Berkshire Healthcare
NHS Foundation Trust

Patient safety incident response plan

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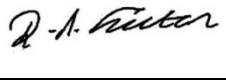
	NAME	TITLE	SIGNATURE	DATE
Author/s	Helen de Gruchy	Head of Patient Safety / Patient Safety Specialist		February 2026
	Gumisayi Tsapayi	Patient Safety Specialist		February 2026
	Daniela Ungurusan	Patient Safety Specialist		February 2026
Reviewer/s	Daniel Badman	Deputy Director of Nursing Patient Safety & Quality		February 2026
	Debbie Fulton	Director of Nursing and Therapies		February 2026
	Tolu Olusoga	Medical Director		February 2026
Authoriser/s	Mortality and Patient Safety Group	All committee members		

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1. Introduction

This patient safety incident response plan (PSIRP) sets out how Berkshire Healthcare NHS Foundation Trust intends to respond to, and learn from, patient safety incidents to continually improve the quality and safety of the care we provide.

It is our plan for the next 18 – 24 months but we acknowledge that it is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

The document should be read alongside guidance for the national Patient Safety Incident Response Framework (PSIRF) (NHSE 2025[1]), which sets out the requirement for this plan to be developed, as well as our local Patient Safety Incident Response Policy (CCR173).

In order to develop PSIRF-compliant and effective patient safety incident response systems, we need to ensure that we[2]:

- ***Compassionately engage and involve those affected*** *by our patient safety incidents* – seeking patient, family and staff input into a response and developing a shared understanding of what happened using approaches that prioritise and respect the needs of those affected.

- ***Apply a range of 'system-based approaches'*** *to learning from our patient safety incidents* – PSIRF recognises the complex interactions arising from the healthcare system and the need to move away from root-cause analysis approaches to system-based investigations.

- ***Decide on 'considered and proportionate responses'*** *to our patient safety incidents* – PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm. It promotes a range of learning responses which we can apply if an incident requires further review - meaning that an investigation is only one of a toolkit of methodologies that can be used.

- ***Have supportive oversight*** *that focuses on improvement.*

The purpose of our plan is to specify the methods we intend to use to maximise learning and improvement and how these will be applied to different patient safety incidents that occur within our services.

It has been developed based on a thorough understanding of our current patient safety profile, ongoing improvement priorities and available resources. In addition, there has been collaboration and

[1] NHS England » Patient Safety Incident Response Framework

[2] How we will achieve these 4 main areas is described in more detail in our Patient Safety Incident Response Policy (CCR173)

discussion with our key stakeholders as well as assistance from, and approval by, our local Integrated Care Boards (ICB's).

This plan will be updated regularly based on new learning, our changing patient safety and risk profile and ongoing improvements. In this way, 'incident response' becomes part of a wider safety management system approach across Berkshire Healthcare.

2. Changes to our last patient safety incident response plan

The key changes within this PSIRP since our first plan in January 2024 are:

- Removal of references to the previous SI framework and work and changes that had already taken place during our transition phase – recognising that PSIRF and our PSIRP are now business as usual.
- Removal of appendices which outlined original feedback and data for our patient safety profiles as compiled from stakeholder events in 2023.
- Removal of appendices with example family engagement letters as we now have patient safety pages on our Trust intranet with several resources including all relevant and current letter templates to guide staff.
- Changes to our patient safety profile recognising we now have a much richer understanding of what our safety issues are from when we first started on our PSIRF journey.
- Changes to our local priorities for patient safety learning responses.
- Inclusion of a set of questions which will be considered and explored to decide if a learning response will be undertaken.
- Updates of the definitions of systems-based learning response methodologies based on current guidance.
- The incorporation of Walkthrough Analysis as a tool to support our methodologies and aid understanding of a task or process and increase the proportionality of responses.
- Removal of the mortality section acknowledging that our Learning from Deaths policy has been updated and should be considered as the key resource to identifying how we respond to deaths and should be read in conjunction with our PSIRP.

This is based on an evaluation of our initial PSIRP towards the end of 2025, and the areas for improvement identified. We have also considered national feedback on PSIRPs and reviewed the current updated guidance on PSIRF standards.

