

Patient Safety Incident Response Plan

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
Version 2.0: Patient safety committee	Jessica Higson Deputy Chief Nurse	
Version 2.0: Quality Governance Committee	Janet Lippett Chief Medical Officer Katie Prichard-Thomas Chief Nursing Officer	
Version 2.0: BOB ICB System Quality Group	ICB Chief Nursing Officer Sarah Bellars	

Change History

Version	Date	Author, job title	Reason
1.0	April 2024	Sharon Andrews. Associate Director of Safety and Risk	New
2.0	September 2025	Nunurai Moyo Associate Director of Safety	Review of the PSIRF priorities Strengthen governance process



Foreword from the Chief Nursing Officer

We are delighted to present the updated Patient Safety Incident Response Plan (PSIRP) for Royal Berkshire Hospital Foundation Trust. This plan sets out how we will continue to respond to patient safety events in alignment with the National Patient Safety Strategy for England and the Patient Safety Incident Response Framework (PSIRF).

PSIRF represents a bold and exciting shift in how we approach patient safety incidents. It is not simply a rebranding of existing processes, but a genuine cultural and systemic transformation. Our focus is moving away from producing reports to meet mandated criteria and timescales, and instead toward achieving meaningful outcomes that drive learning and continuous improvement. This new approach is rooted in collaboration. We have engaged widely with staff across the Trust, Patient Safety Partners, and gathered valuable feedback from patients and their families. Their voices form the golden thread running through all our patient safety responses. We are committed to ensuring patients, families, carers, and staff are meaningfully involved at every stage of the process.

We recognise that adopting this new way of working will be a journey. We may not get everything right at the outset, but we will continuously monitor, evaluate, and adapt our implementation to ensure it delivers the intended impact. Our commissioners, partner providers, and stakeholders have supported us in embracing this nationally driven change, and we are grateful for their collaboration.

Above all, PSIRF offers us the opportunity to learn, improve, and embed practices that promote safe, effective, and compassionate care for our patients, their families, and carers, while safeguarding the wellbeing of our staff.

Katie Prichard-Thomas
Chief Nursing Officer

Contents

Other relevant corporate or procedural documents:

This document must be read in conjunction with:

- Patient Safety Incident Response Framework Policy (CG819)

1.0 Purpose and Scope

Aim of the Plan

This Patient Safety Incident Response Plan sets out how the Royal Berkshire NHS Foundation Trust will respond to patient safety incidents over the three-year period from 2026 to 2029. The plan is not a fixed rulebook; it is designed to remain flexible, adapting to the specific circumstances of each incident and the needs of those affected.

Under the PSIRF framework, NHS organisations are required to undertake annual reviews of the types of incidents to be investigated. These reviews are based on local risks, trends, and priorities, and form the organisation's Local Priorities.

Principles

This plan is underpinned by the Patient Safety Incident Response Framework Policy (CG819) and guided by the following principles:

- Compassionate engagement with patients, families, and staff to improve experiences when incidents occur.
- A system-based learning approach.
- Proportionate responses based on risk.
- Supportive oversight and governance.

2.0 Our Services

The Royal Berkshire NHS Foundation Trust is one of the largest general hospital foundation trusts in the country. We are the main provider of acute and specialist services for Reading, Newbury, Henley-on-Thames, Wokingham and surrounding villages in Berkshire West and South Oxfordshire; serving a catchment area of over 600,000 people. In addition, we provide specialist Cancer, Cardiology and Renal services that serve a wider population of up to 1 million.

We work across our 7 main sites - Bracknell Healthspace, Dingley Child Development Centre, Prince Charles Eye Unit, Royal Berkshire Hospital, Townlands Memorial Hospital, West Berkshire Community Hospital and Windsor Dialysis Unit - as well as providing care in different community settings and in people's homes.

3.0 Our patient safety profile and priorities

Since our first plan, our understanding of patient safety challenges has deepened. We now benefit from hundreds of system-based learning responses, two years of patient safety event data (LFPSE), and the integration of systems-thinking across all safety activities.

Our patient safety incident profile, and therefore our priorities for improvement and local investigations, are drawn from multiple sources.

