Patient Safety Incident Reporting Framework (PSIRF) standards: co-production of adaptations for the care home sector to improve cross-system integration

Abstract

Context

The National Health Service (NHS) in England has introduced the Patient Safety Incident Response Framework (PSIRF) which seeks to guide learning from safety incidents, including those that occur across different health and social care services. At the foundation of PSIRF are standards that stress a set of minimum expectations of patient safety incident reporting and learning, however, their development has side-stepped social care and the care home sector.

Objectives

This study aimed to co-produce recommendations for adapting PSIRF standards for care homes.

Methods

Nominal Group Technique workshops were conducted with key stakeholders. Participants generated and developed consensus on recommendations for adapting PSIRF standards, with data analysed inductively and conceptually mapped.

Findings

People (n=17) from senior roles in care homes, external organisations and public involvement representatives participated. There was high agreement that PSIRF standards insufficiently represented care homes. Required revisions to PSIRF included addressing use of NHS-centric language, approaches to training, resource provision, oversight, and implementation support.

Limitations

Almost all participants were at senior levels, which may impact on whether adaptations to PSIRF standards would result in standards that could be implemented.

Implications

Resources in care homes to support cross-system learning are currently lacking, and PSIRF standards do not sufficiently link care and communication across boundaries. Once identified issues are addressed, PSIRF is promising for integrating safety incident responses between NHS and care home sectors. Care home sector should be involved at the outset of future patient safety policy developments that aim to improve integrated and cross-sector working.

Key words

Care homes, safety, incident reporting, governance, regulation

Acknowledgements and declarations

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Background

Care homes in England provide various types of care, ranging from temporary day or respite care through to long-term residential and nursing care. Some care homes have dual registration and provide multiple services, and many care homes have residents with varying levels of support need, such as people with learning disabilities and older adults with or without nursing care. This is further complicated by care homes operating across public, private and the third sectors, sometimes with mixed funding models, which introduces different priorities and demands on service providers and can impact on the quality of care provided (Patwardhan et al., 2022). This study specifically focuses on long-term care for older adults provided by residential and nursing care homes across all sectors.

The National Health Service (NHS) Patient Safety Strategy 'Safer culture, Safer Systems, Safer Patients' outlines the need for a whole-system approach to patient safety (NHS, 2019). A key objective is to equip patients, staff and partners with the skills and opportunities to improve patient safety, especially in priority areas such as the safety of older people. This includes optimising co-ordination and collaboration of safety investigation across multiple health and social care settings. This strategy introduced the Patient Safety Incident Response Framework (PSIRF) to support insight generation at the point of care and to promote learning from investigations (NHS England, 2022a). At the foundation of PSIRF are standards that stress a set of minimum expectations for patient safety incident reporting, however their development and implementation appear to have side-stepped social care and the care home sector, as evidenced by them not being mentioned in PSIRF. Consequently, there has been a lack of consideration and research which has investigated the care home perspective of the PSIRF standards, despite the shared objective of older people safety, the high frequency of integrated and person-centred transitions between hospitals and care homes, and that some care homes operate under the NHS standard contract.

Working towards a whole-system approach comes with a spectrum of challenges, from differences in understanding the concepts of safety and safeguarding in care homes (Scott et al., 2017), and aligning heterogeneous and complex sociotechnical patient safety approaches that currently exist across care services (Carayon, 2012). Care home safety incident reporting systems are idiosyncratic to the care home and fragmented (Scott et al., 2024a) with limited connectivity and integration across the boundaries of care (including the NHS), and characterised by low levels of incident reporting (Newman, 2024). Adding to this complexity, there is evidence of variation in the quality of care provision and approaches to safety in care homes across the UK (CQC, 2023). Moreover, external forces including regulation, shortcomings in the structure of the health and social care system in the UK and complex relationships between care homes and other agencies are known to impact safety practices (Kirkpatrick and Nyatanga, 2023). Complex and bureaucratic processes counteract quality improvement (Speroff et al., 2010) and become a barrier to improving shared perceptions relating to resources, practices and behaviours that are necessary for developing an effective patient safety culture and optimising the patient safety climate across organisational boundaries (Ginsburg and Oore, 2016). Additionally, very little is known about the attitudes, perceptions, competencies, and patterns of behaviour that determine safety culture within care homes (Gartshore et al., 2017).

