Royal Berkshire NHS Foundation Trust

Patient Safety Incident Response Framework Policy (CG819)

Approval

Approval Group	Job Title, Chair of Committee	Date
BOB ICB System Quality Group	ICB Chief Nurse	March 2024
Quality Governance Committee	Chief Medical Officer & Chief Nursing Officer	March 2024
Patient safety committee	Jessica Higson Deputy Chief Nurse	March 2026 via email
Quality Governance Committee	Janet Lippett Chief Medical Officer Katie Prichard-Thomas Chief Nursing Officer	March 2026
Policy Approval Group	Chair, Policy Approval Group	April 2026

Change History

Version	Date	Author, job title	Reason
1.0	March 2024	Sharon Andrews- Associate Director of Safety and Risk; Sarah Brown- Head of Patient Safety Hannah Spencer, Deputy Chief Nurse	New Policy
2.0	March 2026	Nunurai Moyo - Associate Director of Nursing Safety; Patient Safety Specialist Jessica Higson Deputy Chief Nurse Dr Andrew Jacques Associate Medical Director	Update and restructure of policy

Contents

Other relevant corporate or procedural documents:

This document must be read in conjunction with:

- Patient safety Incident Response Plan
- Duty of Candour Policy CG605
- Improving Together Methodology via Workvivo.

1.0 Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how the Royal Berkshire NHS Foundation Trust (RBFT) will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a coordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports the development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF; and which also align to our existing Trust values:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents and safety issues.
- Supportive oversight focused on strengthening response system functioning and improvement.

This policy should be read in conjunction with our current Patient Safety Incident Response Plan (PSIRP) and the NHS England » The NHS Patient Safety Strategy

2.0 Scope

This policy applies to all people working for the Trust including substantive staff, temporary or agency staff locums, apprentices, students, and volunteers.
This policy is specific to patient safety incident responses conducted solely to learn and improve across the Trust.

Responses under this policy follow a systems-based approach which recognises the complexity of patient safety. This means:

- Safety is not solely the result of individual actions, but arises from the interactions, structures, and processes within the healthcare system.
- Learning is prioritised, with a focus on understanding how conditions, decisions, and systemic factors contribute to outcomes.
- We use data and perspectives from clinical, operational, and governance areas to spot patterns, find risks, and guide improvements.
- Solutions aim to improve system design, resilience, and culture, rather than fixing single problems.

A patient safety incident response conducted under the PSIRF is designed solely for learning and improvement. It does not seek to determine liability or apportion blame.

The following processes are **outside the scope** of this policy:

- Claims handling
- Coronial inquests and criminal investigations
- Employee relations investigations into employment concerns
- Professional standards investigations (e.g. GMC/NMC referrals)
- Information governance concerns (e.g. data breaches)
- Estates and facilities concerns
- Financial investigations and audits
- Safeguarding concerns
- Structured Judgement Reviews
- Complaints, *except where a significant patient safety concern is identified*.
    - Where possible, the complainant's concerns will be addressed within the patient safety investigation.
    - If not, a follow-up will be provided after the investigation concludes.

The Trust acknowledges that overlaps may occur when engaging with patients, families, carers, and staff. In such instances, every effort will be made to ensure a streamlined, compassionate approach that minimises duplication and reduces unnecessary distress.

3.0 Table 1. Roles and Responsibilities

Role	Responsibility
Chief Executive Officer	The Chief Executive Officer is responsible for all aspects of patient safety, including managing safety events. This includes ensuring that appropriate structures are in place to enable appropriate investigation, analysis and learning and ensuring resources are available to comply with this policy. The Chief Executive is responsible for providing appropriate policies and procedures for all aspects of health and safety (Health and Safety at Work Act 1974).
Chief Medical Officer	The Chief Medical Officer is responsible for ensuring there are effective patient safety structures in place across the Trust. Specifically, the Chief Medical Officer has responsibility for providing assurance around clinical effectiveness of care delivered. The Chief Medical Officer chairs the Quality Governance Committee (QGC) jointly with the Chief Nursing Officer.
Chief Nursing Officer	The Chief Nursing Officer is the Executive Lead and Responsible Officer for PSIRF and responsible for ensuring that the organisation meets national patient safety incident response standards. The Executive Lead will ensure PSIRF is central to overarching safety governance arrangements and is responsible for ensuring there is an Executive review of all safety reports in line with the PSIRF standards and that each is signed off as finalised. The Executive Lead, alongside the Chief Medical Officer, will also provide direct leadership, advice, and support in complex/high profile cases, and consult with external bodies as required.
Deputy Chief Nursing Officer	The Deputy Chief Nurse is responsible for monitoring, assessing and reviewing the processes and procedures in place for patient safety, risk, and clinical effectiveness. The Deputy Chief Nurse chairs the Patient Safety Committee (PSC) which reports to the Quality Governance Committee.