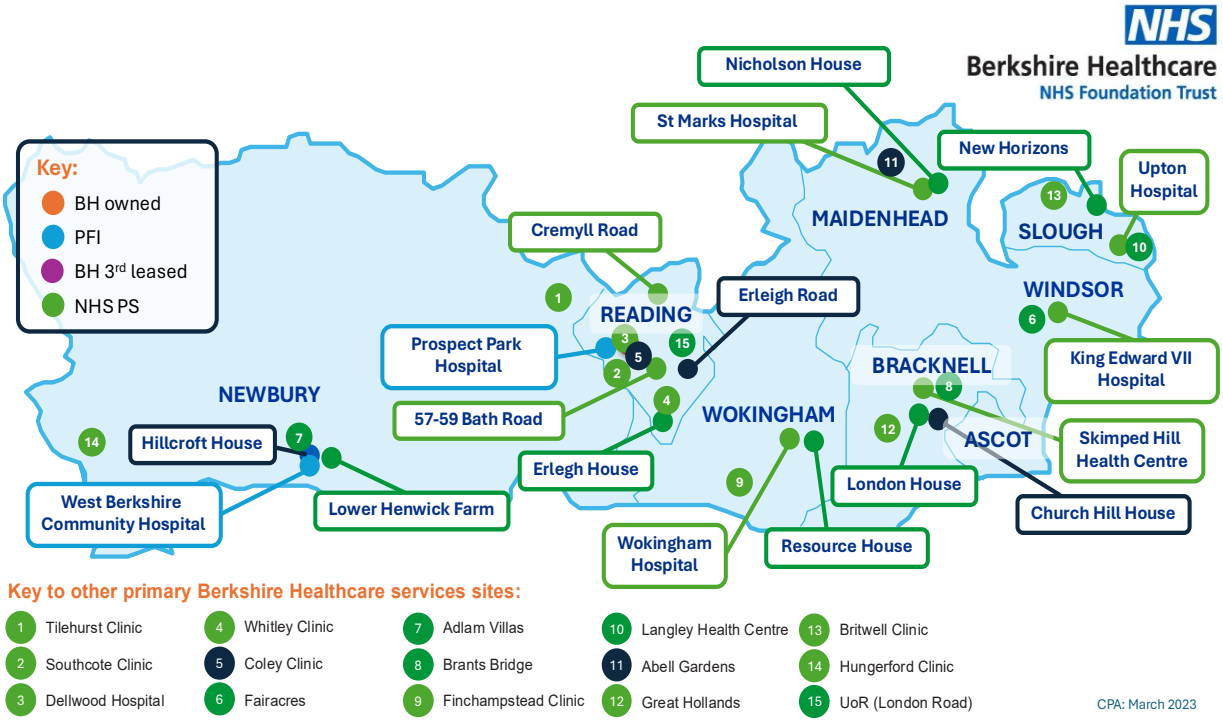
3. Our services

We are a community physical health and mental health NHS organisation providing a wide range of services to people of all ages living within Berkshire County.
We have a population of just under one million, covering 500 square miles. The Trust operates from multiple sites across Berkshire. Since 1998, Berkshire has been made up of six unitary authorities:

- West Berkshire
- Reading
- Windsor, Ascot & Maidenhead
- Wokingham
- Bracknell Forest
- Slough

Our current structure includes three divisions:

- **Mental Health Services.** This includes three overarching services: Urgent Mental Health Care, Specialist Mental Health Services and Community Mental Health Services
- **Community Physical Health Services.** This includes two overarching services: Urgent Community Services and Scheduled Community Services
- **Children, Families and All Age Services.** This includes CAMHS, Learning Disability, Neurodiversity, Universal Services, Perinatal and Eating Disorder services.



4. Our patient safety incident profile

4.1 Approaches to defining our patient safety challenges/issues

Our understanding of patient safety challenges has grown since the data profiling completed for our first plan. Since publication of our initial plan, we have the benefit of system-based learning responses,

a further 2 years of intelligence from our improved internal incident reporting system (Datix) amongst other insight sources and incorporation of systems-thinking across all patient safety activities.

Our current patient safety profile, and therefore our priorities for both improvement and local patient safety incident investigations and other learning responses has been based on:

- Engagement with internal and external subject matter experts and stakeholders.
- Consideration of data from the following sources.
    - Themes, level of harm and level of concern from over 13800 patient safety incidents reported between January 2024 and December 2025.
    - Themes associated with 27 commissioned patient safety incident investigations (PSIIs) between January 2024 and December 2025 including a review of the common contributory factors and recommendations identified in the learning response.
    - Themes associated with 142 commissioned patient safety reviews (PSRs) between January 2024 and December 2025 including a review of the common contributory factors and recommendations identified in the learning response.
    - Themes from patient safety related patient complaints
    - Themes from 4 PFDs between January 2024 and December 2025
- Triangulation with Trust quality account priorities 2025/26.
- Triangulation with the following external or national sources.
    - National patient safety priorities of NHS England
    - Published priorities of the Patient Safety Commissioner
    - National patient safety alerts
    - Healthcare Safety Investigation Branch investigations

4.2 Other approaches to inform the development of our plan

- Participation in the BOB Safety Improvement Forum where we have considered shared safety priorities across the wider local healthcare system
- Review of published PSIRPs to identify ideas and best practice
- Recommendations from the Patient Safety Learning[3] review of PSIRPs

4.3 Our profile – challenges/issues according to Division and Service

The authors wish to acknowledge that the Patient Safety Learning review (2025) identified that organisations outlined their patient safety issues most pertinent to them in several different ways. They found some PSIRPs were very specific about an issue, and some were a lot more general. In addition, the Patient Safety Learning review believes that the underlying causes and contributory factors to a patient safety incident should themselves be identified as priorities for action and these were not always reflected in the first publications of PSIRPs.

[3] Patient Safety Learning (2025). *Patient Safety Incident Response Plans: An analysis and reflection by Patient Safety Learning*. https://d2z1laakrytay6.cloudfront.net/Report_PSIRPS_AnanalysisandreflectionbyPatient-Safety-Learning_Issued.pdf

We have considered this feedback carefully. For each of our identified patient safety priorities, we have aimed to be as specific as possible. This applies whether the priority is based on impact (on patients and service users), identified gaps or omissions (such as underlying contributory factors), or issues associated with processes.

How we will respond to patient safety incidents relating to this profile, will be discussed in section 6.

