Patient Safety Incident Response Framework (PSIRF) Policy

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Note: This policy has been written using the national standard NHS England template for use by the Independent Health Group.

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1.0 Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Independent Health Group's [IHG] approach to developing and maintaining 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 co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- 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.

1.1 Definitions

N.B The definitions noted below are defined by the national NHS definitions

Incident/Event	An unexpected or unintended occurrence that could have, or did, result in harm, loss, or damage to a patient, staff member, or visitor.
Patient Safety Incident Response Framework (PSIRF)	the NHS's approach for responding to patient safety incidents, with the primary goal of learning and improving patient safety through a system-based approach.
Patient Safety Incident Investigation (PSII)	A process used to thoroughly examine an incident or near-miss indicates significant Patient Safety risks and potential for new learning, focusing on improving systems and processes rather than blaming individuals. A PSII offers an in-depth review of a single Patient Safety Incident/Event or cluster of Incidents/Events to understand what happened and how. This replaces Root Cause Analysis (RCA) Investigations and reports.
No harm /Near miss event	A patient safety incident with the potential to cause harm but did not, either because it was prevented before it

	reached the patient (near miss) or because no discernible harm resulted from it reaching the patient (no harm). These incidents are critical for learning and improvement because they highlight risks and allow for prevention before a serious adverse event occurs
Harm	Any negative effect on a person, which can include physical or mental impairment
Low Harm/Impact	A patient safety incident where minimal harm occurred, requiring only a minor increase in treatment or observation, such as extra observation, a single GP visit, or short courses of oral medication
Moderate Harm/Impact	An incident that results in a moderate increase in treatment and causes significant but not permanent harm to a patient.
Severe Harm/Impact	An incident that results in permanent harm or long-term disability or requires an immediate life-saving clinical intervention. This includes events that lead to permanent changes in a patient's body or function, a reduction in life expectancy, or a long-term or permanent limitation of a patient's independence.
Death	The irreversible loss of the capacity for consciousness combined with the irreversible loss of the capacity to breathe
Learning From Deaths (LFD)	A clinical governance process that involves consistently reporting, reviewing, and investigating patient deaths to improve patient care and safety.
Learning from Lives and Deaths (LeDeR)	A national service improvement program that reviews the deaths of people with a learning disability and autistic people to identify how to improve health and social care.
Never Event (NE)	A serious, largely preventable patient safety incident that should not occur if existing national safety guidelines and recommendations are implemented.
Patient Safety Learning Response Toolkit	A set of tools and guides, based on the Patient Safety Incident Response Framework (PSIRF), that helps healthcare organizations understand and learn from patient safety incidents
Learning from Patient Safety Events (LFPSE)	The national service for recording and analysing patient safety events to improve patient care
Independent Investigation	A review commissioned to examine the care and treatment of an individual, often after a serious incident like a

	homicide or death conducted by a nominated individual or external organisation.
PSIRG	The Patient Safety Incident Review Group (PSIRG) is a multidisciplinary group commissioned to advise, review, and approve Patient Safety Investigations/Learning responses and event data. Trained in Learning response and Oversight.

2.0 Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement relating to the services provided by IHG. Please note this below list is not exhaustive, as IHG grows the list of services will increase, additional services will be included as and when the policy is updated.

- Cataract Surgery
- Hand Surgery
- Hernia Surgery
- Podiatric Surgery
- Vasectomy Surgery

All types of investigations e.g. HR, Legal, Complaints, Concerns, Professional Standards, Coronial Inquests, Safeguarding, Information Governance and Estates and Facilities will be investigated in line with PSIRF principles.

We are clear that patient safety event responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoid-ability or cause of death.

The following processes are outside of the scope of this policy: claims handling, human resources investigations, professional standards investigations, coronial inquests, and criminal investigations.

Patient Safety responses under this policy follow a systems-based approach. IHG recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

3.0 Our Patient Safety Culture

IHG has committed to embedding a “Just Culture” which promotes openness and learning, encouraging staff to feel confident to speak up.

IHG aims to work in collaboration with those affected by a patient safety event – patients, families, staff, 3rd party providers and carers to arrive at such learning and improvement within a learning culture.

We are clear that patient safety event responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoid-ability or cause of death.

To enhance our safety culture, safety discussions are carried out within the appropriate forum to ensure oversight and accountability.

We will utilise findings from our staff survey and provider feedback to assess if we are sustaining and improving our safety culture.