All Other Executive / Non-Executive Directors	All Directors who sit on the Trust Board (either Executive or Non-Executive) have responsibility for adhering to, championing, and supporting the implementation of this patient safety policy within the remits of their identified portfolios.
Associate Medical Director for Safety Associate Director of Nursing for Patient Safety	The Associate Medical Director for Safety and Associate Director of Nursing for Patient Safety support the Chief Medical Officer, Chief Nursing Officer, and their Deputies across all aspects of the Patient Safety and Learning portfolio. The Associate Director of Nursing for Patient Safety holds overall responsibility for the Trust's Patient Safety and Learning function and provides strategic direction for this policy's development and implementation. This includes: • Defining the Trust's patient safety and improvement profile • Overseeing review of patient safety incident insights • Engaging internal and external stakeholders • Ensuring patient, family, and carer voices are heard across all levels • Sourcing PSIRF-related training and supporting investigation teams • Leading the Patient Safety Team to maintain this policy and incorporate emerging themes and trends
Patient Safety Specialists (PSSs)	PSSs provide oversight to Board, act as local champions, embedding national principles such as systems thinking, human factors, and just culture, while supporting the implementation of frameworks like PSIRF. They lead and influence key functions including: • Patient safety incident reporting • Risk management • Investigation and learning responses
Patient Safety Partner (PSP)	• Acting as knowledge brokers, offering cross-system perspectives and lived experience • Supporting insight, involvement, and improvement activities in various safety and quality committees • Promoting systems thinking, human factors, and just culture principles • Encouraging a shift from Safety I (why things go wrong) to Safety II (why things go right)
Patient Safety Reviewers	Patient Safety Reviewers are responsible for leading Patient Safety Incident Investigations (PSIIs) and other learning responses aligned with the Trust's patient safety priorities. They are supported by the Patient Safety Team, who collaborate with Care Groups to embed PSIRF principles, including: • A whole-system approach to safety • Psychological safety for staff • Compassionate engagement with patients, families, and carers
Head of Patient Safety	The Head of Patient Safety supports the Associate Director of Safety & Risk in the development, implementation, and monitoring of PSIRF across the Trust. They oversee the Patient Safety Team and also serve as the Patient Safety Specialist. Key responsibilities include: • Supporting the embedding of PSIRF principles and processes • Leading Trust-wide thematic analysis and ongoing PSIRF reviews • Overseeing reporting and assurance related to patient safety insights
Care Group Patient Safety Leads	Are responsible for ensuring the PSIRF policy governance and system functions effectively in line with expectations whilst working in partnership with Care Group Teams and governance professionals to implement PSIRF within the organisation.

Care Group Directorate Boards	Care Group Boards and senior leaders are responsible for championing, implementing, and adhering to this policy within their portfolios. They will: • Proactively promote the policy and escalate emerging themes • Ensure directorates respond to patient safety events appropriately and proportionately • Oversee the assessment and sharing of learning through established channels • Ensure actions from patient safety reviews are monitored and completed (oversight)
Learning Response Leads (Lead Investigator)	Learning Response Leads are responsible for completing relevant training and maintaining ongoing professional development in incident response. They will: • Contribute to at least two learning responses per year • Gather and analyse qualitative and quantitative data from diverse sources • Produce clear, structured reports that support learning and improvement
Engagement leads	Engagement Leads are responsible for completing relevant training and maintaining ongoing professional development in incident response. They will: • Communicate with patients, families, staff, and external agencies compassionately and effectively • Maintain clear records of contact and engagement • Identify risks to meaningful involvement and escalate as needed • Recognise when individuals require signposting or referral to support services
Clinical Director/Clinical Lead/Matron/Directorate Manager/AHP lead	Directorate and department leads (nursing/medical/AHP/operations) are responsible for reviewing incidents and commencing PSIRF process. They allocate learning response leads and have ownership and accountability for learning reviews in their clinical areas. They can lead and contribute to being part of the PSIRF process and should have oversight of all reviews in their area. They should have ongoing oversight to ensure action plans have an “owner” and are completed and signed off on Datix.
Medical Devices Safety Officer (MDSO)	Oversee identification, reporting, and classification of medical device - related patient safety incidents. Ensure incidents are recorded accurately on Datix and reported to national systems (e.g., MHRA). Act as the Trust’s link with MHRA, manufacturers, and national safety networks. Ensure national alerts and Field Safety Notices are acted upon and embedded.
Medicine Safety Officer (MSO)	Oversee identification and reporting of medication-related patient safety incidents. Act as the Trust’s link with national MSO networks, NHS England, and MHRA. Ensure national medication safety alerts are implemented and monitored.
All Other Staff	All staff across (including IT, catering etc.) the organisation is responsible: • For promoting an open, honest, just, and fair culture. • Completing all relevant training in relation to PSIRF for their role. • Ensuring any patient safety incident is reported within 24 hours of occurrence or becoming aware of the incident. • Adhering to this policy.