The NHS PSIRF is a contractual requirement under the NHS standard contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers (NHS England, 2022a). Bringing organisations together to adhere to the PSIRF standards presents an opportunity to develop shared patient safety values, systems, and processes. In relation to social care and care homes, the absence of their inclusion in developing PSIRF limits a whole-system approach and represents a missed opportunity for safely integrating health and social care services. Successful service delivery requires normative integration by which values and goals for the policy or intervention are

shared between actors at macro-, meso-, and micro-levels of health services (Bhat et al., 2022, Oksavik et al., 2021). In relation to patient safety, it is vitally important that the NHS and care homes share the values and goals to optimise safety within and between their services. The purpose of this study is to bring together key stakeholders in health and social care to investigate how the PSIRF standards translate into the context of residential and nursing care homes for older adults, thereby highlighting any potential adjustments which could be made to these standards to support the development of the PSIRF framework into care home provision.

Method

Study design

This study utilises Nominal Group Technique (NGT)(Harvey and Holmes, 2012) to generate ideas (items) on the areas of PSIRF which need revising (including adding content) or omitting from the standards in order to make them relevant for care homes. The NGT process used for all workshops are demonstrated in Figure 1.

Figure 1. Detailed outline of the virtual NGT process

For the purpose of this study, a care home was defined as a residential care facility that provides temporary or permanent accommodation with nursing and/or personal care (Age UK, 2022). The study was guided by a community forum consisting of patient and public representatives. A patient and public representative was also a co-applicant and co-author on this manuscript, who contributed from study design through to analysis and dissemination. The study protocol was previously published [removed for peer review]. Ethical approval was granted by Health Research Authority (reference: [removed for peer review]) and via [removed for peer review] University ethics online system (reference: [removed for peer review]). All participants provided written or verbal informed consent.

Participants and sampling

Existing research networks in the North East and South West of England, including a care home provider, the patient and public involvement (PPI) group, National Health Service (NHS) and Local Authority partners disseminated information about the study to their members. A recruitment email was sent via a contact or gatekeeper inviting those who were interested in participating to reply directly by return of email. Purposive and snowball sampling techniques were used to facilitate contact and to obtain a maximum variation sample of key stakeholders who were involved in one or more of the following: reporting, managing, commissioning, safeguarding, quality improvement, regulation or could provide a public and or patient perspective of safety incident reporting. The sample size was informed by guidance on conducting NGTs (McMillan et al., 2016), with information power reflected upon by the research team and considered to be sufficient using related to sample specificity and quality of dialogue (Malterud et al., 2021).

Data Collection

Virtual Nominal Group Technique (Workshops)

Nominal Group Technique (NGT) is a structured procedure for gathering information from groups of people who have insight into a particular area of interest (Harvey and Holmes, 2012). NGT is known as an evaluative methodology, 'semi quantitative and qualitative' in nature, and is an effective method for obtaining group consensus from thoughts and ideas (Perry and Linsley, 2006). Additionally, NGT requires direct and individual participant involvement, thereby minimising social hierarchy to promote each participant's voice equally (Lennon et al., 2012).

Each participant was invited to complete four NGT activities, one per each of the four PSIRF standards. The PSIRF standards are 1) Policy, Planning and Oversight, 2) Competence and

Capacity 3) Engagement and Involvement of those Affected by Patient Safety Incidents, and 4) Proportionate Responses (NHS England, 2022b). Each workshop was scheduled on different days and to last three hours. Prior to attending the workshop, it was recommended participants familiarise themselves with the PSIRF standards. To promote the care home perspective, participants were arranged into groups at a ratio of two care home participants for every one non-care home participant.

All NGT workshops were facilitated by one researcher (CN) with other researchers in workshop 1 (JS, KS, CM & PD) and workshop 2 (JS, PD & CM), supporting facilitation by dealing with participant requests or comments via the chat function, taking notes and to construct the survey for ranking the items (ideas) generated. NGT consists of five stages; (1) introduction and explanation, (2) silent generation of ideas, (3) sharing ideas via round robin, (4) group discussion and clarification, and (5) voting and ranking. During the research team's introductory presentation and as part of explaining the NGT procedure, participants were informed that each PSIRF standard and its subthemes would be diagrammatically presented via screen sharing at the 'silent reflection' and 'round robin' stages to help them form their ideas. For the round robin stage, the participants were asked to state the numbered section of each standard/sub theme (as presented to them virtually) and state whether it should be revised (including adding something) or omitted, or to state whether their idea was a more general point.

Surveys were constructed to have items presented and scored using a 5-point Likert scale, using 'Strongly Disagree' (not important at all), 'Disagree' (not important), 'Undecided' as a neutral mid-point, Agree (important) and Strongly Agree (very important). A 5-point Likert using an 'agreement' context is a familiar format to survey respondents, and it lends itself well to measuring constructs like attitudes (Passmore et al., 2002).

