Patient Safety Incident Response Framework Policy: Including the Incident Reporting Policy

April 2026

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Document Control

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Version	Version 1
Status	Approved
Approved by	Quality and Risk Group
Approval date	17th May 2026
Ratified by	QRG
Ratification date	17th May 2026
Issue date	May 2026
Next review date	May 2029
Target audience	All BPAS employees
Related policies	PSIRF Plan Complaints Policy Disciplinary Policy Medicines Management Policy Health and Safety Policy Freedom to Speak Up Policy PMA policy Safeguarding Policies Duty of Candour Policy

Version History

Version	Date	Author	Status	Notes / Comments
V1.0	April 2026	Lisa Aguado		This policy supersedes the previous PSIRF policy. Includes pathways and processes for PSIRF activity. Job titles changes for key stakeholders. Addition of incident reporting section.

Version	Date	Review Due	Document Owner
V1	April 2026	April 2029	Patient Safety and Risk Lead

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PART ONE – PSIRF POLICY

1. Introduction

Policy Statement and Introduction

BPAS is committed to providing safe, effective and compassionate care. We aim to create an environment in which patients, staff and visitors feel supported, respected and protected from harm.

We recognise that healthcare is complex, and that despite best efforts, incidents can occur. When they do, it is essential that we respond in a way that is open, fair and focused on learning. BPAS is committed to ensuring that incidents are identified, reported and managed consistently, with the aim of understanding what happened, why it happened, and how we can reduce the risk of recurrence.

BPAS is committed to fostering a strong learning culture that supports compassionate engagement with those affected by incidents, including patients, families and staff. We recognise the importance of listening to people's experiences, involving them meaningfully in the response, and providing appropriate support throughout.

Our approach is grounded in system-based thinking, including human factors principles, to understand how incidents occur within the wider context of care delivery. Incidents are rarely the result of a single action and are more often linked to a combination of interacting factors. A structured and proportionate approach to incident response enables focused improvement activities.

BPAS is committed to ensuring that insights from incidents are disseminated in a timely and meaningful way across the organisation. We also recognise that patient safety is strengthened

through collaboration, and we will work with commissioners, partner organisations and the wider healthcare system to share learning and contribute to system-wide improvement.

A culture of openness and psychological safety is central to this approach. BPAS promotes a just culture, where staff feel confident to report incidents, near misses and concerns without fear of blame, and where supportive oversight is focused on strengthening systems, rather than attributing fault.

As a provider of NHS-funded services, BPAS is committed to ensuring that incidents are managed effectively, transparently and in line with regulatory expectations. This includes safeguarding those who use our services and those who work within them, meeting reporting requirements, and sharing learning both within the organisation and, where appropriate, across the wider healthcare system.

This policy aligns with the NHS England Patient Safety Incident Response Framework (PSIRF), and supports BPAS in embedding a consistent, compassionate, system-focused and improvement-driven approach to patient safety.

2. Purpose

This policy sets out how the organisation will meet the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF). It establishes the systems and processes for responding to patient safety incidents in a way that supports learning and improvement.

In line with PSIRF, this policy promotes a coordinated, multidisciplinary and data-informed approach to incident response. It positions patient safety within a wider system of continuous improvement and supports a proactive and systematic approach to safety management.

This policy supports the development and maintenance of an effective patient safety incident response system that:

- Ensures compassionate engagement with, and involvement of, patients, families and staff affected by patient safety incidents
- Applies system-based approaches, including human factors and ergonomics, to learning from incidents
- Delivers proportionate and considered responses to patient safety incidents and safety concerns
- Provides supportive oversight to strengthen system effectiveness and drive improvement

This policy should be read in conjunction with the Patient Safety Incident Response Plan, which sets out how these principles will be implemented in practice.

3. Scope

This policy applies to all individuals working within or on behalf of BPAS, including permanent employees, temporary staff, bank workers, agency personnel, contractors and volunteers. Where individuals are not directly employed by BPAS, relevant local management and escalation arrangements will apply in line with their employing organisation.

The policy covers the management and response to patient safety incidents across all BPAS services. It applies to incidents arising from both clinical and non-clinical activities where there is an opportunity to identify learning and improve safety.

The primary focus of this policy is to support learning and improvement. Incident responses undertaken under this framework are designed to understand how and why events occur, identify contributory factors, and inform actions that reduce the risk of recurrence. They are not intended to attribute blame or determine liability.

Where other processes are required to address specific concerns, such as employment matters, professional conduct issues, claims management or criminal investigations, these will be managed through separate procedures. While these processes may run alongside patient safety incident responses, they operate with different purposes and are not governed by this policy.

4. Objectives

- This policy provides clear, consistent and effective arrangements for the identification, reporting, review and management of patient safety incidents, and supports the implementation and delivery of the BPAS Patient Safety Incident Response Plan (PSIRP).
- The policy promotes a just culture in which colleagues feel safe to report incidents, near misses and concerns.
- The policy ensures that BPAS meets its statutory and regulatory requirements and that the effectiveness of learning responses and improvement actions is monitored to support continuous improvement in patient safety.

5. Definitions of Terms

These are contained within the Supporting Information Section of this policy.

6. Roles and Responsibilities

Although certain roles carry defined patient safety responsibilities, patient safety is everyone's responsibility. All staff are accountable for working in a way that promotes safe care, prevents harm, and supports continuous improvement.

Executive Leadership

Chief Executive Officer (CEO)

The Chief Executive Officer holds overall accountability for patient safety, quality and risk management within BPAS. This includes ensuring that effective systems and processes are in place for the identification, reporting, management and learning from patient safety incidents.

The CEO is responsible for ensuring that BPAS meets its statutory and regulatory obligations, and that a culture of openness, learning and continuous improvement is embedded across the organisation.

Chief Nursing and Midwifery Officer

The Chief Nursing and Midwifery Officer holds executive leadership responsibility for patient safety, quality and clinical governance within BPAS.

This includes:

- Providing strategic and supportive oversight of patient safety systems and processes
- Ensuring that learning from incidents is translated into improvements in practice
- Supporting the development of a compassionate, just and learning culture
- Ensuring appropriate oversight of patient safety incident responses and investigations

Chief Medical Officer

The Chief Medical Officer provides medical leadership and oversight in relation to patient safety incidents. They are responsible for ensuring appropriate medical input into incident assessment, investigation and learning, particularly in relation to incidents involving clinical decision-making and treatment.

The CMO works collaboratively with the Chief Nursing and Midwifery Officer to ensure robust clinical governance, effective learning, and safe clinical practice across BPAS services.

Other roles and responsibilities

The executive leads for patient safety are supported by other executive colleagues and the Board of Trustees.

Operational oversight and response to patient safety events are co-ordinated by the BPAS Quality and Patient Safety Team with structured and purposeful engagement in identifying stakeholders, involving patients and staff and managing the conduct, delivery and assurance of improvements arising from learning responses.

7. Governance Meetings and Oversight Structure

BPAS has a structured governance framework to support the oversight, review and learning from patient safety incidents which aligns with the Patient Safety Incident Response Framework (PSIRF).

The framework operates at different levels of the organisation to provide coordinated oversight, escalation, assurance and learning.

Divisional Patient Safety Huddles

Divisional Patient Safety Huddles provide local, multidisciplinary oversight of patient safety events, complaints and clinical complications within each division. They support the timely review of incidents and ensure that learning and improvement are identified and embedded at a local level.

The huddles review incidents at a divisional level, considering both individual cases and themes to identify patterns, contributory factors and emerging risks. They also scrutinise the quality and accuracy of incident data, including categorisation and level of harm, and support proportionate and timely learning responses such as Local Learning Reviews and SWARMs.

Learning is disseminated through services, with a focus on ensuring that improvement actions are implemented and embedded in practice. The huddles also consider Duty of Candour and regulatory reporting requirements and identify incidents that meet the threshold for escalation to WPSM (Weekly Patient Safety Meeting), as per the PSIRF Plan which is a key document to be utilised alongside this policy. In addition, CQC notifications to be highlighted for submission.

Divisional Patient Safety Huddles are co-ordinated by members of the Quality & Patient Safety Team.

Weekly Patient Safety Meeting (WPSM)

The Weekly Patient Safety Meeting provides multidisciplinary and organisational oversight of patient safety incidents which are escalated from Divisional Patient Safety Huddles. It applies systems-based, proportionate decision-making and considers statutory Duty of Candour

requirements, alongside identifying any immediate safety actions required and determining the appropriate learning response, and is a point of escalation for ongoing learning responses.

WPSM also provides assurance on compliance with PSIRF and organisational expectations, and reviews organisational patient safety data and trends through the triangulation of data from complaints and legal notifications/claims.

WPSM is chaired at executive level and brings together senior clinical, operational and governance leaders to ensure consistency, oversight and alignment with organisational safety priorities and emerging themes.