Patient Safety Priority – current issues / challenges **(This could be an Impact, Gap or Process)**	**Division**	**Service**
Absent without leave and welfare escalations	Mental Health CFAA	Inpatients Campion Ward
Concerns about communication affecting the patient journey and subsequent care. Current communication safety issues include: • Communication with private providers • Communication where patients are being looked after by both mental health and physical health services • Triangulation of safeguarding concerns with other agencies • Impact of poor discharges into our community services (both inherited and from our own inpatient wards) • Multiple referrals within our services not leading to a clear care pathway	All 3 divisions	All services across all 3 divisions
Deterioration of pressure ulcers leading to significant harm	Physical Health Mental Health CFAA	Inpatients & community services Inpatients Specialist Children's services
Diagnostic results interface between community services and GPs	All 3 divisions	All services across all 3 divisions
Environmental issues which have an impact on the safety of patients	Mental Health CFAA	Inpatients Campion and Phoenix
Falls leading to significant harm/injury	Physical Health Mental Health	Inpatients Inpatients
Robustness of handover processes	All 3 divisions	All services across all 3 divisions

Impact of hospital admission on risk to self in patients with EUPD diagnosis	Mental Health	Inpatients
Incidents of attempted suicide / significant self-harm	Mental Health CFAA	All services Neurodiversity services, mental health services (e.g. CAMHS, BEDS, LD)
Incidents causing harm (all levels) relating to discharge or transfer of care instigated by Berkshire Healthcare to other internal or external services (if reported to us by other providers).	All 3 divisions	All services across all 3 divisions
IT systems and infrastructure including RiO, ICE and ePMA	All 3 divisions	All services across all 3 divisions
Length of stay leading to unintended negative effects	Mental Health CFAA	Inpatients Campion
Management of mental health therapeutic observations	Mental Health CFAA	Inpatients Campion
Management of patients who present with substance use and (including use of prescription medications) including how we follow up on those asked to self-refer to substance misuse services.	All 3 divisions	All services across all 3 divisions
Medical devices - Inconsistent management in accordance with statutory regulation and expected standards	All 3 divisions	All services across all 3 divisions
Medication errors which impact on patient outcomes especially high-risk medicines frequently implicated in harm	All 3 divisions	All services across all 3 divisions
Missed visits	All 3 divisions	Community services across all 3 divisions
One Team Model implementation including: • Triage processes (variation at the front door) • One Assessment • Named worker allocation • Risk formulation and care planning • Clarity of offer and coordination of care including role of MDT • Staff skills and confidence in delivery of offer • Red lines • Outcome measures (lack of) • Discharge planning • SMI thresholds and definitions • Face to face vs telephone contact	Mental Health CFAA	All services within the division Perinatal Mental Health Service (PNMH)

• Duty offer • Escalation from primary to secondary care • New personalised approach to risk and the disconnect with wider agencies		
Patients not attending planned appointments (including not being brought for appointments) and then being discharged for 'non engagement'	Mental Health CFAA	Community LD
Physical health complexities of patients on mental health wards including management of the physically deteriorating patient	Mental Health CFAA	Inpatients Campion
Physical health complexities / acuity of patients on physical health rehabilitation wards including management of the physically deteriorating patient	Physical Health	Inpatients
Resource to deliver against guidelines e.g. Assertive Outreach	Mental Health	All
Restrictive interventions	Mental Health CFAA	Inpatients Campion
Robustness of the 72 hour follow up	Mental health	All services within the division
Safety of patients on waiting lists	Physical Health Mental Health CFAA	Community services Community services Neurodiversity services, CAMHS
Safety plan adaptation for those with a learning disability, neurodiversity or other needs	Mental Health CFAA	All services Neurodiversity services, mental health services (e.g. CAMHS, BEDS, LD, PNMH)
Search policy, process and practice	Mental Health CFAA	Inpatients Campion and Phoenix
Sexual safety	Mental Health CFAA	Inpatients Campion
Staffing issues affecting patient safety including: • Staffing levels • Skill mix • Burnout • Turnover • Reliance on temporary staff	All 3 divisions	All services across all 3 divisions
Suicide prevention	Mental Health CFAA	Community services Neurodiversity services, PNMH, CAMHS and LD

Transitioning from children to adult mental health services	Mental Health Children, Families and All Age Services	Community services Neurodiversity services, All Mental Health services (e.g. CAMHS, BEDS)
Voice of the family including: • Not being heard • Not being asked • Collateral information given but not being used • Collateral information not being recorded	All 3 divisions	All services across all 3 divisions

5. Our patient safety improvement and transformation profile

This section is about improvement and service transformation work that has an impact on patient safety and that is already underway or planned across Berkshire Healthcare. It includes relevant national and regional improvement programmes as well as locally driven service improvements.