4.0 Patient Safety Partners

We understand the importance of the Patient Safety Partner (PSP) role; please refer to our Patient Safety Incident Review Plan (PSIRP).

A Patient Safety Partner (PSP) is actively involved in the design of safer healthcare at all levels within an organisation that includes roles in safety governance – e.g., sitting on relevant committees [Integrated Governance and Business Committee, and Clinical Review Meetings] to support compliance monitoring, and how safety issues should be addressed and providing appropriate challenge to ensure learning and change – and in the development and implementation of relevant strategy and policy. Framework for involving patients in patient safety (england.nhs.uk)

The Patient Safety Partner should ensure that any committee/group of which they are a member considers and prioritises the service user, patient, carer, and family perspective and champions a diversity of views.

IHG is committed to involving PSPs in patient safety and has developed processes to support quality PSP involvement including the following:

- Establishment of a working party to define the objectives and standards for involving PSPs

- A position description in line with the values of the organisations where “Patients always come first” and “Teamwork underpins all that we do” that includes:

  - Skills and experience required of a PSP
  - Understanding and demonstration of a broad interest in patient safety.
  - Ability to communicate well and understand read comprehensive reports.
  - Ability to understand and evaluate a range of information and evidence.
  - Confidence to communicate and advocate for patient safety.
  - Involvement in patient safety improvement projects
  - Involvement in staff patient safety training
  - Participation in investigation oversight groups

- IHG website used to recruit a diverse range of PSPs
- The PSP/s will comply with relevant IHG policies and maintain strict confidentiality in respect to discussions and information when required.
- Training Requirements of a PSP
  - Information Governance
  - Equality and Diversity
  - Safeguarding Children and Adults level 1

5.0 Addressing Health Inequalities

The NHS has a responsibility to address health inequalities by enhancing access to services and designing them to meet the diverse needs of local communities in an inclusive manner. IHG is dedicated to fulfilling its legal duties under the Equality Act (2010) and will use data proactively to identify and assess any disproportionate safety risks affecting patients across protected characteristics.

Through our learning responses, we aim to promote health equity, reduce disparities, and adopt a more adaptive approach to data usage, enabling us to better detect and respond to risks impacting patients with specific characteristics.

IHG also integrates considerations of inequality into its application of the Systems Engineering Initiative for Patient Safety (SEIPS) framework. We will ensure that staff are equipped with the necessary training and skills to support a systems-based approach, and that our engagement with patients, families, and carers is inclusive and reflective of the diverse populations we serve.

Health inequalities, along with equality, diversity, and inclusion, are embedded within our “People” portfolio, supported by population and patient safety data.

6.0 Patient Safety Incident Response Planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

6.1 Resources and Training to Support Patient Safety Incident Response

IHG continues to work in line with the PSIRF principles utilising the NHS England patient safety response standards (2022).

IHG has established governance processes to ensure that learning responses are not led by individuals directly involved in the patient safety incident or by those who manage them. Staff affected by such incidents are provided with appropriate leadership support and the necessary time to engage meaningfully in learning responses. All staff operate within the principles of a just and restorative culture, and where appropriate, draw on additional resources or external agencies to ensure dedicated support is available for effective engagement and involvement.

6.2 Our Patient Safety Incident Response Plan

Our plan sets out how the Independent Health Group intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

6.3 Reviewing Our Patient Safety Incident Response Policy and Plan

Our Patient Safety Incident Response Plan is a dynamic, evolving document that will be regularly updated as we apply it in practice. As our patient safety incident profile evolves through ongoing improvement efforts, this review process will also serve as an opportunity to re-engage stakeholders—allowing us to reflect on and agree upon any changes made during the previous review period.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII)

reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

7.0 Responding to Patient Safety Incidents

7.1 Patient Safety Incident Reporting Arrangements

IHG staff have access to the organisation's incident reporting system, Radar, which enables the reporting of patient safety incidents and automatically alerts incident response leads to initiate timely action. With the integration of the Learn from Patient Safety Events (LFPSE) service, these reports will be submitted to the NHS England system to contribute to national learning.

Potential patient safety incidents are reviewed and triaged daily by dedicated teams within each service, with appropriate cases escalated for further response. Emerging issues are discussed during weekly incident review meetings, where trends across incidents, complaints, and risks are monitored and addressed.

Incident reporting will continue in accordance with IHG's existing policy on incident investigation. Our approach to responding to incidents prioritises learning and improvement, rather than relying solely on predefined harm categories. We assess incidents in context, considering the specific populations affected, rather than limiting our focus to those that meet nationally defined thresholds.