Learning Response Review Group (LRRG)

The Learning Response Review Group (LRRG) evaluates completed PSII prior to closure, assessing the quality of investigations using a structured approach, including the HSIB Learning Response Tool.

LRRG provides constructive feedback and may request further work where required prior to approval. It also confirms that improvement actions are clear, proportionate, and have defined ownership and timescales, and ensures that patients, families and staff have been appropriately involved and supported.

Escalation and Flow of Information

Organisational oversight and assurance are provided through the Quality and Risk Group (QRG), which reviews patient safety activity, learning and emerging risks, and provides scrutiny to ensure that improvements are implemented and sustained. The QRG reports into the Clinical Governance Committee, ensuring that patient safety risks and learning are escalated appropriately and receive Board-level visibility.

This governance structure ensures that learning is identified and acted upon at the most appropriate level, risks are escalated effectively, and that there is consistency, transparency and organisational assurance in the management of patient safety incidents.

Patient Safety Incident Response Plan (PSIRP)

The Patient Safety Incident Response Plan (PSIRP) sets out how BPAS will approach the management of patient safety incidents, including the identification of local and national priorities for learning and improvement. It operates alongside and is supported by this policy, providing the detailed framework for incident response.

The PSIRP is a dynamic document and is subject to regular review to ensure it remains effective and responsive to organisational and system needs. As a minimum, it will be reviewed every two years, with input from both internal teams and external stakeholders. This process enables reflection on learning, consideration of emerging risks and agreement of any required updates. Revised versions will be made publicly available.

In addition, a more comprehensive review of the PSIRP will be undertaken at least every four years, or sooner where required in agreement with the relevant Integrated Care Board (ICB). This review will take a broader, strategic view of patient safety activity and organisational learning.

This includes:

- Reviewing organisational capacity to undertake learning responses
- Mapping services and areas of risk
- Analysing a wide range of data sources, such as incident investigations, improvement plans, complaints, claims, staff feedback and inequality data
- Engaging with stakeholders to inform future priorities and ensure alignment with wider system expectations

This approach ensures that BPAS maintains a balanced and effective focus on both learning and improvement.

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V1	April 2026	April 2029	Patient Safety and Risk Lead

PART TWO – INCIDENT MANAGEMENT

8. Incident Reporting Procedures

Reporting an Incident

Patient safety incidents may be identified through a variety of sources, including patients, visitors or staff and external notifications. All colleagues have a responsibility to recognise and respond appropriately when an incident or potential safety concern arises.

All incidents must be reported on the InSight system which is accessed via single sign-on. All incidents should be reported as soon as possible, ideally within 24 hours. For support with using InSight please refer to information on the BPAS Intranet.

Automated notifications are issued from Insight to relevant individuals responsible for oversight and management of the incident, based on its nature and categorisation.

9. Management and Actions Following an Incident

Immediate Actions Following an Incident

When a patient safety incident is identified, immediate and proportionate action should be taken to ensure the safety of patients, staff and others, and to minimise the risk of further harm. Steps should be taken to make the environment safe and to prevent further risk or recurrence, including securing or isolating any equipment or items involved where appropriate.

Those affected by the incident, including patients and those close to them, should be provided with appropriate support, and relevant senior staff should be informed in a timely manner to ensure oversight and coordination of the response. At the same time, key information should be preserved to support subsequent review and learning, and accurate records of the incident and actions taken should be documented in the patient's clinical record where appropriate. The incident must also be reported promptly through the organisation's incident reporting system.

Detailed guidance on immediate actions, including role-specific responsibilities, is provided within the Supporting Information Section of this policy. Supporting information is also provided to support staff managing concerns about colleagues as a result of a patient safety incident review.

Incident Triage and Determination of Learning Response

All incidents will be reviewed through the Divisional Patient Safety Huddles for discussion and identification of any escalation requirements. Where an incident meets the criteria for a formal learning response, this will be escalated to the Weekly Patient Safety Meeting (WPSM), which is responsible for determining the appropriate learning response in line with PSIRF principles.

Assessment of Harm

An initial assessment of the level of harm is essential to support effective patient safety management and learning and to ensure appropriate actions are taken in line with statutory requirements, including Duty of Candour and any external reporting obligations.

Definitions to support this discussion are outlined in the Supporting Information section.

10. Duty of Candour

Duty of Candour will be applied in line with regulatory requirements and organisational policy. This includes:

- Providing a clear explanation of what is known about the incident at the time
- Offering a sincere apology
- Keeping patients and families informed as further information becomes available
- Providing appropriate support throughout the process

Duty of Candour will be considered as part of the incident review and governance process, including discussion at Divisional Patient Safety Huddles and, where appropriate, escalation to the Weekly Patient Safety Meeting.

Please see Supporting Information for further information.

11. Compassionate Engagement

Compassionate Engagement and Support for Patients and Their Families

Engagement should begin as early as possible following an incident and continue throughout the response and learning process. This includes:

- Providing clear and accessible information about the incident and the actions being taken
- Offering opportunities for patients and families to ask questions and share their experiences
- Involving patients, families and carers, where appropriate, in learning responses

Where incidents involve shared care or cross-organisational boundaries, BPAS will work openly and constructively with other providers and system partners to ensure a coordinated approach to communication, investigation and learning.

Supporting Colleagues Involved in Incidents

BPAS recognises that being involved in, witnessing, or responding to a patient safety incident can be a difficult and distressing experience for colleagues. This may include those directly involved in the event, those who witness it, and those participating in the subsequent review or learning response.

Colleagues will be offered appropriate support following an incident, which may include:

- Support and guidance from their line manager or another appropriate person
- Clear information about the incident response process and what to expect
- Opportunities to reflect and contribute to the learning response in a supportive environment, including access to Professional Midwifery or Nurse Advocacy services
- Access to wellbeing support, including employee assistance services or occupational health where appropriate
- Ongoing communication and updates regarding the progress and outcomes of any review or investigation

BPAS is committed to creating an environment where colleagues feel safe to speak up, share concerns and contribute to learning. Supporting staff effectively is essential to maintaining a positive safety culture and ensuring meaningful improvement.

12. Learning From Patient Safety Incidents

Local Learning and Improvement

Local learning is a key component of the organisation's approach to patient safety, supporting the timely identification of risks, sharing of insight and implementation of improvements. This includes learning from incidents, near misses, patient feedback and emerging trends.

Learning at a local level may take a range of forms, including team discussions, multidisciplinary reviews and Local Learning Reviews. These approaches enable teams to understand what has happened, identify contributory factors and take appropriate action to improve practice.

Mechanisms are in place to support the dissemination of learning across divisions and at organisational level, enabling wider improvements in patient safety and quality of care.

Response to Incidents Requiring Formal Learning

Where an incident results in, or has the potential to result in, moderate harm, severe harm or death, it will be subject to consideration through the established governance framework detailed in Part 1.

In line with the Patient Safety Incident Response Framework (PSIRF), BPAS does not determine its response based on harm alone. While harm remains an important consideration, decisions are informed by the complexity of the incident, the level of uncertainty and the potential for meaningful learning and improvement.

Where a full Patient Safety Incident Investigation (PSII) is required, this will be initiated as soon as practicable. Investigations will be undertaken in a timely manner, recognising that extensions may be necessary to ensure a thorough and meaningful review, particularly where patients, families or staff require additional support or engagement. Within the Supporting Information section there is guidance on the expectations of timeframes for the completion of learning responses to support timely learning.

Appropriate individuals will be identified to lead and contribute to learning responses, ensuring that reviews are undertaken by those with the relevant training, expertise and independence.

Throughout the process, patients, families and staff will be supported and, where appropriate, involved in the learning response. Duty of Candour and any required external notifications will be undertaken in line with regulatory requirements and organisational policy.

13. PSIRF Toolkit and Learning Responses

BPAS has developed a Patient Safety Incident Response Framework (PSIRF) Toolkit to support the consistent and effective application of learning responses across the organisation, this is available on the intranet. The toolkit provides practical guidance, templates and resources to support colleagues in undertaking proportionate and high-quality learning from patient safety incidents. This toolkit is to be used by colleagues leading and contributing to learning responses.

The toolkit outlines the range of learning responses available within BPAS, ensuring that responses are tailored to the nature, complexity and learning potential of each incident. These include:

- Local Learning Reviews: structured, proportionate reviews undertaken at a service level to support timely learning and improvement
- SWARM: rapid, multidisciplinary discussions to explore incidents, understand contributory factors and identify immediate learning
- Multidisciplinary Reviews: collaborative reviews involving relevant teams or services, particularly where care spans organisational or professional boundaries
- After Action Reviews: structured team-based reflections to understand what happened, why, and what can be improved
- Patient Safety Incident Investigations: in-depth, systems-based investigations undertaken where incidents are complex or where there is significant potential for learning
- Thematic reviews: Reviews of a set of incidents to identify key learning points across these

14. Learning Response and Investigation Teams

Those leading and contributing to learning responses will be trained in systems-based approaches to investigation, including human factors and systems thinking.