4.0 Table 2. Definitions

Term	Definition
AAR	After Action review (One of the methodologies for reviewing incidents)
Datix	Incident management system Risk management database, central recording system of incidents, complaints, claims, actions, safety alerts, clinical audit, and Risk Register
ICB	Integrated Care Board
ICS	Integrated Care System
Incident	An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or psychological distress to a patient, staff, visitors or members of the public
LFPSE	Learning from Patient Safety Events (LFPSE) service. A national database for the direct recording of incidents as they are reported. It collects data from all NHS funded providers. The Integrated Care Board (ICB), NHS England and Care Quality Commission (CQC) have access to this database.
MNSI	Maternity and new-born safety investigations
Near Miss	Any event that could have caused harm to patients, staff, or the reputation of the Trust, had it been allowed to reach its natural conclusion.
Never Event	Never Events are incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. A core list of never events is issued by NHS England.
Patient Safety Incident	Any unintended or unexpected incident that could have led or did lead to harm for one or more patients receiving NHS-funded care.
PMRT	Perinatal mortality review tool (a national tool used in the UK to standardise MDT reviews of care for babies who die during pregnancy and shortly after,

PSII	Patient Safety Incident Investigation. Some incidents are classified as Patient Safety Incident Investigations (PSII). This is an incident identified which is investigated through a systematic process which includes systems-based analysis. PSII's are identified on an on-going basis based on the identification of areas of most significant risk, along with those categories for which a PSII is nationally mandated. The Trust publishes its' Patient Safety Incident Response Plan (PSIRP) on the Trust website, identifying those incidents requiring a PSII.
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan. To support local improvement, the Trust must determine which categories of incident are priorities locally and require a Patient Safety Incident Investigation (PSII). In line with the PSIRF, the Trust will do this by reviewing past incident data (from the last three to five years where available) to identify those incidents representing the most significant risks. This list must be set out in the PSIRP, reviewed, and refreshed every 12 to 18 months adapted as new risks.
PSP	Patient Safety Partner
Rapid Review (RR)	Rapid Reviews are completed for safety incidents which do not require PSII but may benefit from a different type of review to gain further insight or address queries from the patient, family, carers, or staff. Different review techniques can be adopted, depending on the intended aim, and required outcome and the Patient Safety Team will advise on the most appropriate technique.
Risk	An uncertain event or set of events which, should it occur, will influence the achievement of objectives. It is measured in terms of likelihood and consequences.
SEIPS	Systems Engineering Initiative for Patient Safety. Framework for understanding outcomes within complex sociotechnical systems such as healthcare.
SJR	Structured Judgement Review
Thematic review	A methodology to investigate patient safety incidents to identify themes and patterns for learning.

5.0 Our Safety Culture

Our safety culture is aligned with the National Patient Safety Strategy (2019) PSIRF objectives below.

- Insight – improving understanding of safety, patient experience, and involvement by listening and drawing insights from multiple sources of information,
- Involvement – to equip patients, colleagues, and partners with the skills and opportunities to improve safety and patient experience throughout the entire system,

- Improvement – to design and support improvement programmes that deliver effective and sustainable change.

6.0 Organisational Approach to National Patient Safety Strategy

The following four sections describe our organisational approach to the National Patient Safety Strategy aligned to the 4 pillars of;

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents and safety issues.
- Supportive oversight focused on strengthening response system functioning and improvement

Pillar 1: Compassionate Engagement and Involvement

Compassionate engagement

PSIRF ensures learning after patient safety incidents by having supportive systems in place. It promotes compassionate engagement with patients, families, and staff, answering their questions and involving them in investigations. RBFT is committed to continuous improvement, openness, honesty and meeting Duty of Candour requirements because transparency is the right thing to do. We offer intermediaries and professional interpreters when needed to ensure clear communication, inclusivity, and accurate understanding. This approach helps prevent recurrence, supports equitable care, and ensures all voices are heard.

Table 3 – Four Steps of Engagement- B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

Being Open & Duty of Candour

This section should be read alongside RBFT's Being Open and Duty of Candour (DoC) Policy (CG605) and the Duty of candour animation - NHS Resolution.

RBFT is committed to being open and honest with patients, service users, families, and carers when a patient safety incident occurs, and we want to support our staff in this process, this is addition to meeting our regulatory and professional requirements for Duty of Candour. Being open must be done in a transparent manner ensuring that the needs of patients and others affected are met. This is regardless of the level of harm caused by an incident. Duty of Candour remains a statutory requirement, and discussions must be recorded on the incident management database, and copies of DoC letters shared with the patients/person(s) affected, where agreed.

Where practical, it is good practice to discuss the level of harm with the patient affected and to consider the patient's perspective on the harm definitions stated below.

Previous harm grades (National Reporting &Learning System (NLRS))	New physical harm grades (Learning From Patient Safety Events (LFPSE))	New psychological harm grades (LFPSE)
No Harm	No physical harm	No psychological harm
Low harm	Low physical harm	Low psychological harm
Moderate harm	Moderate physical harm	Moderate psychological harm
Severe harm	Severe physical harm	Severe psychological harm
Death	Fatal	n/a

For further information on Duty of Candour and the processes to follow please refer to the DoC Policy CG605.

Just Culture

As a learning organisation, the Trust is committed to compassionate and inclusive leadership that fosters psychological safety and supports high-quality, safe patient care. We have fully adopted NHS England's 'Just Culture' principles NHS England » Being fair tool, promoting openness, learning from mistakes, and moving away from blame. This approach underpins our response to safety events, ensuring staff are supported through compassionate, non-punitive processes and consistent practices across teams. We explore contributory factors holistically, to enable meaningful learning and prevent future harm. Staff wellbeing remains central, with access to our Health and Wellbeing Service, including psychological support. The main goals of restoration when an incident has happened have been outlined as follows:

- Moral engagement
- Emotional healing
- Reintegration of the practitioner
- Organisational learning

- Prevention

PSIRF strengthens the link between patient safety incidents and meaningful learning by fostering a culture of openness, collaboration, and improvement. We work alongside staff, patients, families, and carers to understand what happened, whether things went well or not and use these insights to drive system-wide change. Learning responses are solely for improvement, not blame, and appropriate support will be offered to staff involved in safety events.