5.1 National patient safety improvement programmes

They are part of the NHS Patient Safety Strategy and represent the largest coordinated safety initiative in NHS history. These programmes aim to reduce harm and improve care quality through evidence-based interventions, delivered locally by Patient Safety Collaboratives within the Health Innovation Networks. Those currently relevant to Berkshire Healthcare are:

1. **Managing Deterioration Safety Improvement Programme**
    - Focus: Early recognition and response to physical deterioration across all care settings.
    - Includes initiatives like Martha's Rule, NEWS2 adoption, and community deterioration strategies.
2. **Medicines Safety Improvement Programme**
    - Focus: Reducing medication-related harm.
    - Examples: Reducing opioid analgesic use and reducing non serious mental illness antipsychotic prescribing.
3. **System Safety Improvement Programme – Patient Safety Incident Response Framework**
    - Focus: Embedding a learning culture through proportionate, systems-based incident response

5.2 Breakthrough objectives

Breakthrough Objectives help us focus our improvement efforts and are ambitious, long-term improvement priorities that Berkshire Healthcare sets at the Executive/Trust level**.** They are designed to be transformative, each one lasting 1-2 years, and align with the Trust's True North Goals

From the latest QI strategy and internal communications, the Trust's breakthrough objectives include:

- Reducing length of stay for adults and older adults in mental health inpatient wards
- Reducing the length of stay for community inpatients
- Reducing the use of intramuscular rapid tranquillisation in mental health adult inpatient settings
- Reducing physical assaults on staff in mental health adult inpatient settings

5.3 Local patient safety improvement programmes

The following table outlines our current improvement and transformation workstreams that are related to patient safety. There are clear alignments between these workstreams and our patient safety profile in section 4.

The Trust is committed to learning from patient safety incidents and therefore we continue to develop our understanding and insights into required patient safety improvements. Therefore, this list is not exhaustive and local workstreams may further commence.

Workstream/Project	**Division**
1. Martha's Rule	MH
2. Enhanced Care Guidance Implementation	
3. Sexual Safety	
4. Culture of Care Programme	
5. Personalised Approach to Risk	
6. Clinical Risk Training Programme	
7. Psychosocial Interventions Programme	
8. Safe Wards Refresh	
9. NHSP Space Group and Temporary Staffing	
10. PCREF / Anti-Racism and Racial Equality	
11. RCN Pilots (Mental Health and LD Interface)	
12. Physical Assault Reduction Breakthrough Objective PPH	
13. Rapid Tranquilisation Breakthrough Objective PPH	
14. Length of Stay Breakthrough Objective PPH	
15. Peer Review CQC Project at PPH	
16. Preventing Harm to Others	
17. Suicide Prevention Strategy	
18. One Team	
19. Named Worker Transition and Personalised Approach to Care Planning	
20. Redefining Duty, MDT and IMDT	
21. Review of Triage	
22. Streamlining Clinical Documentation	
23. Right Care, Right Person	
24. Clozapine	
25. Assertive Outreach Team	
26. OPMH Review	

27. PICU Pathway	
28. NHS England – Mental Health in ED with RBH	
29. Provider Collaboratives	
30. 72hr follow ups	
31. Efficient use of resources – inappropriate out of area placements	
32. 28 days “stop the clock”	
33. Martha’s Rule	PH
34. Reduction in wait times	
35. Wound care improvement	
36. Frimley integrated pain pathway	
37. Jubilee ward move	
38. Podiatry/MSK waits	
39. POCT device management	
40. Clinical documentation management	
41. Community Front Door	
42. Standardise and Optimise Community Services	
43. Neighbourhood Multidisciplinary Teams	
44. Integrated Neighbourhood Intermediate Care	
45. Intermediate care beds/rehabilitation offer	
46. Band 3 and Band 4 support programme	
47. Unsafe discharge project (collaboration with RBH)	
48. Education, health and care needs assessment requests returned within 6 weeks	CFAA
49. OT waiting times greater than 52 weeks	
50. Access to health visiting mandatory checks – New birth visits AND 2.5 years review	
51. Re-imagining our community MH services for children and young people	
52. Re-imagining community LD services	
53. Adult ADHD – pausing new referrals while defining a future sustainable service model	
54. Improving access to perinatal mental health services for 16-18 years	
55. Campion ward flow	
56. CYP Neurodiversity	
57. SEND action plans	

6. How we will respond to patient safety incidents – our plan

This section will outline the considered and proportionate response methods for patient safety incidents that relate to the current patient safety challenges/issues listed in Section 4.3.

It is important to recognise that our safety profile (section 4.3) is not exhaustive of all patient safety challenges/issues in Berkshire Healthcare but provides guidance for what the focus of our local priorities should be over the next 18-24 months in terms of learning responses.

Furthermore, PSIRF guidance advocates that decisions for a patient safety learning response should be informed by **learning potential and system impact**. Therefore, there is no expectation or requirement that everything included in the safety profile will be subject to a patient safety learning response.

This plan should be read in conjunction with our Patient Safety Incident Response Policy (CCR173) which provides additional information regarding the internal processes of Datix triage, decision making and oversight responsibilities.

National Guidance suggests that a key element of PSIRF is setting out the number of PSII's that will be completed per year to support prioritisation and management of resources. However, it is at the discretion of the Trust to remain flexible and objective in our approach if this is felt necessary to support learning and meet the needs of our patient and families.

Over 2 years we have carried out 27 PSIIs (18 in our first 12 months and 9 in our second 12 months). With a decrease of PSIIs in the second 12-month period came an increase in other learning responses in line with the expected trajectory of the PSIRF journey. Therefore, it currently feels appropriate in terms of capacity, resource and managing proportionality with how we respond, that we would not exceed 12 PSIIs per year.