The composition of the learning response team will be proportionate to the nature and complexity of the incident. This will include involvement of relevant clinical or subject matter expertise, for example medical, nursing, midwifery or other specialist roles.

Investigators will engage with stakeholders to ensure that all relevant information is considered in the preparation of Terms of Reference. Those directly involved in the incident will not lead the review, and any real or perceived conflicts of interest will be considered.

15. Approval and Assurance of Learning Responses

All formal learning responses, including Patient Safety Incident Investigations (PSIIs), will be subject to review and assurance through the Learning Response Review Group (LRRG) or the Quality and Risk Group (QRG). Learning responses will be reviewed against an evidence-based tool which can be accessed within the Supporting Information section of this policy.

Safety Action Development and Monitoring

BPAS is committed to ensuring that learning from patient safety incidents leads to meaningful and sustainable improvement. In line with the Patient Safety Incident Response Framework (PSIRF), the development and implementation of safety actions is a core component of the learning response process.

Safety actions will be designed to address identified contributory factors and reduce the risk of recurrence. Actions will be system-focused, proportionate and developed collaboratively with those who understand the work as it is carried out in practice, alongside relevant subject matter expertise where required.

In developing safety actions, BPAS will align with national guidance, including the NHS England Safety Action Development Guide. This includes identifying areas for improvement, understanding the context in which care is delivered, and developing actions that are realistic, achievable and focused on strengthening systems rather than individual behaviour.

Safety actions will be clearly defined, with identified ownership, timescales and measures to support monitoring of impact. Where appropriate, improvement approaches such as Plan-Do-Study-Act (PDSA) cycles and audit may be used to test and refine changes.

The implementation and effectiveness of safety actions will be monitored through established governance structures, including Divisional Patient Safety Huddles, WPSM and the Quality and Risk

Group (QRG). This provides assurance that actions are progressed, barriers are identified and addressed, and that improvements are embedded in practice.

16. Adopt and Spread

Learning from patient safety incidents is actively shared across BPAS to support continuous improvement and reduce the risk of recurrence. BPAS facilitates a dedicated learning forum known as ShELS (Sharing to Ensure Learning Sessions), which provides structured opportunities for colleagues to come together, reflect on incidents, share insights and promote cross-organisational learning. SHARE debriefs are also completed post-incident with the teams involved and people impacted by the incident, offering a safe space to reflect.

Learning is also shared through targeted safety communications, which support the timely dissemination of key messages and immediate actions across services.

At an organisational level, learning is reviewed and shared through governance structures, including the Quality and Risk Group (QRG). This includes the review of thematic analyses, emerging risks and key learning to provide oversight, challenge and assurance, and to support the identification of organisation-wide improvement priorities.

Thematic reviews may be undertaken to explore patterns across multiple incidents. This supports a broader understanding of system risks and enables more effective, organisation-wide improvement.

17. External Reporting and System Learning

BPAS will meet all statutory and regulatory requirements for reporting patient safety incidents to external bodies.

This includes reporting to relevant regulators and national systems, including the Learning from Patient Safety Events (LFPSE) service, supporting both organisational accountability and wider system learning.

Data from national reporting systems and external sources will be reviewed alongside internal data to identify trends, risks and opportunities for improvement. This supports BPAS in contributing to, and learning from, system-wide patient safety insights.

18. Learning From Deaths

In the event of a patient death, BPAS will ensure that the circumstances are reviewed in a proportionate and compassionate manner, in line with national guidance and in partnership with other organisations where indicated. The required actions are contained within the supporting information section. These actions are monitored within the Patient Safety Dashboard to ensure correct oversight and timely responses to support reviews.

19. Incidents Involving Multiple Organisations

Where patient safety incidents involve more than one organisation, BPAS will work collaboratively with relevant partners to ensure a coordinated and effective response. Engagement with other partners will be co-ordinated by the Quality and Patient Safety team.

Collaborative working supports a more comprehensive understanding of incidents that occur across care pathways and enables more effective system-wide learning and improvement.

20. Addressing Health Inequalities

BPAS is committed to ensuring that its services are equitable, accessible and responsive to the diverse needs of the populations it serves. We recognise that people may experience different outcomes and risks in healthcare based on their individual characteristics, circumstances and backgrounds.

Through the application of the Patient Safety Incident Response Framework (PSIRF), BPAS seeks to identify and understand any variation in patient safety outcomes, including where certain groups may be at increased risk of harm or poorer experiences.

This includes:

- Considering equality, diversity and inclusion as part of incident review and learning responses
- Using data to identify themes, patterns and any disproportionate impact on specific groups
- Ensuring that learning and improvement actions take account of the needs of diverse populations
- Engaging with patients and communities to better understand their experiences and perspectives

Insights gained from patient safety activity will be used to inform service development, quality improvement and organisational learning, supporting BPAS to reduce inequalities and improve outcomes for all patients.

21. Monitoring, Assurance and Review

The effectiveness of learning responses and associated improvement actions will be monitored through the governance framework detailed above.

This policy will be reviewed every three years, or sooner if required, to ensure it remains aligned with national guidance, organisational priorities and best practice.

22. Complaints and Appeals

BPAS acknowledges that, at times, patients, service users, or carers may be dissatisfied with aspects of care or services provided, including the way an incident investigation has been conducted or its outcome.

Any concerns or complaints relating to an investigation process will be managed in line with the BPAS Complaints Policy.

Outcomes and recommendations arising from complaints will be shared with relevant services to support consideration and implementation of any necessary improvements. Feedback will also be used to inform ongoing development of incident investigation processes.

Reference List

This policy is informed by national patient safety guidance and best practice, including the following:

National Policy and Frameworks

NHS England (2022) *Patient Safety Incident Response Framework (PSIRF).*

NHS England (2022) *Patient Safety Incident Response Plan (PSIRP) Guidance.*

NHS England (2021) *Learning from Patient Safety Events (LFPSE) Service.*

NHS England (2019) *The NHS Patient Safety Strategy: Safer Culture, Safer Systems, Safer Patients.*

NHS England (2018) *A Just Culture Guide.*

Investigation and Learning Guidance

Healthcare Safety Investigation Branch (2020) *A Guide to Conducting Patient Safety Investigations.*

National Quality Board (2018) *Learning from Deaths: Guidance for NHS Providers.*

National Reviews and Reports

Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.*

Morecambe Bay Investigation (2015) *The Report of the Morecambe Bay Investigation.*

Berwick Review (2013) *A Promise to Learn – A Commitment to Act.*

Ockenden Review (2022) *Final Report of the Ockenden Review.*

Regulatory Requirements

Care Quality Commission (2023) *Regulation 20: Duty of Candour.*

Health and Safety Executive (2013) *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).*