Interviews (qualitative survey approach)
Supplementary interviews were conducted via videoconferencing where participants were unable to attend NGT workshops due to scheduling conflicts. The four surveys created for each NGT were combined into one survey to guide individual interviews. Interviews were conducted to finish after 45 minutes and were audio recorded. Participants were reminded that they could stop at any time, including if the discussion lasted longer than 45 minutes. Interviews that exceeded this time limit were therefore at the discretion of the participant.

As a primary method, qualitative surveys seek to harness the potential qualitative data offer for nuanced, in-depth and sometimes new understandings of social issues (Braun et al., 2021). The workshop participants were not offered an interview as they had already contributed their views. Participants who agreed to be interviewed were encouraged to familiarise themselves with the PSIRF standards and were given the survey items prior to interview to promote the quicker completion of the survey. Participants were guided through the survey irrespective of whether they had completed it prior to interview in order that all answers could be explored qualitatively. Survey items related to each PSIRF standard and were grouped together. The survey items were shared visually via video conferencing and read out and/or explained if the participant requested further explanation. At the end of each item the participant was asked to state the reason and rationale for their answer using open questions. Participants could choose to answer or state 'pass' if they wanted to move on to the next item. The participant rationale for their response was discussed to elicit the breadth of meaning and reasons for agreement, non-agreement or undecided. Participants could also change their survey answer in the interview if they misunderstood or changed their mind as discussion developed.

Data Analysis
As part of a descriptive statistical approach, frequency data were analysed to determine the number of responses (per Likert category) for each survey item. Deductive and inductive

content analysis techniques were then used sequentially to analyse qualitative data from the surveys and workshop discussions. Conducting the analysis sequentially provided the opportunity to integrate the two data types and provide a deeper exploration of the reasons for consensus or lack of consensus in the survey data.

The online survey platform produced consensus data in real-time and all survey data were analysed as a whole and irrespective of whether the participant took the survey (or part thereof) in an NGT or interview activity. The number of answers against a survey item was calculated in a percentage to highlight the strength of non-agreement, undecided, or agreement. For the purposes of this study, the consensus parameters were, 51% to 74% in either of the disagreement categories (disagree & strongly disagree) or agree categories (agree, strongly agree) represented moderate consensus. Furthermore, 75% (and over) in these categories represented a high level of consensus and 100% complete consensus.

To facilitate analysis, all workshops and interviews were transcribed verbatim. The analysis team (CN, CM) independently extracted data using the transcripts. As part of a deductive approach, survey items were used as a matrix to map the corresponding participant response from their interviews. Each response was categorised into non-agreement, agreement, or undecided reasons. As part of an inductive approach, if the participant response included a barrier or facilitator in relation to the PSIRF standards or implementation thereof, this was coded independently by each researcher. Notes were also made by each of the data analysis team to support reflection and to highlight different perspectives and interpretations of the data coded. A review of the chart data and discussion at the clarification stage of the NGTs during the workshops were also subject to open coding to generate themes from the patterns and similarities in the data. All codes and themes generated were discussed by the analysis team and during dedicated data analysis research team meetings before agreeing on the terminology and how to summarise the data. Finally, themes identified during the inductive analysis of the workshop discussions were arranged and organised into a conceptual map to highlight their scope, hierarchical nature, and interrelatedness.

Results

Seventeen people participated in this study; six participants attended Workshop 1 and five attended Workshop 2 with two of these participants attending both Workshop 1 and 2. Participant information is provided in Table 1.

Table 1. Participant Characteristics

Categories	Characteristics (Number & %)		
Region of England or national role	National (n=2) 12%	North East (n=6) 35%	South West (n=9) 53%
Gender		Female (n=14) 82%	Male (n=3) 18%
Type of organisation		Care home (n=8) 47%	Non-Care Home (n=9) 53%
Care home management: including, managing directors, managers or deputy managers, quality leads, executive officer		(n=1) 6%	(n=5) 29%
Local Authority: including, strategic commissioning management, commissioning quality and development management		(n=1) 6%	(n=1) 6%
NHS: including, bed bureau and clinical quality nurse management		(n=1) 6%	(n=1) 6%
Care staff: including, registered nurses and senior nursing staff		(n=1) 6%	(n=1) 6%
Regulation/Investigation: including Care Quality Commission (CQC) and Healthcare Safety Investigation Bureau (HSIB)	(n=2) 12%		(n=1) 6%
Patient and Public Involvement (representatives)		(n=2) 12%	

Forty-six survey items were developed from the participant ideas in the NGTs (Workshop 1 and 2).

General themes of discussion

In the workshops, participant discussion was focused pragmatically on developing and implementing the PSIRF standards in the context and current state of health and social care, which highlighted potential challenges and benefits from a care home perspective. Whilst participants felt the integration of health and social care was beset with longstanding issues of cultural differences, government reluctance to address social care funding and strong feelings of exclusion and inequality, many participants felt PSIRF could provide a mechanism for joined up working to improve patient safety as a step towards integrating services, sharing best practice and countering blame culture.