In line with the PSIRF Guide to Responding Proportionately to Patient Safety Incidents, IHG complies with nationally mandated responses for specific event categories. The plan outlines whether a mandated response should be a Patient Safety Incident Investigation (PSII) or another appropriate response type. Incidents classified as Never Events and patient deaths require a locally led PSII. The resources allocated to support these investigations are informed by trends from previous years.

7.2 Patient Safety Incident Response Decision-Making

Through its PSIRF policy and plans, our services will have arrangements to meet the requirement to review patient safety incidents under PSIRF, ensuring those that require a mandated/recommended response are reported and investigated as required.

As detailed in our Governance Policy, incidents of note (themes and learning) are shared monthly with the senior leadership and upwards to the board.

Method for agreeing a proportionate response will be discussed and agreed at the weekly incident review meeting. IHG has a robust escalation process which details action to be taken in the case of an event requiring action outside the meeting schedule.

IHG will continually develop a range of response mechanisms to balance the efforts between learning and exploring emerging issues alongside ongoing improvement work.

7.2.1 Types of Proportionate Response Methods

Response Type	Rationale for response
Swarm Huddle	A rapid, post-incident analysis by a multi-disciplinary team (MDT) of healthcare staff to quickly identify learning from a patient safety incident
PSII	A process used to thoroughly examine an incident or near-miss indicates significant Patient Safety risks and potential for new learning, focusing on improving systems and processes rather than blaming individuals.
Early Case Review (ECR)	An ECR review for incidents where the causation factors are easily understood allows us to use a standardised approach to identify the level of potential harm that may have been caused.
After Action Review (AAR)	A structured, facilitated group discussion held after an event to learn from it and improve future performance.
System Engineering Initiative for Patient Safety (SEIPS)	SEIPS focusses on interactions rather than simple linear cause and effect relationships. This response examines the different work system components and their interactions focussing on system issues not individuals. *This model should be used in conjunction with any of the responses noted above.*

7.3 Responding to Cross-System Incidents/Issues

Each time an investigation is initiated, IHG considers whether it involves multiple systems. If a cross-system incident is identified, a lead investigator or their deputy is appointed to coordinate with all relevant organisations, ensuring that the patient and their family receive consistent, unified communication throughout the investigation and action planning process.

When multiple organisations are involved in a single learning response, leadership is assigned to the organisation best positioned to investigate the concerns. This decision is based on factors such as capability, capacity, and organisational remit.

In more complex investigations, commissioners may be invited to act as facilitators. IHG is committed to actively engaging with partner organisations that were involved in the care of the patient(s) where that care may have contributed to the incident. We

work collaboratively across organisational boundaries to support a shared learning response.

7.4 Timeframes for Learning Responses

Learning responses need to balance the need for timeliness with thoroughness and a sufficient level of investigation to identify the key themes and learning for service improvement. We will seek to complete learning responses within one to three months and/or no longer than six months. In exceptional circumstances there maybe occasions where a longer timeframe for completion is required. On these occasions extended timeframes will be agreed in conjunction with all parties at the time of the investigation

7.5 Safety Action Development and Monitoring Improvement

Safety actions will be developed to address areas of improvement arising from learning responses where it is meaningful to do so; these will be developed with relevant stakeholders, including those responsible for implementation.

7.6 Safety Improvement Plans

All learning reviews and outcomes will be reviewed in conjunction with quality improvement workstreams. Consideration is given to any on-going work or if there is a need for a standalone improvement action.

Improvement plans will contain.

- Data analysis of trends and themes
- Review of outputs from learning responses to single incidents, when it is felt that they may contribute to the learning of identified themes, or lead to the identification of a new, emergent theme.