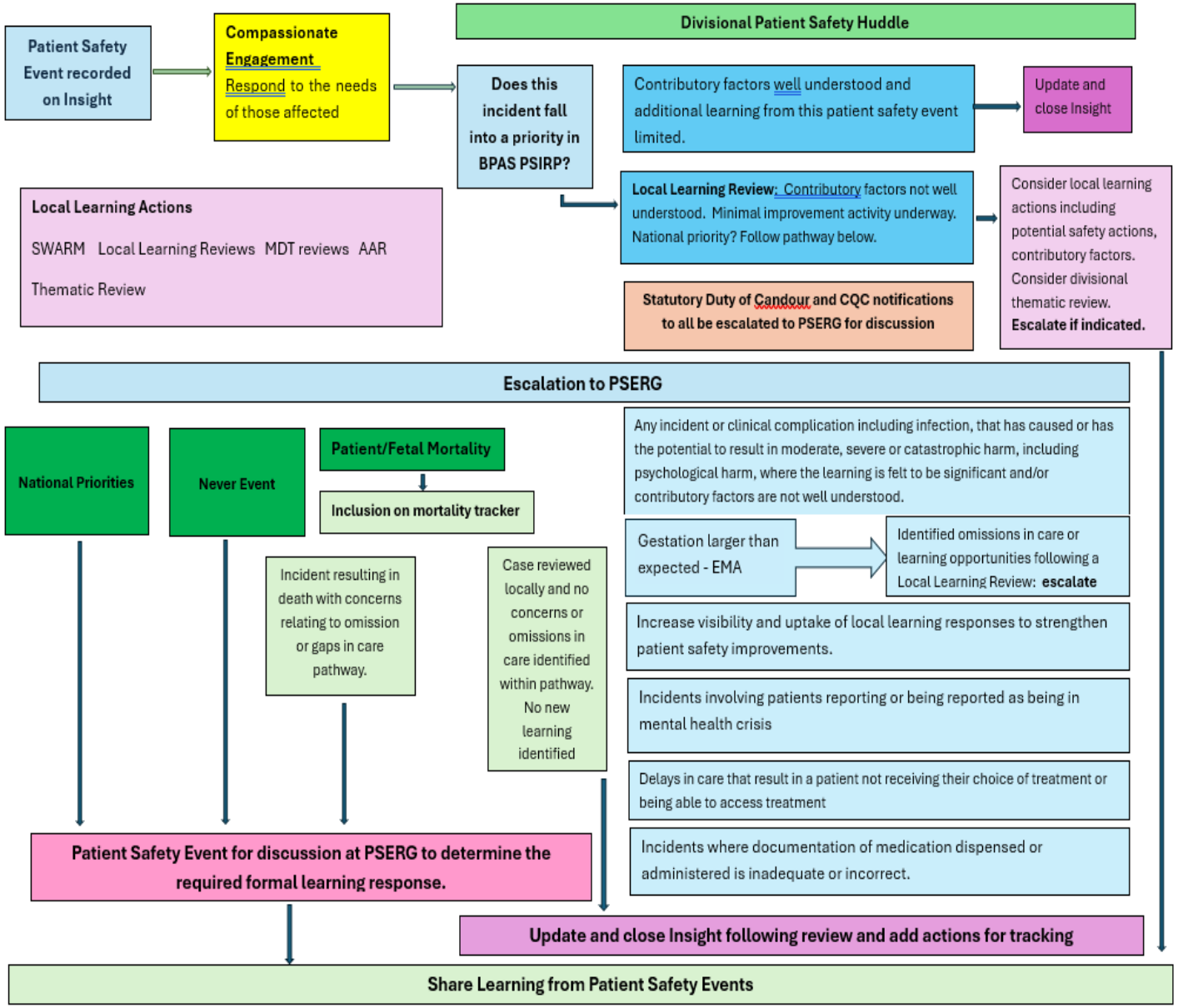
Information Commissioner's Office (2018) *Guide to the General Data Protection Regulation (GDPR) and Data Protection Act 2018.*

NHS England (2021) *Data Security and Protection Toolkit Guidance.*

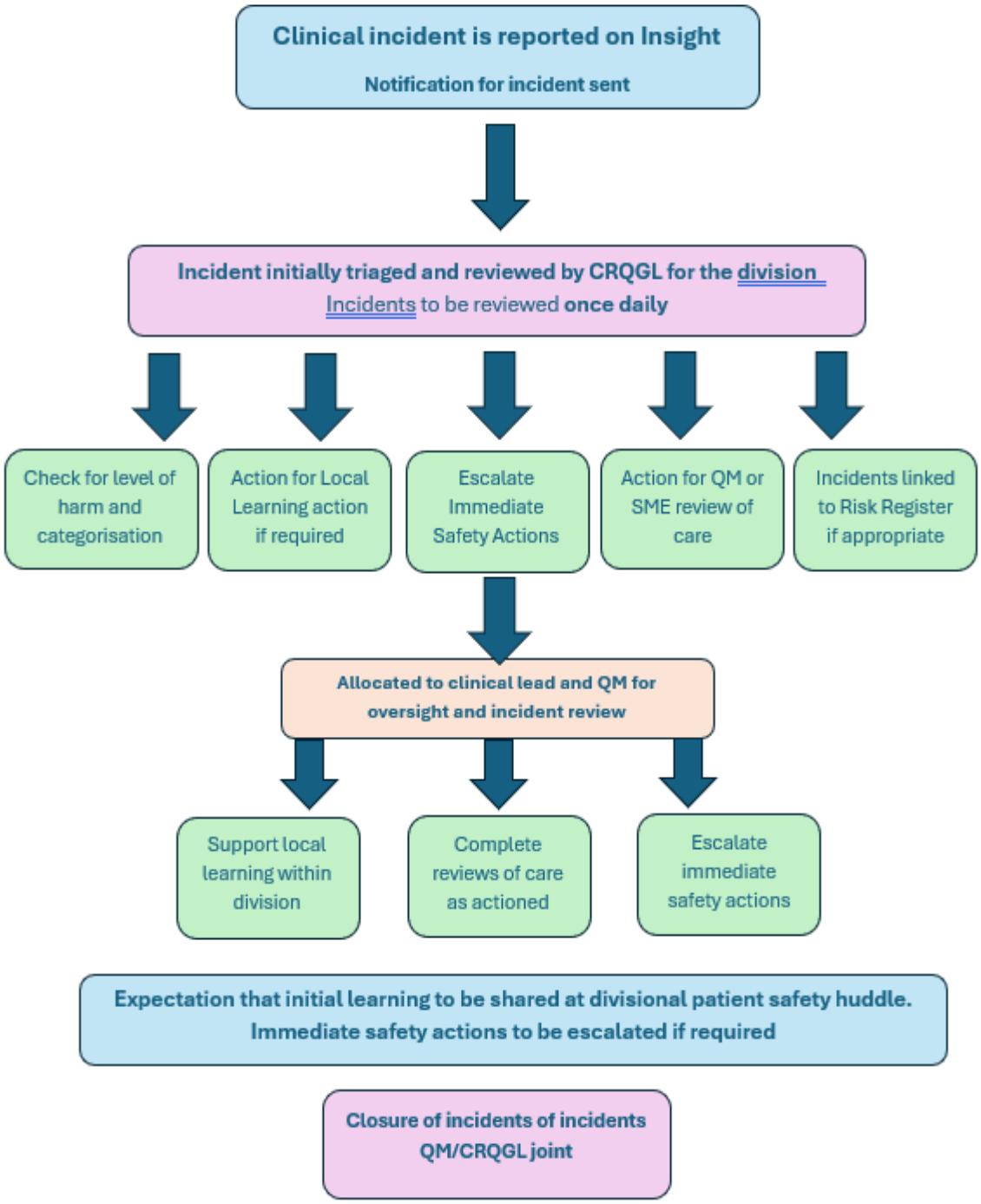
PART THREE – SUPPORTING INFORMATION AND TOOLS

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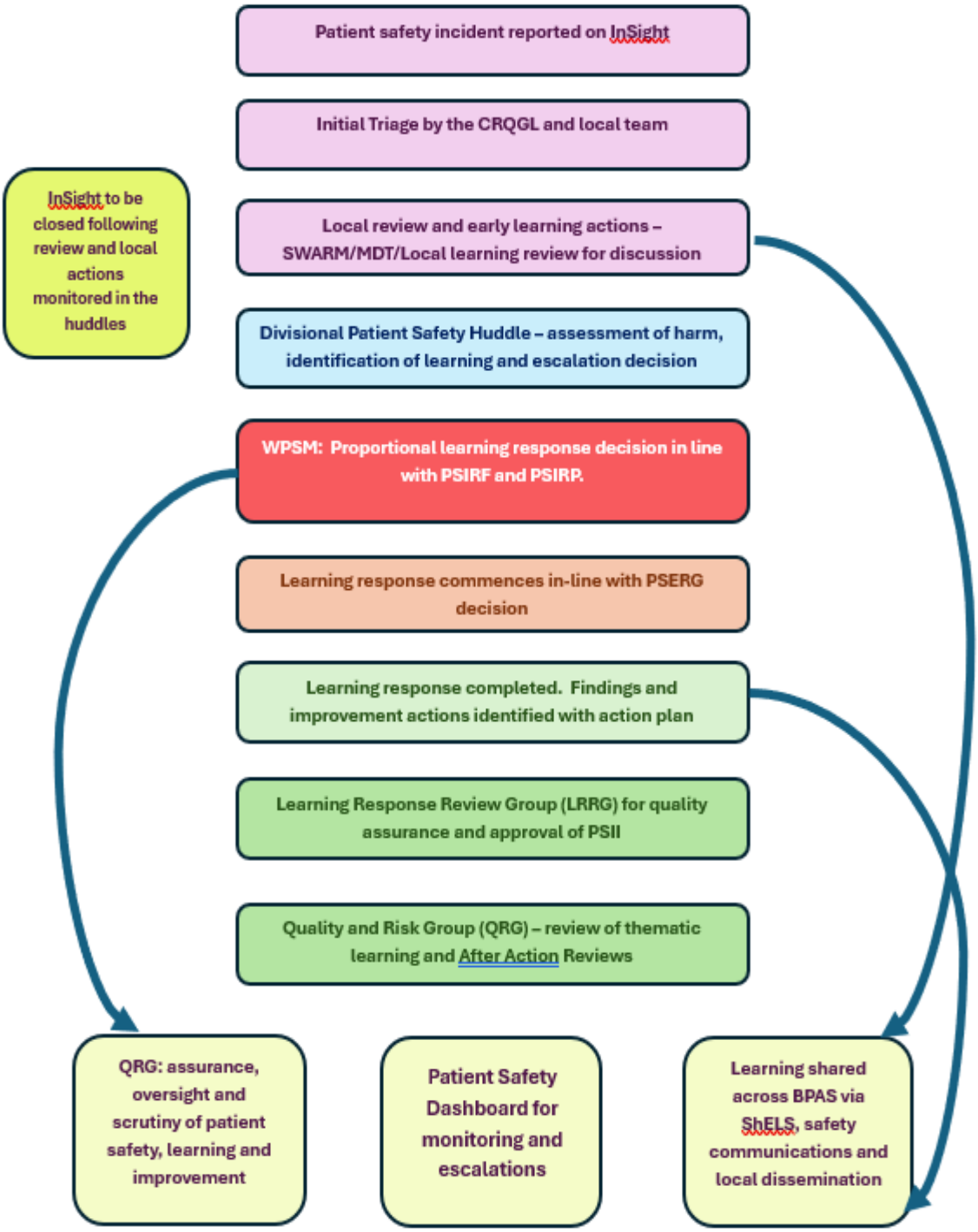
1. Journey of a Patient Safety Incident
2. Triage Flowchart of a Patient Safety Incident
3. Incident Response Governance Flow Chart
4. Levels of Harm (Physical and Psychological)
5. Formal Learning Response Pathways (PSII, AAR, Thematic Review)
6. Duty of Candour Flowchart
7. Managing Concerns about Colleagues Information
8. Learning Response Review Tool
9. Staff Responsibilities for Patient Safety Response
10. Training Needs Analysis
11. Glossary of Terms