Trauma Informed Care

Trauma-informed approaches are ways of supporting people that recognise specific needs they may have as a result of past or ongoing trauma www.thinknpc.org. The Trust recognises the importance of embedding trauma-informed care within the Patient Safety Incident Response Framework (PSIRF) to support patients, families, and staff affected by adverse events. Trauma-informed care focuses on understanding, recognising, and responding to the impact of trauma, creating a culture of safety, empowerment, and healing.

Staff can access support through clinical supervision, 1:1's with line managers, debriefs, TRiM (Trauma Risk Management) practitioners and have access to the support of the Trust Clinical Psychologist with their team. In line with the PSIRF principles of compassionate engagement, a trauma-informed approach ensures that individuals' psychological and emotional needs are prioritised during incident response processes. This reduces the risk of re-traumatisation, fosters open communication, and builds trust in the organisation's commitment to transparency, learning, and improvement.

The engagement and involvement lead involved in a specific incident will lead compassionate engagement with the patient and their family/carers.

Addressing Health Inequalities

RBFT is committed to fair, accessible, and inclusive services and employment practices for all patients, families, carers, and staff. Health inequalities are actively considered in patient safety incident responses through:

- Embedded questions in the incident reporting database to capture protected characteristics and demographic data
- Narrative prompts to explore how identity factors may have influenced or been impacted by the event
- Analysis of trends to identify disproportionate impacts and inform targeted improvement

Where inequalities are identified, they must be reflected in the Terms of Reference and addressed through triangulated learning and action planning.

Inclusive involvement from the outset, of patients, families, and carers is essential to tailoring the learning response, understanding lived experiences, and addressing concerns meaningfully.
Staff must be supported throughout, with reassurance that the process is focused on learning and improvement, not blame. This ensures equity and psychological safety for all, regardless of identity or protected characteristics.

Complaints & Appeals

For concerns outside patient safety, patients and families can use our PALS and Complaints services (PALS@royalberkshire.nhs.uk). We strive for compassionate care and clear communication, but if things don't go as planned, we welcome feedback to help us improve. Concerns about patient safety investigations can be addressed by:

1. Discussing locally with the investigator and engagement lead.
2. Escalating to the Clinical/Departmental Leadership Team.
3. Referring to the Patient Advice and Liaison Services

If complaints remain unresolved the **Parliamentary and Health Service Ombudsman** can review and make a final decision (details at https://www.ombudsman.org.uk). Safety leads will also work with patients, families, and carers to provide additional support.

Pillar 2: Application of a Range of System-Based Approaches to Learning

Learning and Improvement after Patient Safety Incidents

Robust findings from investigations and reviews offer valuable insights and these are the starting point for change. These findings will be consolidated into Safety Action Plans, translating learning into targeted actions and implementation.

Using methods like SEIPS (System Engineering Initiative for Patient Safety), areas are identified for improvement. The author of the Patient Safety Learning response is responsible for making recommendations in partnership with the departmental/service leads. The department team are then responsible for allocating an action plan "owner" and allocating individual actions to colleagues (and ensuring that all colleagues who have an action are aware of their action, agree with the changes and can complete it within the timeframe allocated).

Safety Action Development Process:

1. Agree areas for improvement.
2. Define context and approach.
3. Develop safety actions collaboratively.
4. Prioritise actions based on evidence.
5. Define measurable indicators and assign responsibility.
6. Document actions in a safety improvement plan.
7. Monitor and review impact regularly.

The action plan "owner" needs to ensure that all actions are completed. The Patient Safety Team will support teams and ensure actions are logged onto Datix. Actions will be reviewed through clinical governance groups to track progress.

Appendix 1 contains the flowchart for development and monitoring of patient safety actions.

Pillar 3: Considered and proportionate responses

Reporting Culture

The Trust promotes a strong safety culture, encouraging all staff to report patient safety events as opportunities for learning and improvement. Incident reporting helps prevent recurrence and supports continuous system development.

Datix is the Trust's designated platform for managing incidents, risks, safety alerts, complaints, audits, and claims. All incidents must be reported via Datix in line with operational procedures available on Workvivo. New definitions of harm apply under the NHS England (2023) National Policy link.

Reporting Incidents

- All staff are responsible for reporting incidents, near misses, and safety concerns via Datix.
- Reports must be objective, timely, and documented in the patient's clinical record.
- Concerns should be raised with line managers or the Patient Safety Team.

Reviewing Patient Safety Incidents

The Datix "handler" will review the incident and take appropriate action to review and respond.

This process is supported by daily triage from the Patient Safety Leads. Where further investigation is needed, a Rapid Review (RR) is commissioned.