8.0 Oversight Roles and Responsibilities

Role	Responsibility
Chief Executive Officer	- Overall responsibility for the effective management of all patient safety incidents, including contribution to cross-system/multi-agency reviewed and/or investigations where required. - Alongside the executive and non-executive team, model behaviours that support the development of patient safety reporting, learning and improvement systems. - Ensures that systems and processes are adequately resourced including funding, management time, equipment, and training.
Medical Director	- Responsible Officer and Caldicott Guardian for IHG

	- Oversees the integration of learning from incidents into clinical practice and service design. - Supports a culture of openness, learning, and psychological safety for staff involved in incidents.
Chief Nurse	- Acts as the executive lead for patient safety incident response across the organisation. - Ensures PSIRF implementation aligns with clinical governance and quality improvement strategies - Provides executive nursing leadership for PSIRF implementation and delivery. - Ensures nursing and midwifery perspectives are embedded in incident response and learning. - Promotes staff wellbeing and supports those affected by incidents. - Leads on embedding learning into nursing practice and education. - Supports development of compassionate engagement with patients, families, and staff. - Oversees quality assurance of incident reviews involving nursing care.
Head of Quality and Governance	Acts as organisational investigation lead, nominated Patient Safety Specialist and is responsible for supporting and overseeing the implementation, management and embedding of the Patient Safety Incident Response Framework (PSIRF) which includes but not limited to the following; - Ensuring processes are in place to support an appropriate response to patient safety incidents (including contribution to cross-system/multi-agency reviews and/or investigation where required) - Oversees development and review of IHGs PSIRP. - Agrees sufficient resources to support the delivery of the PSIRP (including support for those affected, such as named contacts for staff, patients, families, and carers where required) - Ensures IHG complies with the national patient safety investigation standards. - Establishes procedures for agreeing patient safety investigation reports in line with the national patient safety investigation standards. - Develop professional development plans to ensure that staff have the training, skills, and experience relevant to their roles in patient safety incident management.

	- Ensures that patient safety investigations are undertaken for all incidents that require this level of response. - Develop and maintain local risk management systems and relevant incident reporting systems to support the recording and sharing of patient safety incidents and monitoring of incident response processes. - Established procedures to monitor/ review investigation progress and the delivery of improvements. - Work with executive lead to address identified weaknesses/areas for improvement in the IHGs response to patient safety incidents including gaps in resource including skills and training. - Supports and advises staff involved in the patient safety incident response.
Matrons	- Act as visible leaders supporting PSIRF delivery at site level. - Promote a culture of safety, openness, and learning within clinical teams. - Support staff involved in incidents and facilitate local learning and improvement. - Participate in or support incident reviews relevant to their areas. - Communicate learning outcomes to frontline teams and ensure changes are embedded. - Champion patient and family involvement in incident response.
Site Seniors	- Conduct proportionate responses as defined through the incident management process - Support staff in understanding and applying the policy. - Ensure any learning is embedded and shared
External	- Integrated Care Boards – IHG Learning profile and Quality workstreams to be included in Quarterly updates and Contract review meetings - All Nationally reportable patient safety events will be cascaded via ICB and CQC