Patient Safety Event recorded on Insight
Compassionate Engagement
Respond to the needs of those affected
Divisional Patient Safety Huddle
Does this incident fall into a priority in BPAS PSIRP?
Contributory factors well understood and additional learning from this patient safety event limited.
Update and close Insight
Local Learning Actions
SWARM Local Learning Reviews MDT reviews AAR
Thematic Review
Local Learning Review: Contributory factors not well understood. Minimal improvement activity underway. National priority? Follow pathway below.
Consider local learning actions including potential safety actions, contributory factors. Consider divisional thematic review. Escalate if indicated.
Statutory Duty of Candour and CQC notifications to all be escalated to PSERG for discussion
Escalation to PSERG
National Priorities
Never Event
Patient/Fetal Mortality
Inclusion on mortality tracker
Any incident or clinical complication including infection, that has caused or has the potential to result in moderate, severe or catastrophic harm, including psychological harm, where the learning is felt to be significant and/or contributory factors are not well understood.
Gestation larger than expected - EMA
Identified omissions in care or learning opportunities following a Local Learning Review: escalate
Incident resulting in death with concerns relating to omission or gaps in care pathway.
Case reviewed locally and no concerns or omissions in care identified within pathway. No new learning identified
Increase visibility and uptake of local learning responses to strengthen patient safety improvements.
Incidents involving patients reporting or being reported as being in mental health crisis
Delays in care that result in a patient not receiving their choice of treatment or being able to access treatment
Incidents where documentation of medication dispensed or administered is inadequate or incorrect.
Patient Safety Event for discussion at PSERG to determine the required formal learning response.
Update and close Insight following review and add actions for tracking
Share Learning from Patient Safety Events

Pathway for initial clinical incident review



Supporting Information: Patient Safety Incident Governance Flowchart



Supporting Information: Levels of Harm

Harm may be physical, psychological or both, and both should be considered when determining the overall level of harm

NO PHYSICAL HARM

An incident occurred or was prevented from occurring, but no harm was experienced by the patient.

- Incidents that affected a patient but resulted in no actual harm
- Incidents that did not reach the patient (near miss)

For example: The wrong intrauterine contraceptive device is passed to the clinician but this was noticed before it was inserted.

Reporting incidents that result in no harm, including near misses, is essential to understanding risks within systems and identifying opportunities for early learning and improvement before harm occurs.

LOW PHYSICAL HARM

Low physical harm is when **all of the following** apply:

- minimal harm occurred – patient(s) required extra observation or minor treatment
- did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit
- did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication
- did not or is unlikely to affect that patient's independence
- did not or is unlikely to affect the success of treatment for existing health conditions.

For example: Patient had a BPAS scan before treatment and we appropriately referred with suspected ectopic pregnancy. Patient had treatment including salpingectomy.

MODERATE PHYSICAL HARM

Moderate harm is when **at least one** of the following apply:

- has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention
- has limited or is likely to limit the patient's independence, but for less than 6 months
- has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

*For example: Patient experiences a major haemorrhage during STOP and requires hysterectomy. Review shows that patient was **suitable** for care with BPAS.*

SEVERE PHYSICAL HARM

Severe harm is when **at least one** of the following apply:

- permanent harm/permanent alteration of the physiology
- needed immediate life-saving clinical intervention
- is likely to have reduced the patient's life expectancy
- needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability of their existing health conditions
- has limited or is likely to limit the patient's independence for 6 months or more.

*For example: Patient experiences a major haemorrhage during STOP and requires hysterectomy. Review shows that patient was **unsuitable** for care with BPAS.*

FATAL

You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

PSYCHOLOGICAL HARM

When recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available.

NO PSYCHOLOGICAL HARM

Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse.

Pain should be recorded under physical harm rather than psychological harm.

LOW PSYCHOLOGICAL HARM

Low psychological harm is when **at least one** of the following apply:

- distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit
- distress that did not or is unlikely to affect the patient's normal activities for more than a few days
- distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

For example: A patient experiences temporary distress or anxiety due to receiving incorrect or unclear information, which is promptly clarified with no lasting impact.

MODERATE PSYCHOLOGICAL HARM

Moderate psychological harm is when **at least one** of the following apply:

- distress that did or is likely to need a course of treatment that extends for less than six months
- distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months

For example: A patient experiences significant anxiety or distress following an incident, requiring additional support or follow-up, with no long-term impact.

SEVERE PSYCHOLOGICAL HARM

Severe psychological harm is when **at least one** of the following apply:

- distress that did or is likely to need a course of treatment that continues for more than six months
- distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

For example: A patient experiences significant psychological trauma following an incident, resulting in long-term anxiety or distress that may require ongoing support or specialist intervention.

If you require support with applying levels of harm to any incident please contact any of the Clinical Risk and Quality Governance Leads.

The level of harm can be changed as more information becomes available

Supporting Information: Formal Learning responses

Compassionate engagement:

This underpins how we complete the following actions. Communication and support for the patient and for staff affected must be prioritised. Consider signposting to PMA service for staff and to the Employee Assistance Programme.

Patient Safety Incident escalated to WPSM from Divisional Patient Safety Huddle.

Expectation that WPSM tool completed within 5 working days.

Decision for Formal Learning Response Made

Review team to be determined, led by the CRQGL allocated to the incident. This must include subject matter experts to ensure learning output robust. Contact person for patient and staff to be determined for investigation updates.

Terms of Reference to be shared within 10 days of decision from WPSM

Updates will be shared via the WPSM for assurance including escalations and anticipated delays for visibility

All learning responses to be assessed against an evidence-based tool

PSII Process:

- Investigation commences immediately following decision
- Statutory Duty of Candour to be initiated if required
- Report to be shared for peer review by 60 working days
- Report to be shared for patient and staff affected for approval by 70 working days
- LRRG to be booked no later than 90 working days following decision.
- Actions for learning to be allocated by the CRQGL team on InSight
- Learning to be shared at ShELS and with Learning from Incidents Slide by the CRQGL
- Activity to be monitored on Patient Safety Dashboard

Thematic Review Process:

- CRQGL coordinates the Thematic Review
- Thematic review to be shared for peer review by 60 working days
- To be presented at the following QRG meeting.
- Actions from learning recommendations to be allocated on InSight by the CRQGL team
- Learning to be shared at ShELS and with Learning from Incidents Slide by the CRQGL

After Action Review Process/MDT:

- CRGQL and QM to arrange the AAR/MDT within 3 working days following PSERG
- AAR to take place as soon as possible of the incident
- AAR template to be completed for approval within 10 working days to be presented at the following QRG meeting
- Actions from learning recommendations to be allocated on InSight by the CRQGL team
- Learning to be shared at ShELS and with Learning from Incidents Slide by the CRQGL
- If written summary to be shared with patient, to be approved prior to sharing.

Learning to be shared with organisation

BPAS Duty of Candour Pathway

1. Something has gone wrong
An error, incident, unexpected outcome or other concern relating to a patient's care is identified.

2. Immediate response
- Ensure patient safety and provide any necessary clinical care.
- Be open and honest with the patient (Professional Duty of Candour).
- Provide an appropriate apology and document clearly in patient record and on InSight

3. Identify potential statutory case
Consider whether the incident may meet the criteria for a Notifiable Safety Incident (NSI) under Regulation 20 (see Section 9 of the policy).