Rapid reviews are scoped and discussed at the Patient Safety Incident Response Group (PSIRG) for next steps. Next steps could include any of the following (see table below for more detail):

- Patient Safety Incident Investigation
- After Action Review
- Multidisciplinary roundtable review
- Thematic review

If the learning falls into any of the RBFT Trust Patient Safety Priorities they will be assessed for new learning and a learning response commissioned only if the work falls outside the scope of the Patient Safety Plan (see Patient Safety Incident Response Plan).

Appendix 2 contains flowchart which documents the process for reviewing incidents on Datix through to rapid review and Patient Safety Incident Review Group.

Learning Responses and Timeframes

Patient safety learning response **timeframes** are agreed in discussion with those affected, particularly the patient(s) and/or their carer(s), where they wish to be involved in such discussions.

Depending on discussions with those involved, learning responses are completed within one to three months and/or no longer than six months. In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

Table 4. Types of learning responses and when each is appropriate:

Learning response methodologies and types	When to use what Learning Response
Rapid Review (within 5 working days)	• Quick and responsive, immediate learning occurs with early actions identified • Connecting immediately after the event may reduce social isolation/ruminating/stress for staff.
Patient Safety Incident Investigation (PSII)	• An in-depth review of a single patient safety incident or cluster of events to understand what happened and how. • Can be adapted to incorporate the systems engineering initiative for patient safety (SEIPS) framework to structure the review.
After Action Review (AAR)	• Strengthens individual, team & organisational learning (including external organisations) to identify work as done, similarities and differences between themselves and others. • It is a group learning process, interactions between team members are available to learn from and improve. This has a strong effect on team performance & patient safety. Highly adaptable, suitable for a wide range of events.
Multidisciplinary (MDT) roundtable review	• An in-depth process of review, with input from different disciplines, to identify learning from multiple patient safety incidents, and to explore a safety theme, pathway, or process. • The participation of many members of the MDT without the spotlight on a single adverse event enables a broad and deep discussion to take place and a system view to be gathered.
Thematic review	• This can identify themes/trends in data to help answer questions, show links or identify issues, typically using qualitative data to identify safety themes and issues
De-escalation	• No further learning or risk has been identified. Incident to be closed locally via Datix. A learning slide may be sufficient.

Competence and Capacity:

- All learning responses must be adequately resourced (including funding, time, equipment, and training).
- Learning responses will not be led by staff who participated in the patient safety incident itself or by those who directly manage those staff.
- Learning responses are not undertaken by staff working in isolation. A learning response team should be established to support learning responses wherever possible.
- Staff affected by patient safety incidents are given time and are supported to participate in learning responses.
- Learning response leads should have dedicated time to conduct learning responses.
- Subject matter experts with relevant knowledge and skills are involved, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proof reading.
- There is a dedicated staff resource to support engagement and involvement of those affected.
- Learning response leads, those leading engagement and involvement, and those in PSIRF oversight roles require specific knowledge and experience.

Responding to Cross-System Incidents/Issues - Multi-Agency Reviews

BOB ICB (Thames Valley ICB from April 2026) ensures providers have systems for a coordinated response to major or complex incidents, including support for those affected. Organisations must identify high-profile incidents, alert partners, and involve risk or governance teams.

A **Patient Safety Specialists group**, hosted by BOB ICB, shares learning and drives new safety initiatives.

If an incident needs input from another organisation, the Trust's Patient Safety Team will arrange a cross-system review. When contacting another organisation, staff must provide:

- Why the organisation is involved
- Purpose of contact (information sharing or joint investigation)
- Clear questions

The Trust supports partners when asked and manages all notifications and communication. Wherever possible, we collaborate locally to ensure system-wide learning.

Pillar 4: Supportive oversight

PSIRF Oversight Responsibilities

Oversight ensures that the PSIRF principles of **learning, improvement, and compassionate engagement** are embedded and functioning effectively across the organisation. It moves away from compliance-driven monitoring and focuses on **supporting improvement and system learning** rather than blame.

The Trust has key leaders within the organisation trained for PSIRF oversight; their core responsibilities are:

Governance and Assurance

- To monitor the effectiveness of PSIRF processes and ensure alignment with national standards.
- Provide assurance to the care group and Trust Boards and regulators that patient safety responses are proportionate and learning-focused.

Decision-Making and Escalation

- Participate in panels (e.g., PSIRG) to review escalated incidents.
- Decide on commissioning learning responses or investigations, including cross-system reviews where needed.

Promoting Improvement

- Ensure improvement work is underway for known safety challenges.
- Oversee thematic analysis and sharing of learning across care groups and systems.

Engagement and Transparency

- Confirm compassionate engagement plans for patients, families, and staff affected by incidents.
- Support openness and psychological safety to enable learning.

Data and Insight

- Use a variety of data sources to monitor safety culture and system performance.
- Avoid creating unnecessary reporting burdens; focus on meaningful metrics.

Training and Competence

- Oversight roles require mandated PSIRF training under the National Patient Safety Syllabus, covering systems thinking, human factors, risk expertise, and safety culture.