6.1 National event response requirements (relevant to Berkshire Healthcare)

6.1.1 National requirements for a PSII

National criteria	Response
Death thought more likely than not due to problems in care (Learning from Deaths criteria)	**Locally led PSII**
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	**Locally led PSII**

6.1.2 National requirements for other events

National criteria	Response
Incidents meeting the Never Events criteria 2018, or its replacement.	Proportionate learning response
Mental health-related homicides	Refer to the NHSE Regional Independent Investigation Team for consideration for an independent PSII **Locally led PSII may be required**
Child deaths	Refer for Child Death Overview Panel review

	Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel
Deaths of persons with learning disabilities and autistic people	Refer for Learning Disability Mortality Review (LeDeR) **Locally-led PSII (or other response) may be required** alongside the LeDeR – organisations should liaise with this
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead. Berkshire Healthcare must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards
Deaths in custody (e.g. police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so
Domestic abuse related deaths	A domestic abuse related death is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a Domestic Abuse Related Death Review (DARDR) are met, it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs

6.2 Local requirements for a learning response

Our previous PSIRP approached our local response to patient safety incidents with a table of specificity. As we have matured on our PSIRF journey, we feel this contradicts the principles of PSIRF which advocates flexibility and proportionality as well as a focus on improvement rather than a more prescriptive approach of particular learning responses for specific incidents.

PSIRF recommends applying a systems-based learning response for patient safety incidents when the **contributory factors are not well understood**, or **when existing improvement work is limited in scope** of effectiveness. In these cases, a learning response helps us fully explore the context, providing insights into system factors, human factors, and process weaknesses that influenced the outcome. This approach is especially important for new, emerging, or escalating patient safety issues that have not previously been reviewed through a learning response.

Our learning response activity may include exploration of an individual incident where contributing factors are not well understood, or a thematic review of past learning responses to inform the development of a safety improvement plan. If our Patient Safety Incident Response Group (PSIRG) are satisfied risks are being appropriately managed and/or improvement work is ongoing to address known contributing factors in relation to an identified patient safety incident type, and the effectiveness of actions is being monitored, it is acceptable not to undertake an individual learning response to an incident. It is however critical, that engagement is still undertaken with those affected and the incident is recorded. This proportionality approach is critical in ensuring that available investigation and improvement capacity is optimised by ensuring duplication is minimised.

6.2.1 Decision making processes

A fact find/case note review tool such as a Structured Judgement Review or an Initial Findings Report (for deaths) or a Patient Safety Incident Fact Find (for all other incidents) may be requested for patient safety incidents of interest to inform the decision-making process. This will be a critical role of our multidisciplinary PSIRG as further elaborated in the Patient Safety Incident Response Policy (CCR173).

Overall, underpinning our decision to commission an appropriate, proportionate patient safety learning response, will be consideration of the following questions:

- Are the contributory factors already understood, both generally for this type of incident and specifically for the circumstances of the event?
- Is there potential for new insight, such as a new, emerging, or escalating safety challenge?
- Does this incident align with the local patient safety challenges listed in section 4.3?
- Is improvement work already underway to address the identified contributory factors?
- Is there evidence and are we confident that the improvement work is having the intended effect or benefit?
- What are the views of those affected, including patients and their families?
- What level of senior oversight would be required to consider the complexity of the incident including context of the event and contributory factors?

- Is there sufficient capacity available to undertake a learning response versus the capacity to implement improvement work?
- Is there any concern that health inequalities may be a contributory factor?

These questions will be considered and explored to decide:

a) if a learning response will be undertaken, and if so,
b) which type of learning response (or combination of methodologies) will provide the richest insight into the underlying system factors.

6.3 Our learning response toolkit

PSIRF promotes a system-based approach to learning from patient safety incidents. A system-based approach uses tools and methods which draw on a scientific discipline called Human Factors or Ergonomics. This discipline seeks to identify the interactions between people and other elements of a work system (such as the equipment, technology and environment) and to understand how these influence or contribute to outcomes including patient safety incidents.

A national toolkit of investigation tools, templates and learning response methods is available to help us carry out our investigations and other learning responses with this system focus and we are encouraged to use this toolkit. At the time of writing this PSIRP, we are cognisant that NHSE are looking to revise the guidance on the toolkit of recommended learning responses. Therefore, the following learning response methods proposed for use in Berkshire Healthcare, are based on current national advice:

1. **Patient Safety Incident Investigation (PSII)**

Methodology	**Definition**	**Types of patient safety incidents this response may be appropriate for**
Patient Safety Incident Investigation	A patient safety incident 'review methodology' adopting an 'investigative approach' for the incident response. This leads to an in-depth review of a single patient safety incident with the formulation of a comprehensive report.	The decision to carry out a PSII (that does not come under the national mandate) should be based on incidents involving multiple teams, multifactorial, unclear causes, systemic issues and family concerns which require a structured investigation approach and senior oversight.

