Document Title			Effective From
CMI38 PATIENT SAFETY INCIDENT RESONSE POLICY (Aligned to the Patient Safety Incident Response Framework – PSIRF))			**31/03/2026**
Document Type	**Approval Body**	**Version No.**	**Review Due Date**
POLICY	**QUALITY SAFETY FORUM**	**2**	**31/03/2027**
	Owner	**Department**	
	PATIENT SAFETY & EXPERIENCE MANAGER	**QUALITY AND SAFETY**	

- This policy supersedes all previous issues.
- Printed copies of this document are valid only until midnight of the day it was printed.
- This policy covers both Everyturn and Everyturn Services management

DOCUMENT TYPE	Organisational ☒ Departmental ☐
PURPOSE	The purpose of this policy is to set out Everyturn Mental Health's approach to responding to patient safety incidents for the purpose of learning and improvement, in line with the Patient Safety Incident Response Framework (PSIRF). This policy establishes a system-based, proportionate, and compassionate approach to patient safety incident response and supports the development and maintenance of an effective patient safety incident response system. The policy supports the four core aims of PSIRF: • Compassionate engagement and involvement of those affected by patient safety incidents • Application of system-based approaches to learning • Considered and proportionate responses to incidents and safety issues • Supportive oversight focused on improvement and learning This policy should be read alongside the Patient Safety Incident Response Plan (PSIRP), which sets out how this policy is implemented in practice.
APPLICABLE TO	This policy applies to: • all Everyturn Mental Health employees • agency workers, contractors and consultants • students, apprentices, and volunteers • any partner organisation working on Everyturn premises or delivering services on behalf of Everyturn • service users and carers where relevant

KEY THINGS TO KNOW ABOUT THIS POLICY	• This policy sets out how Everyturn Mental Health responds to patient safety incidents for the purpose of learning and improvement, in line with the Patient Safety Incident Response Framework (PSIRF). • All patient safety incidents, near misses, and safety concerns must be reported via Ulysses, normally within 24 hours of identification, in accordance with the Incident Reporting Policy. • Not all incidents require investigation. PSIRF supports proportionate, system-based learning responses, selected based on risk, learning potential, and the needs of those affected. • Responses under this policy are undertaken solely for learning and improvement and do not seek to apportion blame, determine liability, or assess preventability. • Those affected by patient safety incidents (service users, families, carers, and staff) will be engaged compassionately and appropriately, in line with Duty of Candour requirements where applicable. • The Patient Safety Incident Response Plan (PSIRP) sets out the organisation's patient safety incident profile, priority areas, and planned response methods over a 12–18-month period and explains how this policy is implemented in practice. • Learning identified through patient safety incident responses will be shared and used to inform safety improvement actions, service development, and organisational assurance. • Oversight of patient safety incident response arrangements is provided through Quality & Safety governance structures, with assurance to senior leadership and the Board.
EXPECTED OUTCOME	This policy ensures that colleagues: • Understand their responsibilities for reporting and responding to incidents • Contribute to safer services and workplaces • Support learning from incidents and near misses • Promote a just, open, and learning culture across the organisation

PATIENT SAFETY INCIDENT RESONSE POLICY STATEMENT

Everyturn Mental Health is committed to delivering safe, high-quality, compassionate, and person-centred care and to continuously improving patient safety across all services. The organisation recognises that patient safety incidents, including near misses and safety concerns, are critical opportunities to learn, improve systems, and prevent recurrence.

Everyturn adopts the Patient Safety Incident Response Framework (PSIRF) as the basis for responding to patient safety incidents and safety issues. PSIRF supports a system-based, proportionate, and learning-focused approach, moving away from blame-driven investigations and towards understanding how systems, processes, environments, and human factors interact to influence safety.

Responses to patient safety incidents will be undertaken solely for the purpose of learning and improvement. They will not seek to apportion blame, determine liability, assess preventability, or attribute fault to individuals. Where required, separate organisational, statutory, or legal processes exist to address disciplinary, safeguarding, coronial, or criminal matters.

Everyturn Mental Health is committed to:

- **Compassionate engagement and involvement** of service users, families, carers, and staff affected by patient safety incidents
- **Openness, transparency, and honesty**, including compliance with statutory Duty of Candour requirements
- **Proportionate and considered responses**, tailored to the level of risk, harm, and learning potential
- **System-based learning**, recognising that patient safety is an emergent property of complex healthcare systems
- **Supportive oversight and assurance**, focused on strengthening patient safety systems and improving outcomes

The organisation promotes a just culture, where colleagues are encouraged and supported to report patient safety incidents and concerns without fear of inappropriate blame or punitive action. Staff affected by patient safety incidents will be treated with fairness, dignity, and respect and offered appropriate support.