Factors to consider
- Death
- Severe harm
- Moderate harm requiring treatment to prevent deterioration to severe harm (BPAS threshold)
- Prolonged psychological harm (≥28 days)
- Other Regulation 20 criteria

Roles and responsibilities
- **Staff**: identify and escalate potential cases.
- Appropriate healthcare professional: clinical opinion where required.
- **Weekly Meeting**: consideration, confirmation and oversight.
- **Patient Safety Team**: coordination and tracking.

Unlikely to be an NSI

4a. Continue professional Duty of Candour
- Be open and honest with the patient.
- Provide appropriate apology and support.
- Communicate in a way the patient can understand.
- Record in patient's clinical record and Insight.
- Continue with appropriate learning response.

If not an NSI: record rationale and continue appropriate candour.

May be an NSI

4b. Escalate through governance process
- Record incident in Insight.
- Escalate to the BPAS Weekly Patient Safety Meeting.

5. Weekly Patient Safety Meeting
- Consider information, including clinical opinion.
- Confirm and document the statutory Duty of Candour position on InSight.
- Allocate actions and agree timescales.

Patient communication
- Open, honest and compassionate.
- Appropriate apology.
- Explain what is known/unknown.
- Tailored to patient needs, capacity and circumstances.

6. Does statutory Duty of Candour apply?

No

Document rationale
Record why statutory criteria are not met; continue appropriate candour; maintain Insight/tracker.

Yes

7. Undertake Statutory Duty of Candour
Identify appropriate BPAS representative; verbal notification; written notification; support; ongoing communication; record.

Recording and tracking
- Clinical record: clinical management and significant communication.
- Insight: incident, statutory assessment, rationale and governance.
- DoC tracker: actions, dates and completion.

8. Ongoing communication, learning and closure
Continue to keep the patient/relevant person informed • progress learning response • complete DoC actions • record completion in Insight and tracker.

Supporting Information:

Managing Concerns About Colleagues Practice Identified Through Incident Review

BPAS recognises that patient safety incident responses and people management processes serve different purposes and must remain separate. Patient safety incident responses are undertaken to understand what happened and identify opportunities for learning and improvement, whereas people processes are concerned with individual conduct, capability or behaviour.

Where concerns relating to colleague practice, performance or conduct emerge during incident review or through governance processes, these will be considered separately and managed in line with BPAS People policies. Where appropriate, these concerns will be discussed with the relevant People/HR lead to determine whether any further review or action is required.

Where necessary, a separate people or disciplinary process may be initiated. This will be undertaken independently of the patient safety incident response to ensure that learning is not compromised and that processes remain fair and objective. In some circumstances, both processes may proceed concurrently, provided that this does not impact the integrity or effectiveness of either.

In line with a just culture approach, BPAS does not seek to attribute blame to individuals where incidents arise from system factors. The primary focus of patient safety incident response is to understand what has happened and identify opportunities for learning and improvement.

In a small number of cases, it may be appropriate to consider whether further review is required in relation to individual practice. This will be considered separately from the patient safety incident response and in line with BPAS People policies.

Such consideration may arise where there are concerns that actions were significantly outside expected professional standards, where there is evidence of deliberate or reckless behaviour, or where there is an ongoing risk to patients, staff or the organisation.

In all cases, decisions will be made in a fair, consistent and proportionate manner, informed by just culture principles.

Patient safety incident responses will not be delayed unnecessarily; however, progression of any people or disciplinary process will typically follow initial fact-finding to ensure decisions are informed and appropriate.

Where incidents meet regulatory reporting thresholds, BPAS will ensure that appropriate external notifications are made. This includes reporting to the Care Quality Commission (CQC) where required, and, for information governance or cyber-related incidents, reporting in line with data security requirements, including notification to relevant national bodies where thresholds are met.

Roles and Responsibilities for BPAS Colleagues in Patient Safety Incident Management

Responsibilities are shared across the organisation, with all colleagues contributing to the identification, reporting and learning from patient safety incidents.

Role	Key Responsibilities
Chief Executive Officer	Overall accountability for patient safety, quality and risk. Ensure compliance with regulatory requirements and a culture of continuous improvement.
Chief Nursing and Midwifery Officer	Provide executive leadership for patient safety and governance. Ensure effective systems, oversight of learning responses, and a just and learning culture.
Chief Medical Officer	Provide medical leadership and ensure appropriate clinical input into incident review and learning.
Deputy Chief of Nursing and Midwifery	Supports the operational leadership of patient safety, quality and governance across BPAS, ensuring effective implementation of PSIRF and PSIRP and consistent management of incident response and learning processes.
Chief Operating Officer	Ensure systems support safe service delivery and that learning from incidents is embedded operationally.
Chief People Officer	Ensure appropriate management of staff-related concerns through HR processes. Support staff wellbeing and a culture of speaking up.
Medical Staff (doctors)	Ensure appropriate clinical review of patients involved in incidents. Contribute to learning responses and provide clinical expertise where required in patient safety huddles To be a key part of investigation teams

Head Pharmacist	Provides oversight of medication safety and ensures medication-related incidents are appropriately reported, reviewed and managed. Supports identification of risks and promotes learning to improve safe prescribing, dispensing and administration.
Medication Safety Officer and Governance Pharmacist	Supports the reporting and review of medication-related incidents and near misses. Identifies trends and risks associated with medicines use and promotes learning and improvement to reduce the risk of recurrence.
Patient Safety and Risk Lead	Provide organisational leadership for patient safety processes. Oversee implementation of PSIRF and PSIRP. Monitor trends, risks and learning, and support system-wide improvement.
Lead for Quality and Patient Experience	Ensure patient voice and experience are reflected in incident learning. Support compassionate engagement and alignment with quality improvement initiatives.
Quality Matrons	Provide clinical oversight of incidents. Support immediate response and ensure Duty of Candour is met when required. Ensure appropriate learning responses are initiated and improvements implemented.
Clinical Risk and Quality Governance Leads	Oversee incident management and triage within divisions. Support proportionate learning responses. Identify themes and risks and escalate as required. Promote a positive safety culture. To lead and coordinate investigations and learning responses along with subject matter experts and the QM team
Risk Manager	Support risk identification and management across the organisation. Maintain risk registers and ensure alignment between incident reporting and risk management processes.
Lead Nurses and Midwives	Lead local incident reviews and learning responses. Support staff engagement. Ensure learning is shared and embedded within teams. Escalate risks and themes as appropriate.

Specialist Roles	Specialist roles provide expert input into incident management and learning within their areas of responsibility, ensuring compliance with statutory, regulatory and professional requirements. *Head of Safeguarding*: Provides oversight and advice on safeguarding concerns identified through incidents. Ensures appropriate reporting and management in line with statutory requirements and supports learning from safeguarding-related incidents. *Head of Information Governance*: Oversees the management of information governance incidents. Ensures compliance with data protection requirements, including external reporting where required, and supports learning and prevention. *Health and Safety Lead*: Ensures health and safety incidents are reported and managed in line with statutory requirements. Supports compliance with RIDDOR and contributes to risk management and learning. *Lead sonographer*: Contribute to learning responses and provide clinical expertise and reviews of sonography elements of the patient pathway
Patient Safety Partner	Contribute patient and public perspective to patient safety processes and support organisational learning and improvement.
Freedom to Speak Up Guardians	Support staff to raise concerns safely and confidentially and promote a culture of openness.
PMNA/Lead PMA	To support staff and facilitate restorative clinical supervision following a patient safety incident and to support psychological safety

Terms and Definitions

This glossary provides definitions of key terms used within this policy to support consistent understanding and application.