2. Other learning response methodologies

Methodology	Definition	Types of patient safety incidents this response may be appropriate for
After Action Review (AAR)	AAR is a structured facilitated discussion of a patient safety incident, the outcome of which gives individuals involved an understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning?	AAR may be particularly useful to review incidents involving procedures e.g. a medication error. AAR could also be used to explore a patient fall or pressure care issues or a near miss.
MDT Roundtable	A multidisciplinary roundtable review supports teams to learn from patient safety incidents that may have occurred in the last few days or earlier. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care. It may require some preparation including some focused areas for discussion/reflection and aims to bring together clinical staff with patient safety and governance support.	This methodology should be considered when local, more responsive methods (e.g. Swarm or debriefs) are not enough to understand and explore the system wide themes or pathways. They are useful for evaluating patterns such as delays in recognising deterioration, discharge safety processes, or medication administration pathway issues. They help uncover how care is delivered versus what policies define, revealing hidden system vulnerabilities.
Swarm Huddle	The swarm huddle is designed to be initiated as soon as possible after a	For incidents when immediate clarity and

	single patient safety incident and involves an MDT discussion involving staff who were present at the time of the incident. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.	corrective action are feasible, especially late-stage recognition or process lapses or incidents occurring in discrete settings (e.g., ward) where involved staff are on-site e.g. patient absconds. Ward team and estates swarm to understand environmental gaps, shift logistics, and quickly close vulnerabilities e.g. A high-risk patient falls unexpectedly. Immediate huddle with MDT (nurse, physio, pharmacist, medic) to reassess risk, review prevention tools, and adjust care plan
Thematic review	This methodology enables us to look at patterns of data to help answer questions, show links or identify issues. For example, collating findings from multiple incidents or incident responses to identify interlinked contributory factors to inform and/or direct improvement efforts.	

3. Complimentary tools alongside learning response methods

Methodology	**Definition**	**Types of patient safety incidents this response may be appropriate for**
Walkthrough analysis	A structured approach to collecting and analysing information about a task or process or a future development (e.g. designing a new protocol). Task: Individual actions or steps that together form a process (e.g. check chart for patient details) Process: A sequence of tasks or work conducted by individuals to	Can be applied to, among other issues, medication errors e.g. when needing to look at the administration process or the running of a depot clinic

	produce outcomes (e.g. administering a vaccine). The method is used to help understand how work is performed and aims to close the gap between work as imagined and work as done to better support human performance. It involves a learning response lead (who is not a user) working through a task or process alongside a representative user (someone familiar with the process) to understand how everyday work is done and determine any system redesign needs	

Within Berkshire Healthcare, any patient safety incident responded to by any of the methodologies listed above in Table 2 and Table 3, will be recorded and reported internally as a Patient Safety Review (PSR). For Swarms, this will be the case if the patient safety team have been involved in the process.

It is also important to note that the learning response methodology may be changed during the progress of a review, with the agreement of PSIRG, should it emerge that an alternative methodology may be more suitable.