The challenges raised included poor cross-system integration, lack of resources, difficulty agreeing to change (buying-in) to implementing PSIRF and linking care and communication across boundaries. Feelings of being excluded from government action, focus and funding all fuelled negativity around PSIRF implementation, as did a reluctance to believe care home regulators shared the PSIRF ethos. Instead, some participants saw PSIRF as another layer of regulation and/or purely bureaucratic in nature. Despite this, the participants felt that Integrated Care Boards (ICB; commissioners of services) and Integrated Care Systems (ICS; partnerships between health and social care services) could support care homes to implement PSIRF and would be best placed in an oversight capacity for safety incident responses across boundaries of care. These discussions are presented in a conceptual map (Figure 2).

Figure 2. Workshop (1 &2) Participant Discussion – Conceptual Mapping

PSIRF standard 1: Policy, planning, and oversight

In relation to PSIRF standard 'policy, planning, and oversight' (Table 2), two prominent themes emerged: 1) the language used in PSIRF should promote joint working and be relevant to the care home sector; 2) the need for clarification as to how PSIRF would be implemented into care homes, including how oversight would be managed across the boundaries of care to promote effective partnership working. In relation to the language used in the NHS, a care home nurse reflected that language is already a barrier and needs to be revised in PSIRF for care homes:

> *'I think it's important they should amend because sometimes in the care home, obviously, we are not as clinical as hospital, and they use abbreviations that we have to look up on the internet.'* [P16]

Underpinning many of the proposed revisions was a need for policy to promote a universal understanding of risk (including severity in relation to reporting) and safety incident types (e.g. a pressure injury) and the protocol for cross system/boundary reporting and learning. As such, a high consensus of agreement was seen in items 1 and 13. Items 4, 5 and 8 focused on the language used to make PSIRF more relevant to social care and care homes and the systems involved in safety incident reporting, these items all received a high level of agreement or complete consensus. Items 3, 6, 9 and 10 also achieved a high level of agreement, these items sought guidance on implementation and the workability of many of the PSIRF 'planning' points. In relation to supporting care homes to implement PSIRF, a participant working in health and social care regulation/investigation explained,

> *'…I think that they [care homes] wouldn't be able to do it alone. I think they'd need to be strong support from within the [Integrated Care Board].'* [P10]

Item 7 highlighted the importance of integrated care boards (ICBs) as an intermediary between the NHS and care homes to manage oversight systems. Another participant working in health and social care regulation/investigation highlighted the importance of ICBs and ICSs to the patient journey and how these systems need development,

> *'…it's not one organisation and handoff to the other it's one patient at the centre of pathway of care and quite often we divide out by organisational boundaries, not by what we need to do, which is actually this is a patient's journey. We're all involved in it and just searching that point there around ICB's ICS […] They've not really defined their role for that. There is a role, but I think it needs a bit of a prompt and a bit of a push.'* [P1]

Table 2. Policy, planning, and oversight standard - Agreement frequency and responses during interview

Item number, reason for change and theme	Undecided (%)	Disagreement (%)	Agreement (%)
1. **Revision**. Safety incident types need to be added to Section 2.3.	0% (0/14)	14% (2/14)	86% (12/14)
2 **Omission**. Remove Section 1.6 (organisation's patient safety incident response policy is published on its website)	14% (2/14)	57% (8/14)	29 % (4/14)
3. **Revision**. Section 1.1 needs to specify where the links are, and complaints should go to	7% (1/14)	7% (1/14)	86% (12/14)
4. **Revision**. Section 1.6 and in text prior to any numbered sections, should refer to the interface between care organisations, not only individual organisations	29% (4/14)	0% (0/14)	71% (10/14)
5 **Revision.** The language in section 1.2 should be amended to be more relevant for social care as it is currently more suited to NHS teams	7% (1/14)	7% (1/14)	86% (12/14)
6. **Revision.** The standards need to show how shared learning and feedback will be done with staff (no specific section number)	0% (0/14)	7% (1/14)	93% (13/14)
7. **Revision**. Section 3 is focused on NHS / Integrated Care Boards. This needs to be revised to include social care.	0% (0/14)	0% (0/14)	100% (14/14)
8. **Revision**. All sections need checking for language that is reflective of systems other than the NHS	0% (0/14)	0% (0/14)	100% (14/14)
9. **Revision**. The standards need to clarify who is responsible for leading and resourcing implementation of the standards as care homes may struggle to do this unsupported	7% (1/14)	0% (0/14)	93% (13/14)
10. **Revision**. The standards need to recognise many organisations in social care are responsible for collecting data, and there is a need for clarity on who is responsible for collecting data	7% (1/14)	0% (0/14)	93% (13/14)
11. **Revision.** Section 2.4 needs revising to reflect that improvement efforts are collaborative	7% (1/14)	0% (0/14)	93% (13/14)
12. **Revision.** There needs to be openness and transparency in reporting and learning from incidents	0% (0/14)	0% (0/14)	100% (14/14)
13. **Addition.** Grading systems for incident severity need to be standardised across boundaries	14% (2/14)	0% (0/14)	86% (12/14)