Developing Our PSIRF Plan

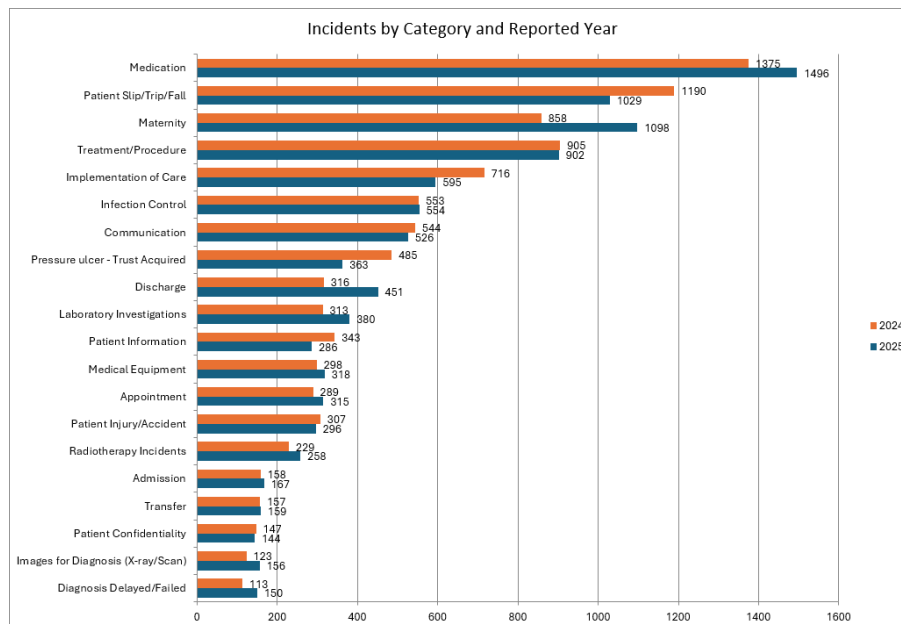
Weighted, Aggregated Data Analysis (April 2024 – March 2025)

Our patient safety priorities were informed by a weighted analysis of multiple evidence sources:

- 8,000+ reported incidents - capturing patterns of harm and contributory factors across services.
- 28 PSII commissioned investigations - providing deeper system-based learning.
- 11 inquests - offering independent scrutiny and external recommendations.
- 306 complaints - highlighting patient and family perspectives on safety and care experience.
- Learning from Death- themes were drawn from Structured Judgement Reviews.
- Risk register entries - consolidating known and emerging organisational vulnerabilities.

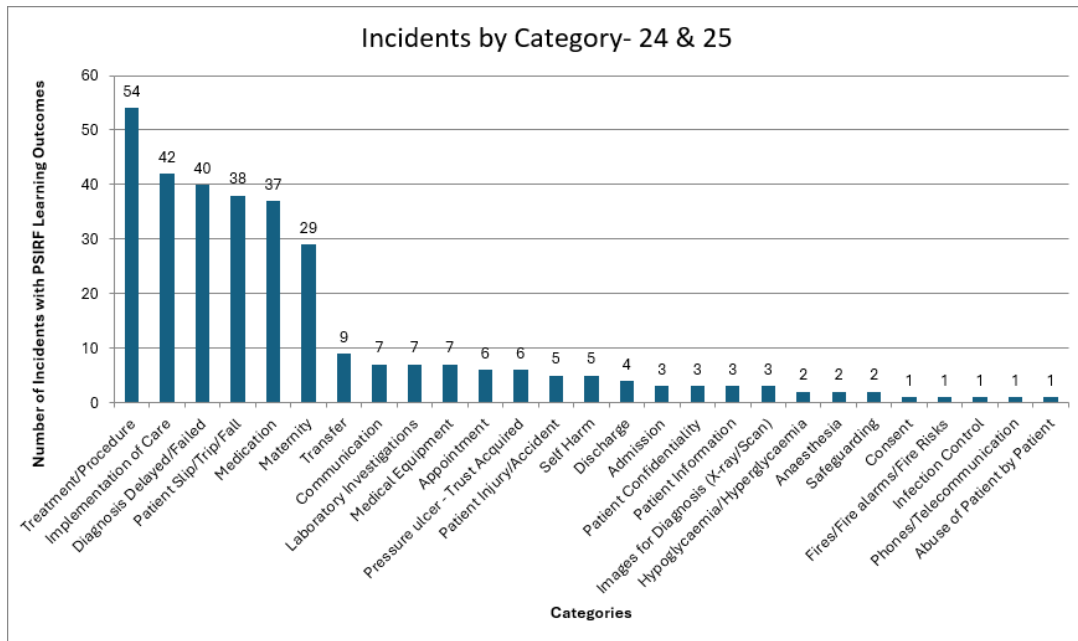
Data sources (April 2023 - March 2025)