Learning identified through patient safety incident responses will be shared appropriately across the organisation, embedded into governance, and used to inform safety improvement actions, service development, and assurance reporting. This ensures that learning leads to meaningful and sustainable improvement, reducing the risk of recurrence and strengthening patient safety across Everyturn Mental Health.

This policy is implemented alongside the Patient Safety Incident Response Plan (PSIRP Appendix A) and works in conjunction with the Incident Reporting Policy, ensuring a clear distinction between incident reporting and learning-focused patient safety response.

PATIENT SAFETY INCIDENT RESONSE ARRANGEMENTS

1.0 Relationship Between the Policy and the Patient Safety Incident Response Plan

This policy sets out Everyturn Mental Health's overarching approach to responding to patient safety incidents in line with the Patient Safety Incident Response Framework (PSIRF).

The Patient Safety Incident Response Plan (PSIRP) is the operational document that implements this policy. It defines:

- The organisation's patient safety incident profile
- Priority incident types and safety issues
- The learning response methods that will normally be applied
- Anticipated improvement routes over a 12–18 month planning period

Responses to patient safety incidents will be delivered in accordance with the PSIRP, unless there is a clear rationale for deviation based on the specific circumstances of an incident.

2.0 Identification and Reporting of Patient Safety Incidents

All patient safety incidents, near misses, and safety concerns must be reported via Ulysses as soon as practicable and normally within 24 hours of identification.

Reported incidents are reviewed by the Quality & Safety Team to:

- Confirm whether the incident aligns with priority areas identified in the PSIRP
- Identify any immediate safety concerns
- Ensure appropriate escalation, support, and engagement with those affected

Incident reporting requirements are set out in detail within the Incident Reporting Policy (GG10), which operates alongside this policy.

3.0 Alignment to the Patient Safety Incident Profile

Learning responses are informed by the organisation's patient safety incident profile, as defined in the PSIRP. This profile is developed using triangulated data including:

- Incident reporting trends
- Risk registers
- Audits and quality reviews
- Staff feedback and Freedom to Speak Up insights
- Patient, service user, and carer feedback

The incident profile is reviewed periodically to ensure responses remain relevant, proportionate, and targeted to areas of greatest risk and learning opportunity.

4.0 Decision-Making for Learning Responses

In line with PSIRF, not all patient safety incidents require formal investigation.

Each incident will be reviewed using a system-based approach to determine the most appropriate learning response, taking account of:

- The nature and context of the incident
- Potential for new learning
- The views and needs of those affected
- Whether improvement activity is already underway
- Whether existing controls are effective

Decision-making will be consistent with the response methods set out in the PSIRP, while allowing flexibility where justified.

5.0 Learning Response Methods

Learning responses will be proportionate and flexible, selected from a range of methods set out in the PSIRP, which may include:

- Rapid reviews
- After Action Reviews (AAR)
- Case or peer reviews
- Thematic reviews
- Patient Safety Incident Investigations (PSII), where required

PSII will normally be reserved for incidents that meet national or local criteria, including unexpected deaths potentially due to problems in care, in line with PSIRF and the PSIRP.

Learning responses are undertaken solely for the purpose of learning and improvement and do not seek to apportion blame or determine liability.

6.0 Engagement and Involvement of Those Affected

Engagement and involvement of service users, families, carers, and staff is a core requirement of PSIRF and is embedded within both this policy and the PSIRP.

Those affected by a patient safety incident will:

- Be engaged compassionately and respectfully
- Be offered opportunities to contribute to learning responses where appropriate
- Be kept informed throughout the response process
- Be supported in line with organisational support arrangements

Engagement will be aligned with Duty of Candour requirements where applicable.

7.0 Cross-System and External Working

Where patient safety incidents involve multiple organisations or cross-system issues, Everyturn Mental Health will work collaboratively with Integrated Care Boards (ICBs) and partner organisations.

Cross-system learning responses will be coordinated to:

- Avoid duplication
- Reduce burden on those affected
- Support system-wide learning and improvement

8.0 Timeframes for Learning Responses

Learning responses will commence as soon as practicable following identification of a patient safety incident.

Indicative timeframes, as set out in the PSIRP, are:

- Normally completed within one to three months
- No longer than six months, unless exceptional circumstances apply

Where timescales are extended, this will be agreed and communicated with those affected.