PSIRF standard 2: Competence and capacity

In relation to the PSIRF standard 'Competence and Capacity' (Table 3), participants highlighted the timescales for NHS PSIRF training were unrealistic in care homes and the training resource was NHS centric and not suitable for non-NHS providers. The suitability of the training would make it difficult to implement into care homes, especially smaller privately run homes that operated with limited budgets and without much contact with the NHS. Although changing training timeframes as per items 14 and 16 received some agreement, high levels of agreement were seen when it was proposed that PSIRF should be revised to be more care home specific and reciprocate knowledge from both sectors rather than being esoteric. A clinical quality nurse lead from the NHS involved in care home transitions explained,

> *'Care homes have not been involved in producing the PSIRF guidance and will require more time to adjust and to be trained.'* This participant added,

> '*language and focus on training policy must take into account different organisations involved in patient care to create an inclusive culture.'* [P11]

A high level of agreement was established in item 19 in relation to including social care within the training syllabuses described where language or focus on NHS systems (e.g., using Agenda for Change (NHS terms and conditions of service) salary banding to ensure seniority in establishing a learning response lead) would not be relevant for care homes and therefore would need to be changed.

Making training relevant and accessible for care home staff was seen as a foundation for learning to take place across boundaries of care and thus to promote joint working, shared responsibility and improvement, as highlighted by high agreement in item 23. However, many care home participants felt the proposed training framework within PSIRF created a burden against very finite resources with complete consensus in item 24 affirming this strength of feeling for non-NHS providers. A care home quality lead participant acknowledged the extra work versus resources but also provided a solution to work with the NHS to guide implementation of learning systems in the care home context.

> *'I think a lot of providers will be quite terrified at the idea of this because it sounds like an awful lot of an additional work, whereas actually, if we have an organisation [NHS] that's used to doing this and as the systems in place, I think it would make that learning process for adult social care probably smoother than just doing it independently.'* [P3]

PSIRF standard 3: Engagement and involvement of those affected by patient safety incidents
Themes associated with this standard related to improvement to and differences in working practices, in relation to engaging and involving those affected by a patient safety incident, and the difference in cultures between care homes and the NHS (Table 4). The participants focused on expertise and access to support services within the NHS that were not afforded to the care home sector. To make it more appropriate for care homes, revisions to items 25 and 26 (relating to specialist support services) received a high level of agreement as did item 35 and the need to name an appropriate support service other than NHS learning response teams. Learning response support is established within the NHS Learn from Patient Safety Events Service (LFPSE), which while open to care homes is rarely used for reporting. A care home quality lead participant provided clarity on the PSIRF reforms in relation to this standard and conveyed improvement was necessary emphasising the need for balance between resources and work pressures,

> *'…care home managers you know are already under, you know, huge amounts of pressure […] things do need to improve, but I think we have to be realistic as well about, you know, that there isn't that wrap around support within adult social care, that there is, within the NHS […] it's just about the challenge for resources.'* [P3]

The need for improvement was shared amongst the participants and explained from one participant involved in family engagement,

> *'…they [patients, care home residents, family] have to repeat their story ten, fifteen, twenty times over. They're really frustrated. They're really distressed. And from that point of view, whatever the setting, I think there's room for improvement.'* [P7]

Care home participants felt strongly about duty of candour and in some cases perceived PSIRF as repetitive policy in this context, one care home manager alluded to this,

'*If it ain't broke, don't fix it. That's not to say we won't be pleased to finally have an opportunity to raise these issues, but the care home will struggle to cope with any further bureaucracy - and it must reflect what we already have to comply with.*' [P15]

Item 35 achieved full consensus as the participants were in complete agreement that establishing responsibility is important especially where cross boundary organisations are involved in responding to a safety incident. Moreover, this should be done to promote joint working and to avoid blame. A care home manager articulated the importance of moving away from a blame culture to improve safety incident responses in transitions of care,

'… that is one of the biggest things that has to be learnt is that the culture around blame, that we don't just all feel that we have to blame something, or we have to assume the blame. It should be an environment and culture of learning. I feel really strongly about that.' [P15]