Table 1. Incidents by Category



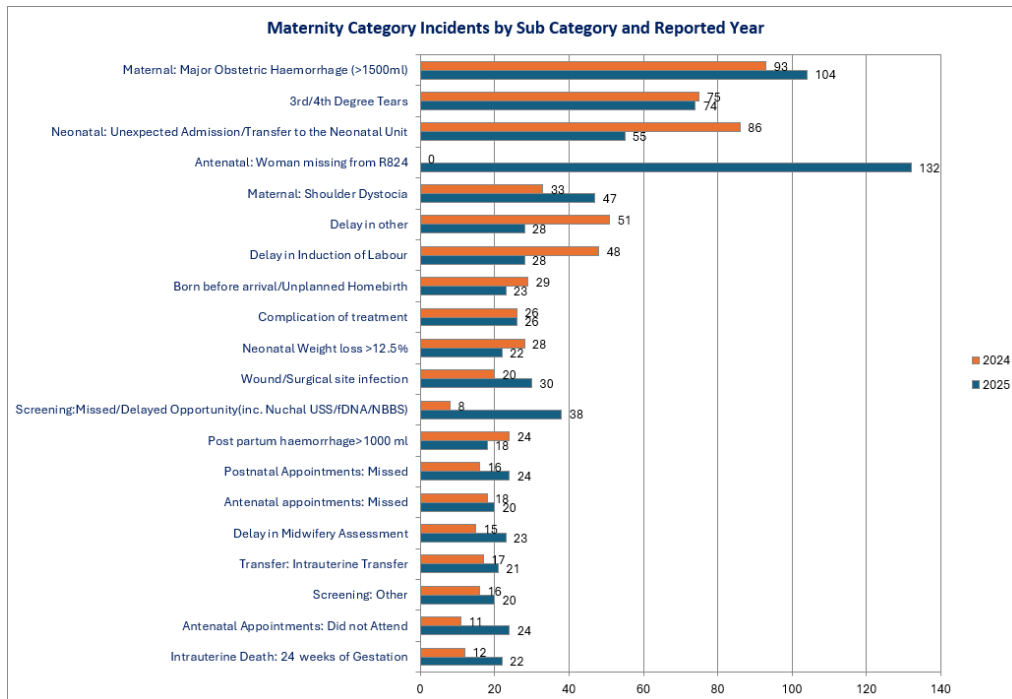
35914 incidents reported over 2 years were reported. Medication, patient falls, and maternity incidents remain the most frequently reported themes, showing consistently high volumes across both years. Several categories, particularly pressure ulcers, discharge, and diagnosis delays, show notable year-on-year increases, signalling areas where focused system-level improvement could have real impact.

Table 2. Number of Incidents with PSIRG outcomes



Learning from PSIRG, Treatment/procedure, implementation of care, diagnosis, patient falls, and medication incidents make up the top five themes, together representing the bulk of PSIRF learning outcomes. Their prominence shows that core clinical processes and decision-making remain the areas where the richest learning, and the greatest opportunities for system-level improvement, continue to emerge.