The Trust monitors patient safety incidents through:

- Patient safety rapid review meeting – Patient Safety Team led meeting to complete initial scoping of an incident.
- Patient Safety Incident Response Group – chaired by a senior clinician (with Oversight training) to discuss rapid reviews and decide on next steps, and sign off completed learning responses.
- Learning responses are taken through department, directorate and care group clinical governance meetings.
- Care group clinical governance reports to the Quality Governance Committee.

Appendix 2 and 3 contain the flow charts for patient safety processes and governance.

Consultation Undertaken

Chief Nursing Officer
Chief Medical Officer
Deputy Chief Nursing Officer
Associate Medical Director for Patient Safety
Care Group Directors
Care Group Directors of Nursing
Lead Nurse for IPC
Lead Nurse Safeguarding
Patient Safety Investigators
Patient Safety Leads
Patient Safety partners
Head of Complaints
Associate Chief Nurses and AHP

Patient Safety Committee

Dissemination/Circulation/Archiving

The policy will be available on the Trust Policy Platform on Workvivo.
The Trust Secretary will be responsible for archiving old versions of this document.

Implementation

This policy has been implemented in conjunction with the Patient Safety Incident Review Plan.

The policy will be reviewed every 2 years unless necessary changes are warranted prior to this.

Training

The Trust will provide patient safety training aligned with the NHS Patient Safety Syllabus, tailored to staff roles. This policy and its associated PSIRF plan will be reviewed every 2 years in accordance with Trust guidance.

The National Patient Safety Strategy (2019) introduced two key initiatives: the National Patient Safety Syllabus (NPSS) and the Patient Safety Incident Response Framework (PSIRF 2022).

The NPSS comprises five patient safety domains and four themes of underpinning knowledge: systems thinking, human factors, risk expertise, and safety culture. Training is structured across five levels, from basic e-learning for all staff to advanced modules for patient safety experts.

National Patient Safety Syllabus (NPSS)

Fig.1 - The National Patient safety syllabus comprises five patient safety themed domains

With four themes of underpinning knowledge and expertise:

- Systems thinking
- Human factors
- Risk expertise
- Safety culture

Table 1. Training delivery is structured as levels from 1 - 5:

Level 1- online- 30minutes	• Essentials for Patient Safety (e-learning) for **all staff** • Essentials of patient safety for **Board and Senior Leadership Teams**
Level 2- online – 40 minutes	• Access to practice – **for all staff** • Sector specific sessions (accessible following completion of level 2 access to practice)
Level 3 & Level 4	• For Patient Safety Specialists/senior leaders/staff with dedicated roles in safety improvement • Delivered through blended learning approach with a number of modules delivered through online and in person events. Run by NHSE & Loughborough University.
Level 5	• For Patient Safety Specialists • Four modules for patient safety experts who will be innovators and leaders in this area. Run by NHSE & Loughborough University.

Level 1 and level 2 essentials of patient safety training is available on Learning Matters. This is part of staff “local compliance” and must be completed.

Training for Patient Safety roles such as oversight, learning response lead and engagement and involvement is offered as appropriate to job role.

Monitoring of Compliance

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual or dept. responsible for the monitoring	Frequency of the monitoring activity	Group/committee which will receive the findings/ monitoring report	Committee/ individual responsible for ensuring

					that the actions are completed
Action plans	Audit	Nunu Moyo	6 monthly audit to be included in Q2 and Q4 patient safety paper	Patient safety committee, Quality Governance committee.	Quality Committee
Duty of candour	Audit	Nunu Moyo	6 monthly audit to be included in Q2 and Q4 patient safety paper	Patient safety committee, Quality Governance committee.	Quality Committee
Governance process for shared learning	Audit	Nunu Moyo	6 monthly audit to be included in Q2 and Q4 patient safety paper	Patient safety committee, Quality Governance committee.	Quality Committee

The Trust reserves the right to amend its monitoring requirements in order to meet the changing needs of the organisation.

Supporting Documentation and References

Patient Safety Incident Response Plan
Duty of Candour Policy

Equality Impact Assessment

Stage 1: Screening

Part 1: Initial Scoping

For each of the nine protected groups identified in the table below, respond to the identified questions with a Yes (Y); No (N); or Unclear (U)

	Age	Sex	Disability	Race	Gender Reassignment	Religion or Belief	Sexual Orientation	Marriage and Civil Partnership	Pregnancy and Maternity
Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy/change proposal?	N	N	N	N	N	N	N	N	N
Is there potential for or evidence that the proposed policy/change will not promote equality of opportunity for all and promote good relations between different groups?	N	N	N	N	N	N	N	N	N
Is there potential for or evidence that the proposed policy will affect different population groups differently (including unintended discrimination against certain groups)?	N	N	N	N	N	N	N	N	N
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups?	N	N	N	N	N	N	N	N	N

Part 2: Evidence and Feedback that has informed your analysis

Please identify below the data, information or feedback that you have drawn on to reach the conclusions above. This will be information that has enabled you to assess the actual or potential impacts in the context of the key needs to **eliminate unlawful discrimination**, **advance equality of opportunity** and **foster good relations** with respect to the characteristics protected by equality law. These sources could include:

- Equalities monitoring information of staff/service users affected by the identified provision/policy etc.
- Engagement (internal/external or both) with or feedback from relevant stakeholders e.g. staff; patient groups, commissioners, external agencies.
- Staff Survey Data; Patient Survey Data etc.
- Research or information available relative to the identified protected group.