Term	Definition
After Action Review (AAR)	A structured team discussion used to reflect on what happened, why it happened and what can be learned from an incident.
Contributory Factors	Factors that influence how and why an incident occurred, including system, environmental, organisational and human elements.
Divisional Patient Safety Huddle	A local multidisciplinary forum for reviewing incidents, identifying learning and determining escalation.
Duty of Candour	A statutory requirement to be open and honest with patients when something goes wrong with their care.
Human Factors	The study of how people interact with systems, environments and processes, used to understand how incidents occur and how to improve safety.
InSight	The electronic system used within BPAS for reporting, managing and monitoring patient safety incidents and risks
Just Culture	An approach that promotes fairness and learning by focusing on system factors rather than individual blame when incidents occur.
Learning from Patient Safety Events (LFPSE)	The national system for recording and analysing patient safety incidents in England.
Learning Response	A proportionate approach to reviewing a patient safety incident to understand what happened and identify opportunities for improvement.
Level of Harm	Physical or psychological injury or damage to a patient arising from, or contributed to by, healthcare.
Local Learning Review	A structured, proportionate review undertaken at a service or team level to understand an incident and identify immediate learning and improvement.
LRRG (Learning Response Review Group)	A group responsible for providing assurance on the quality of learning responses, including PSIIs, prior to closure.
Multidisciplinary Review	A collaborative review involving staff from different professional backgrounds to understand incidents and identify learning across services or pathways.
Patient Safety Dashboard	A reporting tool used to monitor patient safety data, including incident trends, themes, learning responses and improvement actions.
Patient Safety Incident	An unintended or unexpected event that could have or did lead to harm for one or more patients receiving healthcare.
Patient Safety Partner	A person who brings the perspective of patients and the public into patient safety processes and improvement work.
WPSM (Weekly Patient Safety Meeting)	A multidisciplinary group responsible for determining the most appropriate learning response for incidents in line with PSIRF and the PSIRP.
PSII (Patient Safety Incident Investigation)	A structured, systems-based investigation undertaken where there is significant potential for learning.
PSIRP (Patient Safety Incident Response Plan)	A document that describes how an organisation will apply PSIRF, including local priorities for learning and the types of learning responses that will be used.
QRG (Quality and Risk Group)	A governance forum providing organisational oversight, assurance and scrutiny of patient safety, learning and risk.

Risk	The likelihood of harm occurring and the potential severity of that harm.
Safety Communications (Safety Pins/Learning slide)	Targeted communications used to share key safety messages, learning and immediate actions across BPAS services.
ShELS (Sharing to Ensure Learning Sessions)	An organisational forum where learning from incidents is shared, discussed and disseminated to support cross-service improvement.
SWARM	A rapid, multidisciplinary review method used to explore an incident, identify contributory factors and agree immediate actions.
Systems Thinking	An approach to understanding how different elements within a system interact and contribute to outcomes, including incidents.
Thematic Review	A review of multiple incidents to identify common themes, patterns and system learning

Supporting Information

Patient Safety Incident Response Framework (PSIRF) Education Training Needs Analysis

BPAS are committed to equipping staff with the necessary skills required to undertake their roles confidently and competently. In turn, staff must take responsibility for developing these skills and participating in life-long learning.

A Training Needs Analysis (TNA) has been developed to identify the updated training requirements, of all staff groups, following the implementation of the Patient Safety Incident Response Framework (PSIRF) and Insight risk reporting system to BPAS. This TNA has also been updated in response to the NHSE Patient Safety Incident Response Standards in line with national guidance below (NHSE 2024[1]).

Introduction

- BPAS provides sexual and reproductive health services, including abortion care and vasectomy, 95% of which is funded by the NHS.
- BPAS has just under 1100 employees.
- It is expected that BPAS follows risk management training guidance laid out by NHS England (2024).
- Within routine governance and assurance processes and in accordance with contractual obligations, BPAS is expected to monitor training compliance and content.

Scope

This training needs analysis (TNA) aims to provide an update for the training of BPAS staff in accordance with NHS England requirements. It will provide internal and external assurance regarding staff awareness of the use of PSIRF within BPAS and the competency of staff in reporting/investigating patient safety incidents.

Aims

- To review current Patient Safety Incident Response Framework training requirements as guided by NHS England.
- Map these requirements against the current offer and identifying any gaps/shortfall and overtraining in hours and levels of training
- Map the requirements of NHS England in accordance with current job roles/titles (Appendix One)
- To identify changes which may need to be made in regards to hours, content, packages and compliance monitoring
- Create a new training offer for 2025-26

[1] NHS England. (2024, June 11). *Patient safety incident response standards*. https://www.england.nhs.uk/long-read/patient-safety-incident-response-standards

NHS England Training Requirements

- The table below demonstrates the NHSE minimum PSIRF training requirements according to level, competency, role and hours required.

Topic	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
Systems approach to learning from patient safety Incidents	**2 days/12 hours**	• Introduction to complex systems, systems thinking and human factors • Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews • Safety action development, measurement, and monitoring	**Yes**		
Oversight of learning from patient safety incidents	1 day/6 hours	• NHS PSIRF and associated documents • Effective oversight and supporting processes • Maintaining an open, transparent and			**Yes**

Topic	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
		improvement focused culture • PSII commissioning and planning			
Involving those affected by patient safety incidents in the learning process	1 day/6 hours	• Duty of Candour • Just culture • Being open and apologising • Effective communication • Effective involvement • Sharing findings • Signposting and support		**Yes**	
Patient safety syllabus level 1: Essentials for patient safety (for all staff)	eLearning	• Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety	**Yes**	**Yes**	**Yes**

Topic	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
		and is open to learning about risk and safety			
Patient safety syllabus level 1: Essentials for patient safety (for boards and leadership teams)	eLearning	• The human, organisational and financial costs of patient safety • The benefits of a framework for governance in patient safety • Understanding the need for proactive safety management and a focus on risk in addition to past harm • Key factors in leadership for patient safety • The harmful effects of safety incidents on staff at all levels			**Yes**
Patient safety syllabus level 2: Access to practice	eLearning	• Introduction to systems thinking and risk expertise • Human factors • Safety culture	**Yes**	**Yes**	**Yes**

Topic	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
Continuing professional development (CPD)	At least annually	• To stay up to date with best practice (eg through conferences, webinars, etc) • Contribute to a minimum of two learning responses	**Yes**	**Yes**	**Yes**

NHS England (2024)

BPAS Current Offer

Mandatory training

Table: Current BPAS PSIRF Training Offer

Course Name	Duration	Frequency	Type	Staff
HSIB Level 2 – A systems approach to investigating and learning from patient safety incidents	Over a 6-month period	Once	Self-directed E-Learning	Lead investigators and staff in Patient Safety Incident Response (PSIRF) oversight roles.
HSIB Patient Safety Incident Response Framework Oversight	7 hours	Once	Live Session	PSIRF Engagement Leads
HSIB Involving those affected by patient safety incidents in the learning process	1 day	Once	Live Session	Learning Response Leads
Patient Safety Syllabus: Level 1 Essentials for patient safety	30 Mins	Once	e-learning Host: e-lfh	All BPAS staff
Patient Safety Syllabus: Level 2 Access to practice	60 Mins	Once	e-learning Host: e-lfh	Director of Nursing Midwifery & Quality. Medical Director. Head of Corporate Governance. Head of Safeguarding. Consultant Midwife. Head of Safeguarding Senior Quality Matron. Quality Matrons. Lead Nurse/Midwives. Clinical Nurse Managers. Treatment Unit Managers. Operational Quality Managers. Regional Clinical Directors. Governance Partners. Associate Directors. Lead Sonographer.

				Pharmacist. Lead Anaesthetist.
Essentials of patient safety for boards and senior leadership teams.	30 Mins	Once	e-learning Host: e-lfh	BPAS Board ELT members
NHSE Patient Safety Syllabus Training (LEVELS 3 & 4)	5 Modules	Once	Blended Learning - Loughborough University	Director of Nursing Midwifery & Quality. Head of Corporate Governance.

Analysis

The current training offer must be updated to reflect the 2024 NHSE Standards and for BPAS to demonstrate clear alignment between the job roles of our staff and the NHSE definitions of 'Engagement Leads, Learning Response Leads and Oversight Roles'**.** The training proposal must ensure staff are competent to undertake their designated roles within PSRIF. It is also an opportunity to contextualise the training to the work of BPAS, recognising the unique nature of abortion care and the organisations use of the Insight reporting system. Alongside this, BPAS must ensure there is an appropriate training provision available for staff in the use of the Insight System to replace the old 'Datix reporter and reviewer training'.

It is important to support the psychological safety of staff when they are required to be involved in a learning response. There is currently no standardised information for staff about their participation and the expectations if they are invited to be involved.

Proposal

- The proposed offer of risk management training for BPAS aims to bring BPAS in line with NHSE 2024 requirements.
- Provide BPAS specific and PSIRF Role specific training for staff.
- Introduce training for the reporting, reviewing and approving on the Insight reporting system.
- Create a training session tailored to support staff wellbeing by setting the expectation of their involvement and the process of a learning response.