Table 4. Engagement and involvement of those affected by patient safety incidents - Agreement frequency and responses during interview

Item number, reason for change and theme	Undecided (%)	Disagreement (%)	Agreement (%)
25. **Revision.** Section 12.6 needs revising to clarify where the resource would come from to access counselling or therapy.	8% (1/13)	0% (0/13)	92% (12/13)
26. **Revision.** Section 12.6 needs revising to include mention of more specific specialist support (dementia support, occupational therapy etc).	15% (2/13)	0% (0/13)	85% (11/13)
27. **Revision.** Section 13.1 needs clarifying whether the named contact is based in the care home or NHS.	8% (1/13)	8% (1/13)	85% (11/13)
28. **Omission.** Section 13.4 is omitted because it is not realistic or manageable to include every family member / resident in developing terms of reference.	8% (1/13)	15% (2/13)	77% (10/13)
29. **Revision.** All standards need to reflect varying levels of capacity amongst residents, therefore should include family members / carers where appropriate	0% (0/13)	0% (0/13)	100% (13/13)
30. **Omission**. Section 12.7 should be omitted because it is unclear at the outset how it would be known that a learning response is needed	23% (3/13)	31% (4/13)	46% (6/13)
31. **Revision.** All sections of the standards need revising to give clarity on duplication with safeguarding reporting processes, including where joint contracts apply or for self-funded residents in residential home settings	8% (1/13)	8% (1/13)	85% (11/13) *
32. **Revision.** Section 13.1 needs revising to acknowledge that named contacts may be within a service, not a whole organisation. This is to reflect that care home organisations can be geographically or structurally sparse.	15% (2/13)	8% (1/13)	77% (10/13)
33. **Revision.** Section 13.5 needs revising to provide clarity around realistic timeframes for care homes	0% (0/13)	15% (2/13)	85% (11/13)
34. **Revision**. Section 13.8 requires clarity that learning response teams do not exist in care homes, so others may need to be named here	8% (1/13)	0% (0/13)	92% (12/13)
35. **Revision**. All sections of the standards need to provide clarity on who has responsibility for an incident	0% (0/13)	0% (0/13)	100% (13/13)

PSIRF standard 4: Proportionate responses

Many of the participants felt that the proportionate response standard did not sufficiently reflect multiple organisations and cross-system responses in relation to safety incidents that occur during transitions in care (Table 5). The participants also conveyed that the complexities of managing a care home in relation to responding to a safety incident were not recognised. Additionally, many accounts emphasised that care homes are often not part of the safety incident or safeguarding investigation process or not leading the investigation. This is exemplified by a care home quality lead,

> *'To some degree, this is out of our hands because if it was a serious incident like that, then CQC* [Care Quality Commission] *would take the lead on that investigation anyway because they are the body that would also potentially prosecute and take enforcement action.'* [P3]

In recognition that multiple organisations (NHS and care homes) are likely to be involved in a single learning response, item 41 attained high agreement in relation to further clarity on how to decide on the organisation 'best placed' to lead the response. Many participant accounts detailed their experiences of addressing complex issues of care acknowledging a multidisciplinary approach was effective. A local authority strategic commissioning manager explained this in relation to the safeguarding adults review process,

> '*…that multidisciplinary approach and that learning event, is just absolutely best, you know, it just really works.'* [P13]

Potentially difficult decisions i.e. deciding on the response lead may make it difficult to agree learning timeframes (from the outset) with those affected by the patient safety incident as per the subject of item 36. Such difficulties were related to resources and a care home capacity to lead a learning response across boundaries of care. An NHS clinical quality nurse lead participant working with care homes conveyed their concern in relation to the experience and resources in care homes to lead a cross organisation learning response whilst highlighting the importance of their inclusion,

> *'Care homes may not be best to lead a learning response and might not have the resources or the experience to do so but including them as key collaborators is important.'* [P11]

Social care and care home inclusion including the language used was a focus throughout this standard; item 37 attained complete consensus in relation to the use of integrated care systems to facilitate cross-system learning responses and that this should be revised to include the care home context, especially as some care homes operate outside of ICSs. Facilitation was seen as a balance between trust in care home expertise to triage their safety incidents and relinquishing control of the decision-making process, as described by a care home manager,

> '*…who is going to decide when something needs a response. There's no triaging happening here that I can see […] I'm concerned that if we aren't careful when we're, we're not gonna get anywhere. Triage where I think it needs to be independent.*' [P15]

