs, the NHS may deem alternative responses as being more proportionate than instigating a PSII into the incident.

It is therefore worth noting that if you suffer injury or loss due to an incident whilst receiving healthcare, you have a right to complain about your care, treatment or service and a right for this complaint to be investigated.

You are able to make a complaint by:

- In writing or orally directly to your GP Practice or the hospital at which the incident occurred
- If you do not want to complain directly to the organisation at which the incident occurred, you can complain to your local Clinical Commissioning Group or NHS England
- You may wish to liaise with Patient Advice and Liaison Service, which can provide confidential advice and support

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You also have the right to take your complaint to the Parliamentary and Health Service Ombudsman (PHSO), which is an independent entity, if you are unsatisfied with the way in which your complaint has been investigated.

If you need assistance with making a complaint, Action against Medical Accidents (AvMA) is an incredible organisation dedicated to patient safety and justice. They recognise that often patients who have suffered harm want an acknowledgement of fault as a form of redress, separate from any compensation legal damages can award. They also have an article on hints and tips for writing a complaint to the NHS.

It is worth noting that all health service bodies and registered persons owe you (their patients) a Duty of Candour, which requires them to notify the patient or their family as soon as reasonably practicable of a notifiable safety incident occurring.

Making a complaint and the pursuant investigation conducted could assist in any legal claim, should you choose to pursue this, The complaints procedure should not be stopped due to the existence of a legal claim, and there are Regulations and Guidance in place to prevent this. We can help with the complaints process.

You can find out more about the PSIRF on the NHS website.

If you would like any further information about the upcoming changes surrounding PSIRF or any other clinical negligence injury-related query, please do not hesitate to contact our highly experienced clinical negligence solicitors.

Liz Oaten, Partner in our Medical Negligence team, is an AvMA accredited solicitor. You can see further information on AvMA here.

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