- Project leads professional knowledge of the issues the policy/change is seeking to enact.

If the analysis under Part 1 has concluded that there are equality impacts or that the impacts are unclear (i.e. you responded 'Yes' or 'Unclear' in Part 1), **please move on to Part 4 of the assessment**. If no equality impacts are identified, **please move on to Part 3 below** to conclude the assessment

Part 3: Narrative

If you have concluded there are no equality impacts related to the policy/provision, please provide a brief narrative to explain why you have come to this conclusion:

If no equality impacts have been identified, this concludes the equality impact assessment. Please complete the declaration below:

Based on the information set out above I have decided that a full equality impact assessment is (please delete as appropriate):

Necessary / Not necessary.

Stage 2: Full Equality Impact Assessment

Part 4: Identifying the Potential Impacts

Is there concern that the policy/strategy etc. will not promote equality of opportunity, eliminate discrimination or promote good relations?

Looking back at part one of the EIA, please summarise those areas where there are concerns that the policy/strategy etc. could have negative impacts and why this is the case. Consider all equality areas where a potential negative impact has been identified.

What gaps are there (if any) in the information required to identify impacts? How will this be redressed?

Part 5: Previous or Planned Consultation

Using the table below, give a summary of what previous or planned consultation on this policy etc **has or will** take place with groups or individuals from the equality groups and what has this consultation noted about the likely negative impact?

Equality Group/ Representative Body	Summary of consultation and notes of likely negative impacts

What consultation has taken place or is planned with Trust staff including staff that have or will have direct experience of implementing the strategy, policy or practice?

Part 6: Managing and minimising potential negative impacts

If negative/potential negative impacts have been identified, you should identify in this section how the issue/problem will be addressed or mitigated and who will be responsible for addressing it.

Issue	Action/Mitigation	Timescale	Responsible Person

What monitoring and evaluation process is in place to check, review and change (as and if required) the implementation of this policy from an equalities perspective?

This concludes the Equality Impact Assessment.

Mandatory Wording to be included:

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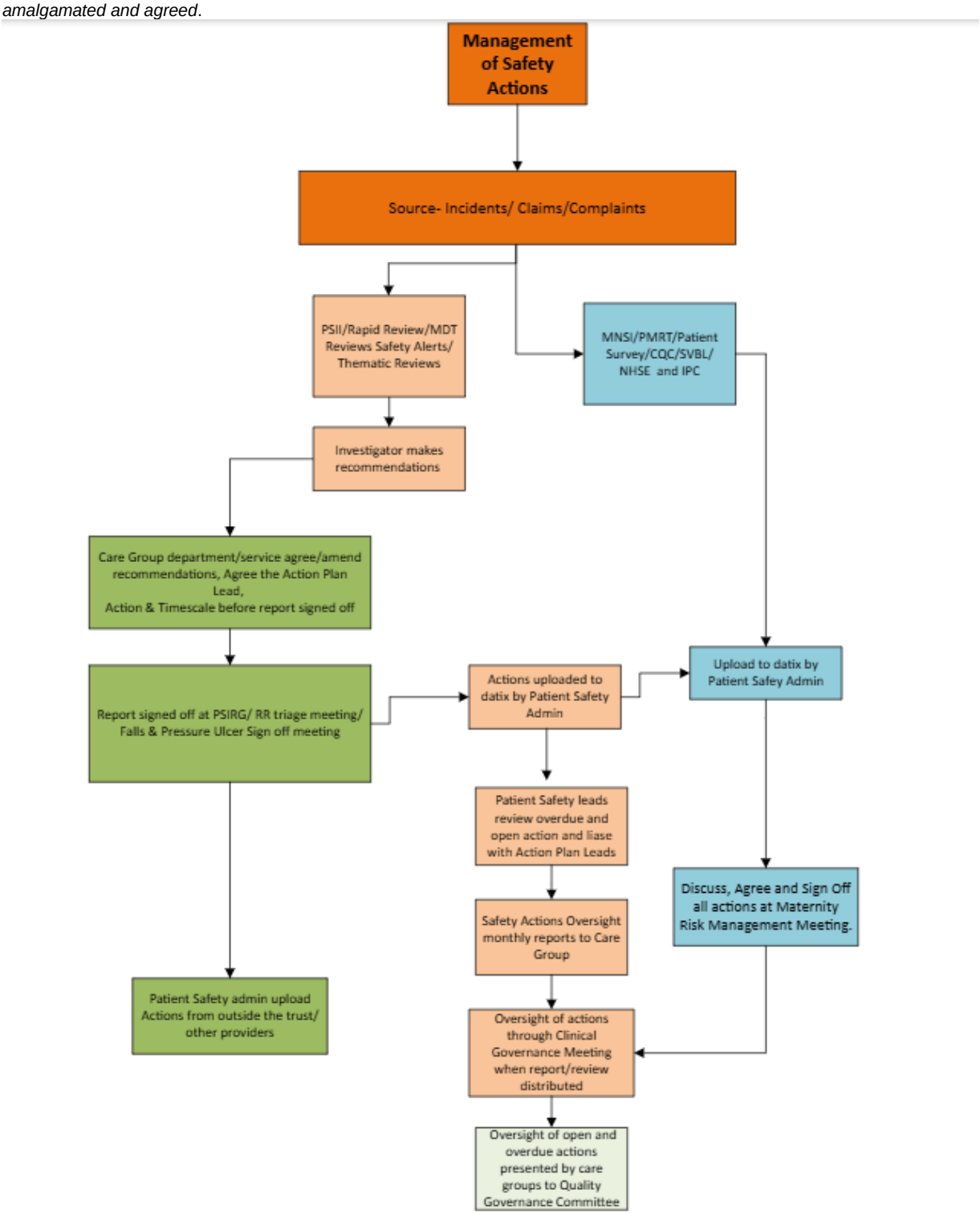
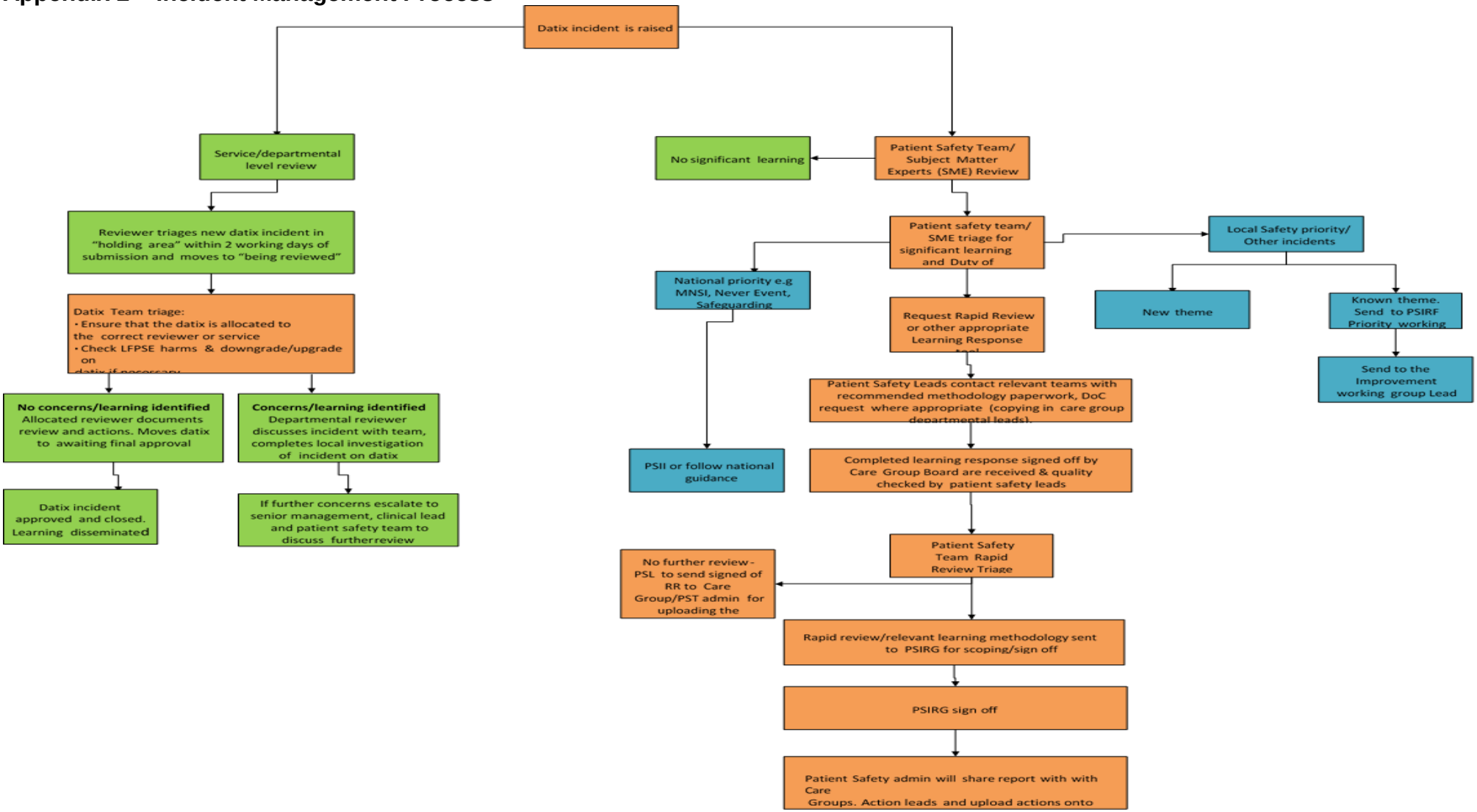
Appendix 1 – Management of Safety Actions

Note: for some MNSI/PMRT cases a rapid review will also be needed to ensure immediate learning is captured as the PMRT/MNSI processes take time. Once rapid review completed it will go to PSIRG sign off once MMNI/PMRT completed so all actions can be amalgamated and agreed.



Appendix 2 – Incident Management Process



Departmental responsibilities
Patient Safety Team Responsibilities
Subject Matter Experts

Appendix 3 Key "Oversight" processes for Patient Safety Reviews