Items 39 and 42 achieved complete consensus and focused on practicalities of responding with proportionality. Item 39 highlighted the importance of applying seniority (care home manager or deputy) to monitoring and overseeing the efficacy of safety actions and item 42 referred to care homes being included to comment on the factual accuracy of reports which could be subsequently used to guide safety actions, direct resources, and for improvement purposes. In relation to item 43 achieving complete consensus, the participants felt very strongly about

duty of candour being part of a proportionate response. Being open and transparent when something goes wrong is a first step in proportionality and involving those who are affected by a safety incident. A care home nurse explained duty of candour as a mechanism to address and reduce errors in care,

> *'its about transparency, again, you know, if you hide things and then it will just […] build-up of something wrong in the organisation that can lead to everything else going wrong.'* [P16]

Table 5. Proportionate responses - Agreement frequency and responses during interview

Item number, reason for change and theme	Undecided (%)	Disagreement (%)	Agreement (%)
36. **Revision.** Section 14.2 needs revising to reflect that timescales are not always able to be set at the beginning or might change during the process.	15% (2/13)	8% (1/13)	77% (10/13)
37. **Revision.** Section 16.1 needs refining to reflect the care home context which may or may not include integrated care systems and other organisations.	0% (0/13)	0% (0/13)	100% (13/13)
38. **Revision**. 15.2 and 15.3 are revised to reflect the reality of care home practice and incident reporting. It should be made clearer that the incident response is separate from other liabilities and responsibilities	8% (1/13)	8% (1/13)	85% (11/13)
39. **Revision**. Section 17.3 should be revised to clarify who a named individual should be, e.g., a care home manager or delegated individual.	0% (0/13)	0% (0/13)	100% (13/13)
40. **Revision**. Section 16.2, reference to 'multiple organisations' needs to be extended and made clearer to recognise the complex setting of care homes and interactions that exist between organisations.	8% (1/13)	15% (2/13)	77% (10/13)
41. **Revision**. Section 16.2 is revised to provide further clarity on how capability, capacity or remit is decided	15% (2/13)	8% (1/13)	77% (10/13)
42. **Revision**. Organisations should be given the opportunity to provide comment for factual accuracy on reports that refer to them (section 17.1)	0% (0/13)	0% (0/13)	100% (13/13)
43. **Revision.** Duty of candour should be reflected in the proportionate response section of PSIRF standards.	0% (0/13)	0% (0/13)	100% (13/13)
44. **Revision**. Care homes should lead on incident responses where they are impacted the most (16.2), even if other organisations are involved.	31% (4/13)	46% (6/13)	23% (3/13)
45. **Revision.** Section 15.7 should be revised so that individual learning responses should continue even when sufficient learning exists to inform improvements	15% (2/13)	8% (1/13)	77% (10/13)
46. **Revision.** Section 16.5 should be revised to add "where required" to "organisations work together and co-operate with any learning response that crosses organisational boundaries"	8% (1/13)	31% (4/13)	62 % (8/13)

Discussion

This study found a lack of attention in the PSIRF standards to cross-boundary working between NHS and care home settings, thus potentially impacting on transitional integrated care and the patient journey across organisational boundaries. In this respect, PSIRF currently does not create a wider policy environment for health and social care that is necessary for relationship building and the normative integration of safety practices, joint working and cross-boundary arrangements that

promote cross-system patient safety (Glendinning, 2003, Hedqvist et al., 2024b, Hedqvist et al., 2024a) and is a priority for future research (Scott et al., 2024b). Focus on patient-centred care with older people with chronic and complex conditions requires comprehensive care coordination and attention to the patient journey (Meyer, 2019). Applying a systems approach to patient safety allows the analysis of the factors that characterise the encounters and the interactions between healthcare professionals and patients during the entire course of care (Beleffi et al., 2021) but at present the policy agenda for joining up health and social care systems for patient safety remains unset. Potentially this creates conditions which counter a complete investigation and analysis in which to create and target learning where it is needed. This study highlights that PSIRF presents a one-sided approach that favours the NHS, consequently not setting a foundation for a whole-system approach to patient safety. Moreover, there is very little focus on safety incidents that occur because of a transition in care which disproportionately impact older adults in care homes (LaMantia et al., 2010, Tjia et al., 2009).

The idea of a whole-systems approach to optimise safety during the patient journey in healthcare is not a new concept within the NHS approach to patient safety (NHS, 2019). However, the increased likelihood of a safety incident during a transition in care is not adequately addressed. Transitional care is a weak link in patient safety (Scott et al., 2019) with a strong correlation of patient handovers with medical errors and adverse events (Alstveit et al., 2011), focus on improving discharge for older patients from hospital (Alstveit et al., 2011, Rennke et al., 2013) and more recently the challenges and associated improvements to hospital to care home discharge in times of COVID-19 (Newman et al., 2023). Despite these problems, PSIRF does present opportunities for improving integration of safety work across health and social care organisations; many participants in this study believed in a whole-system approach that could be achieved through modifications to PSIRF to create a continuum of responsibility across health and social care services, whilst adhering to the well-founded principles, ethos and theories that underpin PSIRF, such as the System Engineering Initiative for Patient Safety (SEIPS) (Wetterneck et al., 2014).