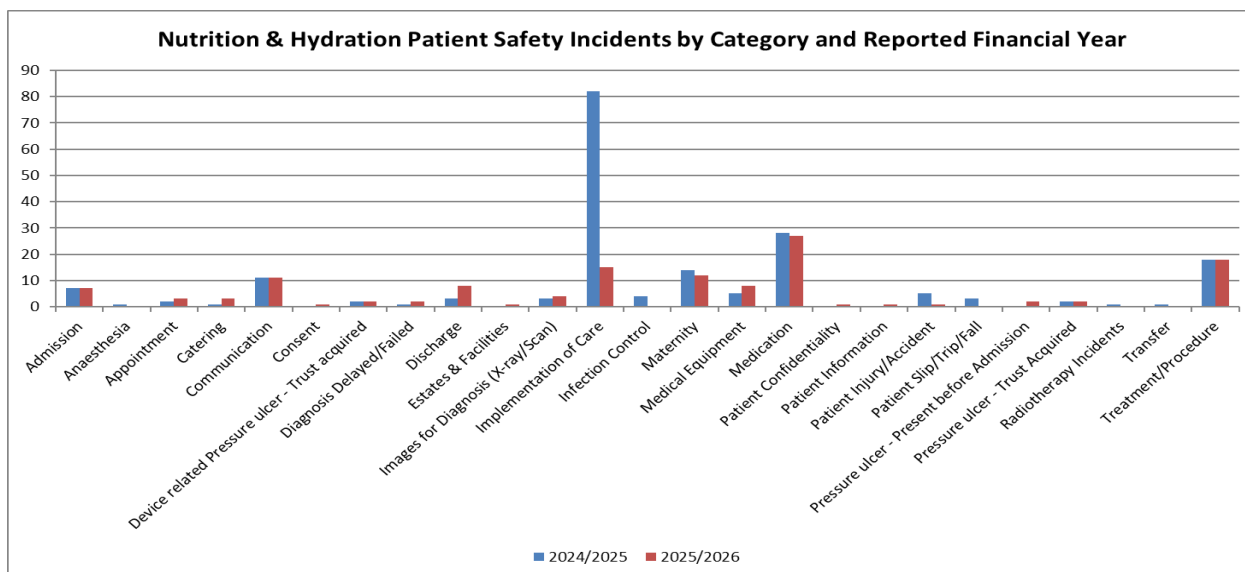
Table 3. Maternity Incidents



The top three themes, major obstetric haemorrhage, women missing from IR24, and unexpected neonatal admissions/transfers, account for the largest share of maternity-related

incidents. Together they highlight pressure points across acute maternal emergencies, antenatal safety processes, and early neonatal care where strengthened pathways could make a meaningful difference.

Table 4. Nutrition & Hydration Patient Safety Incidents.



Treatment/procedure, implementation of care, diagnosis delays/failures, and patient information/incidents make up the top five themes, with infection control dominating the overall profile. Together, these sources provide a balanced view of recurring risks, emerging challenges, and opportunities for improvement, ensuring our priorities are grounded in both data and lived experience. The themes were identified through a comprehensive review of data drawn from PSIRF incidents, complaints, PALS enquiries, Learning from Deaths findings, and system-level risk registers. Incident volumes, recurring patterns, and contributory factors were analysed to understand both frequency and impact across services. This was strengthened by targeted consultation with Care Group governance teams and subject matter experts, ensuring that the emerging themes reflected operational realities, clinical insight, and system-level risks. This triangulated approach ensured the final priorities were evidence-based, aligned with national PSIRF expectations, and grounded in the expertise of those closest to the work.

Based on this analysis, the Trust has identified the following priorities in table 5.

Table 5 - PSIRF Local Priorities

PSIRF Local priorities	Description of Priority
Management of Deteriorating Patients	Highest incident volume across treatment, diagnostics, and maternity. Reflects procedural variation and system gaps in monitoring and escalation.
Medicine Safety	High-risk, high-volume category aligned with national PSIRF priorities. Issues include prescribing, administration, and monitoring.
Discharges and Transfers of Care	Strong operational roots. Drives harm, complaints, and system pressure, especially in diagnostics, discharge, and treatment pathways.
Maternity Safety	The top themes for maternity are major obstetric haemorrhage, management of deterioration of the mother and new-born and perinatal mortality

Nutrition & Hydration Safety	Issues span NG tube safety, radiology delays, feed prescribing, equipment reliability, and stock management. High volume of near misses indicates significant latent risk
------------------------------	---

National Requirements for Patient Safety Incident Investigations

Certain incidents require nationally mandated responses (Table 6)

