Independent providers may well be providing a range of services under different contracts e.g services commissioned by the Local Authority these will not mandate PSIRF. However, we understand that some organisations are looking to adopt the PSIRF approach to incidents relating to these other services for consistency, and that some Local Authorities are considering using PSIRF principles for patient safety issues within their contracts.

# What is PSIRF? Key changes and how to prepare

# PSIRF and Inquests

Heather Caddy, Partner, Browne Jacobson

We have prepared a **detailed checklist** which you can find here

to help with this

It is too early to determine how things are going to pan out in the coronial setting. However, NHS England and the early adopters during the pilot phase have done some events for Coroners so they are aware of the changes ahead.

Many (not all) coroners do use SI reports as a helpful starting point for preparations and so will be just as keen as organisations to ensure clarity on how the information historically presented in those reports can be presented going forward to serve the coronial process.

## Recommendations

**Early engagement** by organisations with their local Coroner specifically about PSIRF. Organisations may already have a process in place for regular meetings with their local coroners in relation to working arrangements.

**Consider presentation of organisational learning.** The

Future Deaths) remains the same. It will therefore be important to consider how organisational learning can be evidenced without SI reports and the Action Plan contained within them to rely upon. Not all deaths will lead to a PSII report and other responses may not provide a sufficient level of detail. One suggestion is a standalone organisational learning statement, which can be appropriately tailored to include all relevant learning with an action plan where applicable.

**Consider who should present the organisational learning.** Think about who is best placed to prepare those statements and whether these should be done at a local or central level.

**Ensure learning is shared throughout the organisation**, not just at the local provider level and document how that has been done.

**Consider presentation of causation.** PSII reports will look very different from an SI with the focus on exploring outcomes within

# Discussion

## How we can help

There was some discussion around a number of issues including

**Whether any independent providers attending the session have made any proactive moves to engage their local Coroner in relation to PSIRF.** The Chief Coroner has issued a learning newsletter including information regarding PSIRF. NHS England were hoping to contribute to the coroners training scheme. Coroners who are keen to understand the PSIRF principles are asking questions.

**The challenge of engaging with local coroners for providers with sites in multiple coronial jurisdictions.** A clear plan defining responsibilities and ensuring sufficient resources are

should be able to demonstrate that efforts have been made to

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