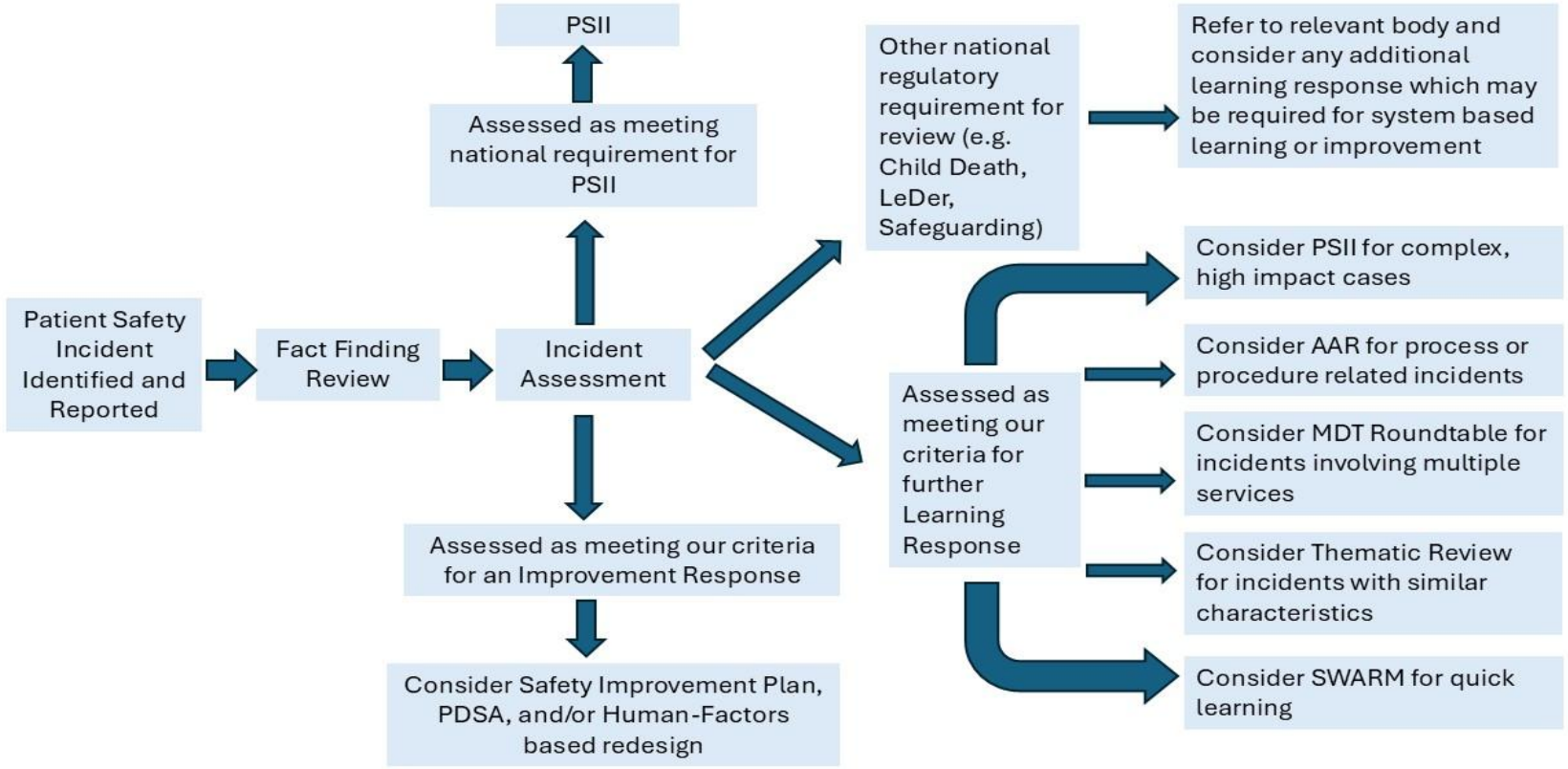
6.4 Improvement response

Where a safety issue or incident type is well understood (e.g. because previous learning responses or investigations into incidents of this type have been completed) **AND** improvement interventions or plans (of any type) targeted at system based contributory factors are being implemented and monitored for effectiveness, resources are better directed at improvement rather than carrying out further learning responses.

In these situations, an 'improvement response' is indicated. This still requires compassionate engagement steps to be fulfilled, but no individual learning response to understand the context and underlying system factors. Instead, methodologies will include quality improvement tools and structured change processes, such as Safety Improvement Plans, PDSA cycles (Plan-Do-Study-Act) and Human Factors-based redesign.

Within Berkshire Healthcare, any patient safety incident responded to as an improvement response, will be recorded and reported internally as an additional field on our PSR log.

Figure 1: Patient safety incident response selection flowchart



To note:

The fact finding review might require completion of a written tool such as a SJR (deaths), an IFR (deaths) or a Patient Safety Incident Fact Find

The incident assessment may take place within the local team/service leading to an immediate Swarm or it may take place at PSIRG.

6.5 Collaborative working

PSIRF encourage learning responses covering the wider system or patient pathway in which care is delivered. When a patient safety incident occurs that spans across other organisations, Berkshire Healthcare is committed to working alongside their partner agencies and colleagues in completing a single learning response. In accordance with our PSIRP, underpinning our decision to be involved in a joint learning response, will be consideration of the questions outlined in section 6.2.1.

6.6 Considering success

We recognise that safety is not only about preventing things from going wrong (Safety-I) but also about understanding and reinforcing what enables things to go right (Safety-II). Our learning responses will therefore:

- **Explore everyday work**: Investigate how care is delivered in practice (Work-as-Done) rather than relying solely on policies or assumptions (Work-as-Imagined).
- **Learn from success as well as failure**: Capture examples of resilience and adaptive behaviours that prevent harm or enable safe outcomes.
- **Strengthen system resilience**: Identify factors that support flexibility and adaptability under varying conditions.

Furthermore, alongside incident analysis within a learning response, we will collect and review examples of "what went well" to inform improvement strategies.

7. Compassionate engagement

7.1 Compassionate engagement principles

Compassionate engagement and involvement mean working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. When a PSII or any other learning response is undertaken, we will meaningfully involve those affected, where they wish to be involved. We believe that compassionate engagement with people affected is the most important aspect of responding to a patient safety incident.

Compassionate engagement covers both;

- How we communicate with, and support people affected (patients, families/carers and staff) by a patient safety incident. This is based around proactively identifying support needs, questions and concerns and meeting those needs. This includes taking a just and restorative approach to those affected, and a systems-based approach, rather than seeking to blame individuals.

- Meaningfully involving people affected in learning responses when they are carried out, to ensure their recollections, perspectives and thought processes and ideas for improvement are used to gather insight into work as done.

The Trust is committed to being open and honest with patients, families and carers who are directly impacted by a patient safety incident. This goes beyond the regulatory requirement of Duty of Candour and includes the adoption of the nine engagement principles in the national guidance for engaging and involving patients, families and staff following a patient safety incident[4]. It is important to remember that under PSIRP, our learning responses to our patient safety incidents are not necessarily associated to the degree of harm. However, the principles of Duty of Candour and our responsibility (as per Regulation 20 of the CQC guidance) will always apply to notifiable patient safety incidents. This is further explained in the Patient Safety Incident Response Policy (CCR173) and our Duty of Candour Policy (ORG072).

7.2 Compassionate engagement processes

To achieve compassionate engagement, we will consider:

- The identification of those affected at PSIRG when decisions about a further patient safety learning response are made. This will include affected staff as well as affected patients/families/carers.
- The appointment of an engagement lead to guide patients/families/carers through the process and identify any support needs they may have.
- The training requirements for engagement leads.
- The use of clear documentation such as the Learn Together[5] resource for our PSIIs.
- Signposting to our Wellbeing Service (for staff) and use of the Being Fair Tool (when applicable).

