

The Patient Safety Incident Response Framework (PSIRF) and its impact on maternity services

10 January 2023

Following our recent Shared Insights session on **The Patient Safety Incident Response Framework**, we have published the attached [document](#) on the key points regarding PSIRF, which replaces the Serious Incident Framework 2015, and is due to be implemented by Autumn 2023. In that document we set out what PSIRF includes, what this means for litigation and for coroners and key considerations regarding disclosure. You can also read more about PSIRF in our article [here](#).

In terms of the specific impact on maternity services, they will be subject to the PSIRF in the same way as all other secondary care services in an organisation. Trusts must therefore consider maternity services, maternity safety improvement and how to respond to maternity incidents as part of their overall PSIRF preparation, planning and implementation.

Incidents which meet the Every Baby Counts (EBC) criteria will still need to be referred and investigated by HSIB (or the Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from April 2023). Trusts do not need to do a separate local patient safety learning response to these incidents. However, the incident still needs to be reported on the relevant incident reporting systems and duty of candour requirements still need to be complied with. Organisations must also take any immediate actions identified as necessary to avoid and/or mitigate further serious and imminent danger to patients, staff and the public.

For all other maternity patient safety incidents (those not referred to HSIB/MNSI), Trusts need to determine how they intend to respond based on the individual Trust risk profile as outlined in their Patient Safety Incident Response Plan (PSIRP).

The PSIRP should be developed with a specific maternity section setting out how the Trust intend to respond to the different types of non-HSIB/MNSI referred maternity patient safety incidents and should include input from regional maternity teams, local maternity and neonatal systems (LMNSs) and Maternity Voice Partnerships.

Our specialist team can provide advice and support to help with the transition to PSIRF and ensure that when PSII investigation reports are required they are prepared and written to a high standard. Areas we can help with include:

- Deep dives of claim/inquests to assist with identifying your risk profile
- Support and training in relation to drafting PSII reports to ensure they are clear and effectively communicate findings which are based on the evidence and linked to appropriate areas for improvement and developing safety actions
- The documentation and storage of records produced in respect of responses other than PSII
- Supporting you to support your staff through the inquest and litigation process
- Training on other areas relevant to PSIRF including statement writing and duty of candour.

If this is something which you feel would be of assistance to you please do not hesitate to get in touch. Browne Jacobson's [maternity resources hub](#) provides resources and information about our specialist teams and the support we can provide in relation to maternity issues.

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