National criteria	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation	Safety Improvement actions or improvement Incorporate insight into ongoing improvement plans.
Death thought more likely than not due to problems in care (learning from deaths criteria)		
Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations (MNSI) programme criteria	Referred to MNSI for independent patient safety incident investigation	Incorporate insight into ongoing improvement plans. Develop safety actions or improvement to address new insight and/or emerging safety issues identified.
Child deaths	Refer for Child Death Overview Panel review. A Joint Agency Review (JAR) will be completed for all child deaths. A locally-led PSII (or other response) may be required alongside the panel review – based on discussion with the panel.	
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). A locally-led PSII (or other response) may be required alongside LeDeR review – based on discussion with the panel.	
Safeguarding incidents (as per PSIRF)	Refer to local authority safeguarding lead. The organisation will contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	
Incidents in NHS screening programmes	Refer to 'Managing Safety Incidents in NHS Screening Programmes' guidance . Refer to local screening quality assurance service for consideration of locally led learning response.	
Accidental or unintended exposure to ionising radiation	Refer to Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and reporting requirements.	

	Consider appropriate and proportionate local response.	
Haemovigilance (blood transfusion)	Refer to Serious Hazards of Transfusion (SHOT) guidance and reporting requirements. Consider appropriate and proportionate local response.	

Expected learning response and patient safety incident investigation

Any new incidents or events reported that do not fit into local or national priorities will be reviewed to understand whether they highlight any new issues that may not have already been identified.

Investigation and Learning Methodologies

- **PSII** for complex/systemic issues.
- **Rapid reviews** for urgent learning.
- **After Action Reviews** – reconcile work as done
- **Multidisciplinary reviews** for cross-service incidents.
- **Thematic analysis** for trends.

Improvement response

Where a safety issue is already well understood and improvement interventions are in place, resources will be directed toward strengthening those improvements rather than repeating learning responses. Compassionate engagement remains essential, but the emphasis will be on monitoring and sustaining effective change.

The Trust also recognises other important patient safety themes, aligned with established groups and programmes. Oversight of these activities will continue through the Patient Safety Committee.

Table 7: Other Safety Improvement Groups

Care Group/committee(s) with responsibility for improvement delivery	Patient safety theme(s)
Maternal and Neonatal Improvement Group	Maternal and Neonatal Safety
Hospital Transfusion Committee	Blood transfusion safety
Infection Prevention and Control Committee	Infection prevention and control
VTE Improvement Group	VTE prevention
End of Life Committee	Palliative and end of life care safety
Medical Exposure and Radiation Protection Committee	Radiation safety
Nutrition Steering Group	Nutrition and hydration safety
Medical Device Committee	Medical device safety
Estates development	Improving the safety of the physical estate

Patient safety incident response capacity (on 5-12- 2025)

Resources and Training

- NPSS training for staff.
- Access to investigation tools and templates.
- PSIRF Training for -:
 - Learning Response Leads
 - Engagement & Involvement Leads
 - Oversight Leads

Table 8: Learning Response Capacity

Role	Number*
Trained learning response leads	67
Trained patient safety incident investigation leads (clinicians with PA team)	7
Trained engagement leads	40
Trained oversight leads	40

Investigation and Learning Methodologies

The Trust will primarily use the following methodologies:

- Patient Safety Incident Investigations (PSII) for complex/systemic issues.
- Rapid Reviews for urgent learning.
- After Action Reviews to reconcile work as done.
- Multidisciplinary reviews for cross-service incidents.
- Thematic analysis for trends.

Alternative methodologies may be used if system-based and developed in liaison with the Patient Safety Team. Templates are available on Datix, and outputs must be recorded within the patient safety incident record.

Response selection principles

Selecting an appropriate and proportionate response requires careful consideration of several factors:

- Whether contributory factors are already understood, both generally for the type of incident and specifically for the circumstances of the event.
- The potential for new insight, such as emerging or escalating safety challenges.
- Alignment with local patient safety priorities.
- Whether improvement work is already underway to address contributory factors.
- Evidence that improvement work is achieving the intended effect.
- The views of those affected, including patients and families.
- Which type of learning response - or combination of methodologies - will provide the richest insight into underlying system factors.
- Available capacity to undertake a learning response versus capacity to implement improvement work.
- Any concern that health inequalities may be a contributory factor.