7.3 Our steps of engagement

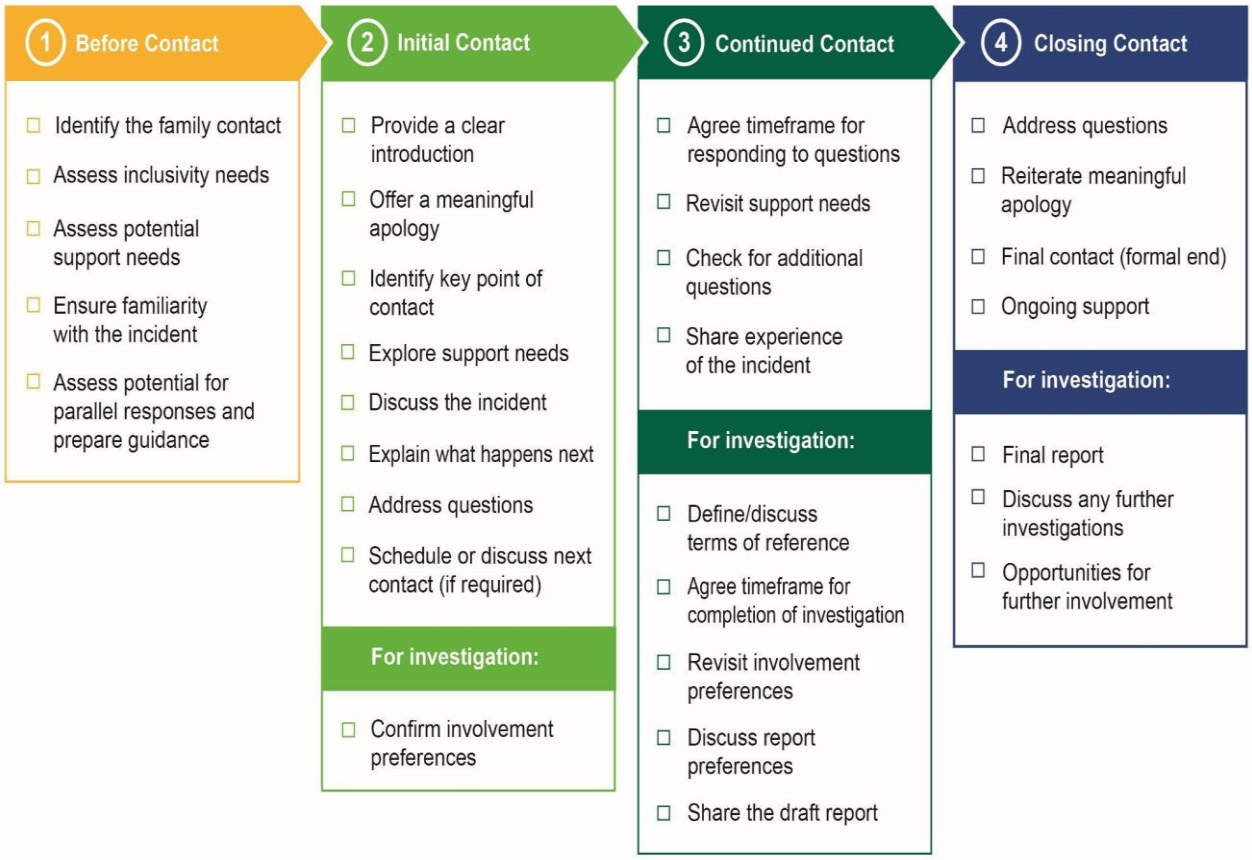
We will aim to follow clear steps of engagement as detailed in Figure 2.

Not all steps may be required, some steps may need to be repeated, and the process may not be as linear as implied. Our approach will be adapted to meet the circumstances of each patient safety incident and the individuals affected. For example, careful consideration must be given to the sequence (including timing in relation to the incident, such as avoiding the anniversary of a death) and complexity of what is being asked of those being engaged and involved, remembering that this can be emotionally demanding for them.

[4] NHS England (2022). *Patient Safety Incident Response Framework supporting guidance; Engaging and involving patients, families and staff following a patient safety incident.* Available from https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

[5] Support for Patients and Families – learn-together.org.uk

Figure 2: Steps of engagement



These steps will be initiated as soon as is reasonably practicable once a decision about a learning response has been made.

Appendix

Glossary - Definition of terms used in our PSIRP

Patient Safety Incident Response Framework (PSIRF)	National framework which sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Patient Safety Incident	An unplanned, unexpected or unintended event where something has happened, or failed to happen, as a result of the care or treatment provided that could have or did lead to patient harm.
Patient Safety Incident Review Group (PSIRG)	A weekly meeting to discuss and review patient safety incidents of interest for a collaborative decision between the Patient Safety Team and Divisional representatives. The PSIRG will have delegated responsibility for the consideration of which patient safety incidents should be PSII or require an alternative patient safety learning response or can be closed at local level.
Learning Response	Generic term for a tool that is designed to facilitate learning in response to a patient safety incident. It applies to any of the methodologies included in the toolkit of our PSIRP.
Patient Safety Incident Fact Find	A locally developed tool to aid a case record/note review to determine whether there were any problems in the care leading up to the patient safety incident in order to learn from what happened. May also involve using other sources of evidence to understand the sequence of events.
Initial Findings Report (IFR) for deaths	A locally developed tool to aid a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened. May also involve using other sources of evidence to understand the sequence of events.
Structured Judgement Review (SJR) for deaths	A case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened in accordance with national guidance.