There appears to be many symptoms of non-integration, with this study highlighting the challenges to establishing a cross-system approach to patient safety between the NHS and care homes. These challenges include the current use of different reporting systems, the acknowledgment of poor communication between organisations, and a lack of cross boundary collaboration resource issues threatening care home commercial viability. Together, these challenges impact the cognitive participation of care home staff to PSIRF (as shown in Figure 2). Many of the participant responses centred around the need for social care to be included as an equal partner in PSIRF, starting with the intended audience for PSIRF and the language used. As such, greater inclusion of social care in PSIRF could promote more meaningful integration to optimise cross-system responses to patient safety incidents. Whilst a cross-system response was covered in the PSIRF standards (NHS England, 2022b), it failed to sufficiently represent or acknowledge the importance of social care and the care home sector.

The introduction of PSIRF echoes previous policies that omit social care and care home perspectives (Hunter et al., 2015, Forbes et al., 2010) and signify deep-rooted differences between different sectors of care. For instance, the NHS and wider care system are commissioned and funded separately and subject to different governance, accountability and regulatory regimes (Humphries, 2015). In relation to these differences, evidence about integration suggests that it takes time and requires effective policy, organisational stability and continuity of leadership; characteristics which have been lacking in English health and social care for some time (Davies et al., 2011, Humphries, 2015, Wetterneck et al., 2014).

The participants in this study agreed that obtaining resources to properly implement PSIRF may be challenging, especially for smaller care homes, and this may introduce competing priorities that could impact resident care or the viability of the care home. The PSIRF standards present both minimum

expectations in patient safety practice and suggest an infrastructure of supporting roles (e.g.., learning response leads and oversight). The resources required by care homes to train and maintain staff in these roles was highlighted in relation to the limited resources and the commercial fragility of care homes, particularly during a workforce crisis following the COVID-19 pandemic (Scales, 2021). There is a longstanding distinction between NHS care that is mostly free at the point of use and funded through general taxation and publicly funded social care which is subject to a financial assessment, commonly referred to as a 'means' test (Humphries, 2015). The divisions between a free NHS and either self-funded or means-tested long-term care is causing increasing difficulties in terms of equity, efficiency and effectiveness, which is compounded by reductions in local authority care budgets (Humphries, 2015, Iliffe and Manthorpe, 2014). Moreover, the social care workforce crisis is also putting a huge strain on care and nursing homes (Age UK, 2023), and there is little or no 'business case' and therefore no 'market incentive' to implement PSIRF from a care home perspective. Likewise, regulation was seen by participants in this study as a barrier to implementation as the culture of regulation in England was perceived as utilising a risk reduction approach, which is not aligned with the PSIRF ethos. Despite this, the participants from various backgrounds across health and social care in this study supported moving away from a blame culture to a culture of learning to improve services together, and recognised the benefits of PSIRF standards as a common frame of reference to achieve this vision.

Strengths and limitations

A strength of this study was that we were able to obtain representation from a wide range of stakeholders across hospital, local authority and care home settings, including representation from people involved in regulating health and social care services as well as investigating safety incidents. We were also able to obtain consensus on adaptations required for PSIRF standards in care homes, highlighting issues that exist as organisations attempt to work together to improve patient safety. A limitation of this study was that almost all participants were at senior levels, which may impact on whether adaptations to PSIRF standards would result in standards that could be implemented. Future research should address this by examining challenges associated with PSIRF implementation in care homes, including the views of staff at all levels. As this study focused on long-term care for older people in the form of residential and nursing care homes, future research should examine the suitability of (adapted) PSIRF standards for other types of care homes, such as domiciliary care and day centres, and residents, such as people with learning disabilities.

Conclusion

There are many positive aspects of PSIRF standards that would benefit social care and the care home sector, and their genuine inclusion into the PSIRF standards has the potential to improve care provision, advance a whole-system approach to patient safety that can improve quality of integrated care services, and with a potential for fewer patient safety incidents reduce the demand on the NHS and non-NHS providers. This study used a novel approach to understand the attitudes of care home and non-care home stakeholders towards adapting these PSIRF standards for the care home sector. With NHS ambitions to support 'out of hospital care' and care homes, there is an inevitability that patient safety standards, including the regulatory framework, will need to be aligned and extra resources will be needed by care homes to support the implementation of PSIRF standards. Any future revisions to PSIRF would benefit from social care and care home perspectives from the outset to support a whole-system approach to patient safety.

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