Collaborative working

Internal Collaboration

A systems approach to patient safety often reveals incidents involving multiple Care Groups or departments. Many patient pathways require collaboration across specialties to deliver high-quality care. Incidents involving non-patient owning services (e.g., diagnostics, theatres, or corporate teams) will also involve the Care Group responsible for the patient's care.

Collaboration between Care Groups or departments must ensure:

- A plan for compassionate engagement with all affected people.
- Agreement on a proportionate response based on contributory factors.
- Appointment of a single learning response lead and delivery of a unified collaborative learning response.

External collaboration across multiple providers

PSIRF encourages learning responses that span the wider system or patient pathway. Where incidents cross organisational boundaries, a single collaborative learning response should be commissioned, rather than siloed or disjointed work.

System vulnerabilities often occur at provider interfaces and may not be visible to individual organisations. Disjointed approaches also hinder compassionate engagement with patients and families.

Where incidents involve other providers:

- Collaborative learning should be considered.
- If not possible, the incident must be shared with the other provider(s), alongside details of compassionate engagement undertaken to date (including verbal duty of candour).
- Cross-system learning responses may be commissioned, generally managed by local Trusts to ensure involvement of affected people and service leads.
- For complex or multi-provider incidents, escalation to PSIRG may be required, with consideration for the BOB ICB to lead the response.

Governance and Review (see PSIRF policy)

Routine Oversight

- Daily review of incidents by the Patient Safety Team and departmental leads.
- Rapid Review Meetings led by the Patient Safety Team.
- Clinical and quality governance reviews.
- Care Group sign-off groups and management oversight.
- Trustwide oversight by the Patient Safety Incident Review Group (PSIRG).
- Patient Safety Committee and Quality Governance Committee.
- Annual review and refresh of priorities.

The following governance processes will be used to agree a proportionate response, allocate response resource and respond to significant emerging issues where this is the potential for significant new insight;

First line - Patient Safety Team/ Care Group Reviews

- Daily review of incidents recorded on Datix, supported by fact-finding.
- Agreement of compassionate engagement plans and proportionate responses.
- Appointment of learning response, engagement, and oversight leads.
- Escalation where:
 - Support is needed for compassionate engagement.
 - Determining the most proportionate response requires input (including possible PSII).
 - Collaboration across Care Groups, sites, or external providers is required.
 - Significant potential for new insight is identified

Second line - Trust Executive oversight

- Bi-weekly PSIRG Panel with Trust Executive input and Trustwide representation.
- Provides senior decision-making and oversight of escalated issues.
- Reviews events where:
 - A PSII is indicated by national requirements.
 - A PSII may be considered under local priorities.
 - Significant new insight or escalating risks are identified.
- Decisions include:
 - Agreement of compassionate engagement plans.
 - Commissioning of proportionate learning responses, including PSII.
 - Requests for Integrated Care Board-led cross-system learning responses.

Table 9: Learning Methodologies

Methodology	Timeframes	Patient safety incident response use	Types of Patient Safety Incidents this response might be appropriate for	Other uses
Patient safety incident investigation (PSII)	Not more than 6 months	For in-depth system-based investigations in line with; national priorities listed above local priorities where the incident is selected by the organisation for investigation. PSII's may incorporate other additional methodologies to support analysis.	Where a patient safety incident investigation is indicated.	Nil
After action review	28 days	A structured, facilitated, supportive discussion of an event to help understand how the design of the system contributed to an event outcome differing from what was expected and to identify areas for improvement.	Incidents within a defined team and relatively short time span (e.g. inpatient medication safety incident, safer procedures)	Learning from good care (appreciative enquiry)
Rapid Review	5 working days	Gather initial findings, immediate actions and learning to be shared	All incidents.	Learning from everyday work (safety II)
Walkthrough analysis		Process mapping work as done of a process or task.	Task or process related incidents or patient safety themes (e.g. referral management or medication administration)	Proactive risk identification
Multidisciplinary team (MDT) review	28 working days	Open MDT discussion regarding one or more patient safety incidents (or a theme). Involving multiple staff who have different perspectives on how the system functions in practice (work as done) to identify areas for improvement.	Any patient safety theme, including clusters of incidents, particularly where it is not possible to involve directly staff affected in an after-action review.	Proactive risk identification Learning from good care (appreciative enquiry) Learning from everyday work (safety II)
Thematic Review	Proportionate	Systematic review of multiple incidents relating to a theme.	Themed Review using SEIPS tool.	Nil