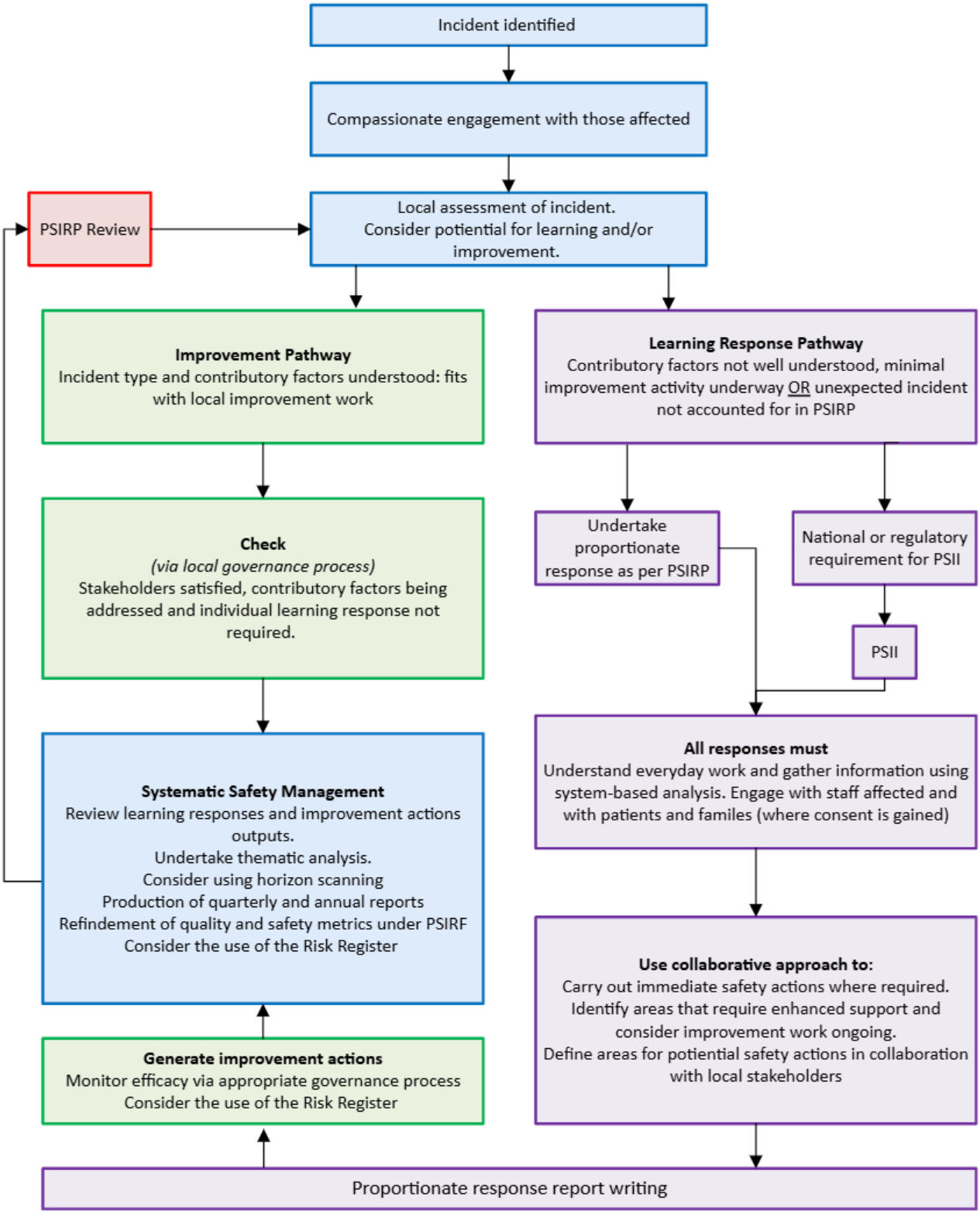
9.0 Complaints and Appeals

The IHG Feedback Policy sets out how we manage, respond to and learn from complaints made about our services. We are committed to providing high quality services and will strive to ensure that all compliments, concerns and complaints are addressed, resolved and shared as quickly as possible. Any concerns not addressed

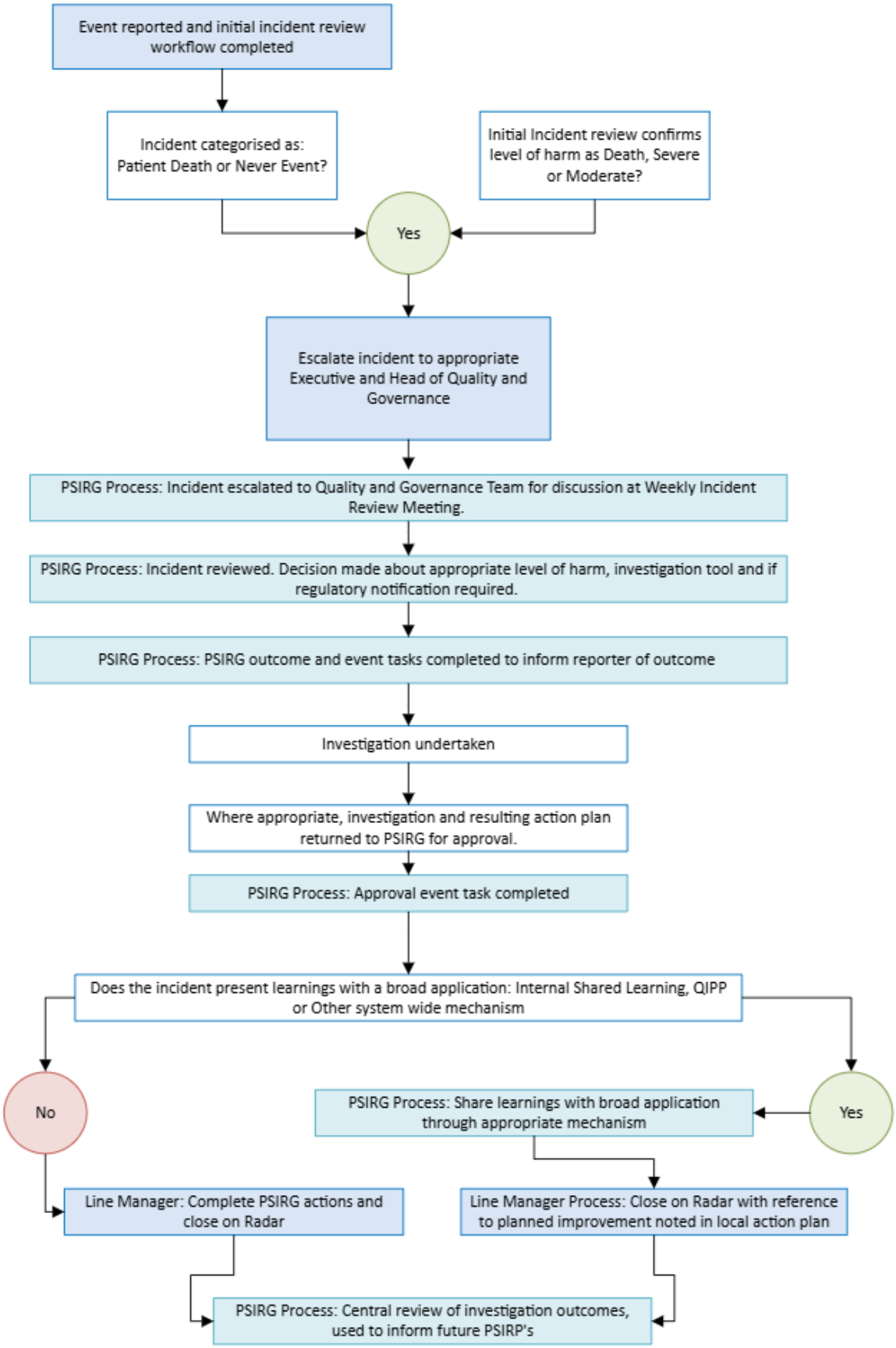
as part of a PSIRF response should be raised through our concerns/complaints process.