Training courses:

Proposed PSIRF training by required topic and job role

Topic	Training Provider	Duration	BPAS Job Roles
A systems approach to investigating and learning from patient safety incidents	HSIB (Level 2)	Over a 6-month Period	Learning Response Leads

Oversight of learning from patient safety incidents	BPAS	3.5 hours	PSIRF Oversight Roles
Involving those affected by patient safety incidents in the learning process	HSIB	1 day	Engagement Leads
Patient Safety Syllabus: Level 1 Essentials for patient safety	E-Learning for Health	30 Mins	All BPAS Staff
Patient safety syllabus level 1: Essentials for patient safety (for boards and leadership teams)	E-Learning for Health		PSIRF Oversight Roles
Patient safety syllabus level 2: Access to practice	E-Learning for Health		Learning Response Leads Engagement Leads PSIRF Oversight Roles
Continuing professional development (CPD)	Variable	• Stay up to date with best practice • Contribute to a minimum of 2 learning responses a year	Learning Response Leads Engagement Leads PSIRF Oversight Roles
PSIRF & Learning Response Participation: Expectations & Process	BPAS	30 Mins	All Staff
HSSIB Training for Investigators: • Demystifying thematic analysis • Investigative interviewing • Writing effective learning reports • An introduction to After Action Review	HSSIB	14 hours in total over the 4 sessions	Patient Safety and Risk Lead Clinical Risk and Quality Governance Leads

Training courses content:

HSIB Level 2 – A systems approach to investigating and learning from patient safety incidents

Description: This course is aimed at those who lead investigations and other learning responses and those in Patient Safety Incident Response Framework (PSIRF) oversight roles. This course meets the minimum training requirement of this specific element of PSIRF.

Content:

- Complex systems, systems thinking and Human Factors
- Investigation practices such as interviewing, capturing work-as-done, using a systems framework (SEIPS), synthesising data, and writing reports
- Developing effective safety actions and recommendations
- Engaging and involving those affected by patient safety incidents

This is a self-directed online learning course with bitesize modules. Training must be completed in 6 months.

This course meets the minimum training requirement of this specific element of NHSE PSIRF.

HSIB Patient Safety Incident Response Framework - Oversight of learning from patient safety incidents

This live course is designed to introduce the principles of patient safety incident response oversight. It covers the mindset and the culture underpinning effective oversight, as well as the theory and practice of measurement and monitoring of patient safety.

This is a seven-hour course, delivered in two sessions of 3.5 hours each, with a gap of about a week between the sessions.

HSIB Involving those affected by patient safety incidents in the learning process

This one-day live course is aimed at those who have a lead role in engaging and involving those affected by patient safety incidents. Those affected includes patients, family members or healthcare staff.

The day is split into four modules:

- Creating the right foundations.
- Before and initial contact.
- Continued and closing contact.
- Additional considerations.

The course meets the minimum training requirement of this specific element of the Patient Safety Incident Response Framework (PSIRF). It also aligns to the accompanying PSIRF guidance ‘Involving those affected by patient safety incidents in the learning process’. To reach the minimum training requirement you are required to attend the whole day.

Patient Safety Syllabus level 1: Essentials for patient safety

This session introduces patient safety for all staff. It focuses on the essentials for creating patient safety. These include listening to patients and raising concerns about the systems approach to safety, where instead of focusing on the performance of individual members of staff, the aim of improving the way we work avoiding inappropriate blame when things don't go well creating a just culture that prioritises safety and is open to learning about risk and safety.

This course meets the minimum training requirement of this specific element of NHSE PSIRF.

Patient Safety Syllabus level 2: Access to Practice

This training provides a basic introduction to the key elements of safety science. The elements of safety science that we focus on, and which have underpinned all domains of the syllabus are: systems thinking, risk expertise, human factors and safety culture plus additional maternity care sector training.

This course meets the minimum training requirement of this specific element of NHSE PSIRF.

Essentials of patient safety for boards and senior leadership teams.

This session builds on the 'Essentials of patient safety for all' session and introduces patient safety measurement, monitoring and governance for patient safety to boards. It will also focus on board opportunities and responsibilities in patient safety, human and financial costs and safety aspects.

PSIRF & Learning Response Participation: Expectations & Process

The aim of this session is to support staff psychological safety by building a shared understanding of the principles at the heart of PSIRF. It will outline how a patient safety incident progresses through BPAS and clarify what is expected of staff when they are asked to participate in a learning response. The session will also explore how learning is shared across the organisation and clearly signpost where staff can access support throughout the process.

HSSIB Training for Investigators:

An overview of the principles that underpin a professional safety investigation interview with either a member of staff, a patient or a family. Designed to enable those undertaking investigative interviews do so in a structured and supportive manner, which is of vital importance to the success of PSIRF. To support report writing for investigations and other learning responses and communicate findings and actions in an impactful way. Finally, to understand how thematic analysis can be applied within the organisation, what factors might be considered in using the approach and some of the challenges in using it as part of the broader patient safety strategy.

- Planning and preparing for an interview
- Using a structured hierarchy of questions to facilitate comprehensive, accurate information
- Asking system-focused questions
- Closing an interview
- Important elements of report language including how to write in plain English and using inclusive, neutral language
- The common pitfalls when writing reports following investigations and other learning responses
- The application of report language to the PSIRF investigation report template
- An introduction to a tool to help support the review and development of learning responses
- Factors to consider when reviewing investigation reports and other learning responses
- Defining what After Action Review is
- Understanding the principles of After Action Review
- Discussing the attributes needed to be an After Action Review facilitator

- Exploring how to conduct an After Action Review
- Reflecting on the value of After Action Review

Proposed training offer for BPAS incident management system training.

Training	Host	Duration	Frequency	BPAS Job Roles
Insight Reporter Training: How to use Insight, What is an incident, levels of harm, duty of candor.	Corporate Risk Manager/CRQGL		Once	
Reviewer Training	BPAS Learn via L&D Masterclass	60 Mins	Once	Learning Response Leads Engagement Leads
Approver Training Session	Corporate Risk Manager/CRQGL		Once	

Summary of Recommendations:

Recommendation	Impact	Owner
Achieving NHSE minimum training hours	• Ensure that training hours are achieved • Ensure staff are given time to obtain the hours mandated by NHSE.	ADOs
Training Compliance	• Ensure that BPAS reaches 90% training compliance.	Learning & Development Team
Creating new content	• Creation of new training content as required dependant on organisational need.	CRQGLs Corporate Governance Lead L&D Team
Evaluation	• Seek feedback via BPAS learn platform.	Learning & Development Team

Appendix One

Proposed job role alignment to NHSE pathway

Learning Response Leads

Purpose:
To lead and coordinate the patient safety learning response following a patient safety incident.

Definition:
The Learning Response Lead is responsible for planning, delivering and concluding the agreed learning response in line with PSIRF principles. They ensure the response is proportionate, systems-focused, timely and results in meaningful learning and improvement.

Key responsibilities include:

- Designing the learning response approach (e.g. systems-based review, thematic review, debrief)
- Coordinating contributors and subject matter experts
- Ensuring a just, compassionate and learning-focused process
- Synthesising findings and identifying contributory factors
- Developing clear learning points and improvement actions
- Producing the learning response output/report
- Ensuring learning is shared appropriately within the organisation

Examples:

- Clinical Risk and Quality Governance Team
- Quality Matrons
- Regional Clinical Leads
- Corporate Risk Manager/Head of Corporate Governance
- Lead and Deputy Lead Nurse/Midwives
- Treatment Unit Managers
- Continuity Lead Nurse/Midwife Practitioners
- Theatre Managers/Deputy Theatre Managers
- Clinical Nurse/Midwife Managers
- Head of Safeguarding/Safeguarding Leads

Engagement Leads

Purpose:
To ensure compassionate, meaningful and inclusive engagement with those affected by the incident.

Definition:
The Engagement Lead is responsible for supporting and coordinating engagement with patients, families and staff affected by a patient safety incident, ensuring their perspectives are heard and considered throughout the learning response.

Key responsibilities include:

- Acting as the main point of contact for patients, families and/or staff
- Explaining the learning response process in clear, accessible language

- Supporting individuals to share their experiences and questions
- Ensuring engagement is trauma-informed and culturally sensitive
- Feeding insights from engagement into the learning response
- Supporting closure conversations and feedback on learning outcomes

Examples:

- Quality Matrons
- Clinical Risk and Quality Governance Leads
- Treatment Unit Managers
- Lead Nurse/Midwives
- Corporate Risk Manager
- Operations Managers
- Regional Clinical Directors
- Professional Midwifery/Nurse Advocate
- Medicines Safety Officer
- Patient Safety Partner

PSIRF Oversight Roles

Purpose:
To provide independent assurance that patient safety incidents are responded to appropriately and consistently.

Definition:
The Oversight Role provides governance and assurance that learning responses are proportionate, high quality, and aligned with PSIRF standards, without directing or influencing the findings.

Key responsibilities include:

- Confirming whether a learning response is required
- Agreeing the type and scope of learning response
- Ensuring timescales and standards are met
- Monitoring progress and removing barriers
- Providing constructive challenge where needed
- Ensuring learning and actions are escalated and embedded
- Maintaining independence from the incident and response delivery

Examples:

- Chief Medical Officer
- Chief Nursing and Midwifery Officer
- Head of Safeguarding
- Risk and Patient Safety Lead
- Head of Quality and Patient Experience
- Head of Operations
- Lead Sonographer
- Lead Anesthetist
- Lead Pharmacist

- BPAS Board
- Chief Officers