Table 10: Response flow chart by role

Response	Oversight Lead	Engagement Lead	Learning Response Lead	Oversight Lead	
PSIRF Learning Response identified	Agree an engagement plan, including appointing engagement lead if indicated.	Ensure people affected are supported Facilitate meaningful involvement	Lead patient safety incident investigations using PSIRF-aligned methods such as After-Action Reviews, Rapid Reviews, and thematic reviews. Engage with staff, patients, and families to ensure their voices are central to the learning process.	Ensure learning response reflects involvement of staff and patients affected. Ensure compassionate engagement has been carried out (Inc. statutory duty of candour steps where applicable)	Ensure statutory duty of candour steps (where applicable have been carried out). Debriefing and TRiM conversations for staff.
	Determine proportionate response, including appointing learning response lead.		Undertake system-based learning response Analyse and identify system Develop Recommendations.	Assess learning response to ensure meets requirements Develop and resource improvement interventions to address recommendations.	Monitor delivery and efficacy of improvement interventions
Improvement Response	Agree an action improvement plan, including appointing action completion lead if indicated.	Ensure action lead are aware and have agreed with the action.		Ensure development of improvement actions and signed off before presenting at PSIRG.	Monitor delivery and efficacy of ongoing improvement interventions

Patient safety incident response oversight

Roles and Responsibilities

- Executive Lead: Chief Nurse.
- Patient Safety Team: Coordination and oversight.
- Clinical Leads: Support investigations.
- Patient Safety Partners (PSPs): Co-design and review.

Oversight principles and systems as set out in the PSIRF Oversight responsibilities will be followed [B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf](#).

Oversight processes will focus on the spirit of PSIRF through;

1. **Improvement is the focus** - ensuring **improvement** work is underway for known safety challenges and risks.
2. Ensuring the processes for considering **proportionate responses** and engagement plans are effective.
3. **Blame restricts insight** - ensuring people affected by patient safety incidents are **compassionately engaged** and supported.
4. **Psychological Safety** - ensuring learning responses have been completed, have meaningfully involved people affected and are system based in both their findings and recommendations.
5. **Collaboration is key** on both insight and improvement activities
6. **Being curious** to understand the safety of the system through multiple sources and approaches.
7. Recording risks on the **risk register** for system vulnerabilities that cannot be addressed currently.

Table 11: Oversight Responsibilities

Response Type	Methodology	Incident response	Compassionate engagement	Oversight
Improvement response	n/a	<ul style="list-style-type: none"> - Confirmed contributory factors already understood and effective improvement plan in place. 	<ul style="list-style-type: none"> - Being open [and Duty of Candour where applicable] completed with people affected. - Support needs and questions proactively sought and resolved. 	<ul style="list-style-type: none"> - Plan for continuous monitoring of effectiveness of improvement plan in place. - Any obvious local safety actions implemented. - Processes to monitor effective selection of response, compassionate engagement, and effectiveness of improvement in place.
Learning response	Patient Safety Incident Investigation	<ul style="list-style-type: none"> - Learning response commissioned completed and system insight recorded. 	<ul style="list-style-type: none"> - Being open [and DoC where applicable] completed with people affected. - Support needs and questions proactively sought and resolved. - People affected actively engaged in the response. - System findings shared. - Collaboration with people affected on improvement ideas. 	<ul style="list-style-type: none"> - PSII report reviewed and signed off by Care Group Leadership and Executive Lead for Patient Safety to ensure responses are system based; compassionate engagement principles followed etc. - Insight and recommendations used to generate safety actions and/or inform wider improvement plans. - Monitoring of delivery and effectiveness of improvement plan by Patient Safety Committee.
	After Action Review			<ul style="list-style-type: none"> - Response reviewed by relevant oversight lead/governance meeting to ensure response was system based; compassionate engagement principles followed etc.
	Observational Study			<ul style="list-style-type: none"> - Insight used to generate local safety actions and/or inform wider improvement plans.
	Walkthrough Analysis			<ul style="list-style-type: none"> - Monitoring of delivery and effectiveness of improvement plan agreed.
	MDT Review			