10.0 Appendixes

10.1 Appendix 1 – Incident Learning Review Process



10.2 Appendix 2 – PSIRG Process



10.3 Appendix 3 – Four Steps of Engagement

Before Contact	Initial Contact	Continued Contact (as per agreed frequency)	Closing Contact
• **Identify contact** Patient, family member or advocate • **Assess inclusivity needs** Additional communication or inclusivity needs • **Assess potential support needs for patient/ family/staff** (emotional, practical, information and psychological) e.g. family, advocacy, specialist support organisations (bereavement support etc.) For staff, including manager, management, supervision, Employee Assist • **Ensure familiarity with the incident Facts** to date, who you are talking about and to • **Assess potential for parallel response and prepare guidance** e.g. complaint process, Coroner's inquest	• **Provide a clear introduction** Who you are: name, role, engagement role • **Offer a meaningful apology** For the circumstances/ incident, noting duty of candour requirements (statutory and professional) • **Identify key point of contact** You or someone else • **Explore patient/family/staff support needs** • **Discuss the incident** What has happened, in plain language • **Explain what happens next** Immediate action taken, review of circumstances, planned investigation • **Address questions** • **Schedule or discuss next contact** When and how you/key point of contact will next be in touch	• **Agree timeframe** for responding to questions • **Revisit support needs** • **Check for additional questions** Clarify and signpost, where not in scope • **Share experience of the incident** Empathetic, compassionate conversation - how would you? ✓ Be clear how will be recorded/used ✓ Relaxed setting (away from work/incident environment) ✓ Thank patient/family/staff member for sharing their experience – acknowledge difficulty of doing so and value of contribution • **24–48-hour check** - is any additional support required?	• **Address questions** • **Reiterate meaningful apology** • **Final contact** (formal end) • **Ongoing support** Review support already signposted to and consider any additional support needs

	For Investigations	For Investigations	For Investigations
	• **Confirm involvement preferences** Timing and structure of investigation, engagement and input, preferred contact method (including for investigation process leaflet), dates to avoid, potential disruption (planned leave etc.) Respective input deadlines and involvement preferences for terms of reference, information gathering, draft and final report	• **Define/discuss terms of reference** Scope of investigation and discussion around report format • **Agree timeframe for completion of investigation** • **Revisit involvement preferences** • **Discuss report preferences** Including personalisation • **Share the draft report** Attempt verbal discussion prior to sending and arrange a time to discuss.	• **Final report** Give advance notice; offer face-to-face discussion, ask if they would like someone with them • **Discuss any further investigations** Complaints, Coroner's inquest etc. • **Opportunities for further involvement** Patient participation groups etc
Complete	Complete	Complete	Complete