9.0 Safety Actions and Improvement

Safety actions arising from learning responses will:

- Be SMART
- Have named action owners
- Be monitored through Ulysses and governance processes

Learning and improvement outcomes will feed into:

- Local service improvement
- Organisational quality and safety priorities
- Future iterations of the PSIRP

10.0 Oversight and Assurance

Oversight of patient safety incident response arrangements is provided by the Quality & Safety Team, with assurance reporting through:

- Quality & Safety Forum
- Governance & Risk Committee

This ensures that responses remain aligned with the PSIRP, PSIRF principles, and organisational patient safety priorities.

11.0 Statement on Policy Implementation

11.1 Upon approval, this policy will be uploaded to the policy portal and communicated to staff via Everyturn Intranet.

12.0 Statement on Equality and Diversity

12.1 Everyturn is committed to providing equality of opportunity.

12.2 This policy has been assessed to identify any potential for adverse or positive impact on specific groups of people protected by the Equality Act 2010 and does not discriminate either directly or indirectly. In applying this policy, we have considered eliminating unlawful discrimination, promoting equality of opportunity and promoting good relations between people from diverse groups. Any issues highlighted in the assessment have been considered and incorporated into the policy and approved by the relevant committee.

13.0 Statement on Consultation

A summary of the consultation output and any subsequent amendments to the policy content was shared with the Policy Organisational Development Forum/Quality Safety Forum as part of the policy approval process.

ORGANISATION RESPONSIBILITIES

While overall accountability for safety rests with the highest level of management, the active involvement of all colleagues is essential to ensure a safe, effective, and well-governed organisation.

Everyturn Mental Health recognises that effective incident reporting, patient safety incident response, and organisational learning rely on clear leadership, defined roles and responsibilities, and a shared commitment to safety at every level of the organisation. Safety is a collective responsibility and is supported through strong governance, open communication, and a culture that values learning and continuous improvement.

The organisation is committed to ensuring that:

- Roles and responsibilities for incident reporting and patient safety incident response are clearly defined and understood
- Arrangements support a just culture, where colleagues are encouraged to report incidents and safety concerns without fear of inappropriate blame
- Learning from incidents is identified, shared, and embedded into practice
- Oversight and assurance arrangements provide confidence that safety risks are being effectively managed

The roles outlined below have been assigned key responsibilities for the implementation, monitoring, oversight, and continuous improvement of incident management and patient safety arrangements across Everyturn Mental Health, in line with the Patient Safety Incident Response Framework (PSIRF) and organisational governance requirements.

BOARD OF TRUSTEES	The Board of Trustees holds ultimate accountability for patient safety across Everyturn Mental Health. The Board provides strategic oversight and assurance that effective systems, governance arrangements, and resources are in place to support incident reporting, patient safety incident response, and organisational learning. The Board seeks assurance that patient safety risks are identified, managed, and controlled, and that learning from incidents leads to meaningful and sustained improvement.
CHIEF EXECTUTIVE OFFICER (CEO)	The Chief Executive Officer is accountable for ensuring that effective leadership, governance, and organisational arrangements are in place to support patient safety and compliance with statutory and regulatory requirements. The CEO ensures that: • Patient safety is prioritised across the organisation • Appropriate escalation and oversight arrangements exist for serious patient safety incidents • The Board is informed and assured regarding significant patient safety risks and learning

EXECUTIVE MANAGEMENT GROUP (EMG)	The Executive Management Group provides executive oversight of patient safety arrangements and approves organisational policies. EMG is responsible for: • Ensuring patient safety incident reporting and response arrangements are embedded across services • Providing leadership and challenge in relation to safety, quality, and risk • Supporting a culture of openness, learning, and continuous improvement
EXECUTIVE DIRECTOR OF QUALITY GOVERNANCE & RISK	The Executive Director of Quality, Governance & Risk provides strategic leadership and executive oversight of patient safety incident response in line with PSIRF. Responsibilities include: • Oversight of PSIRF implementation and compliance • Ensuring proportionate, system-based learning responses to patient safety incidents • Providing assurance to EMG and the Board on patient safety performance, risks, and improvement activity
HEAD OF QUALITY & SAFETY	The Head of Quality & Safety provides operational oversight and assurance of patient safety incident reporting and response arrangements. Responsibilities include: • Oversight of patient safety governance and assurance processes • Ensuring learning responses are completed within agreed timescales • Supporting managers and learning response leads • Ensuring statutory, regulatory, and external reporting requirements are met • Monitoring themes, trends, and learning outcomes
SENIOR LEADERSHIP TEAM (SLT)	Members of the Senior Leadership Team are responsible for leading and embedding patient safety arrangements within their areas of responsibility. SLT responsibilities include: • Ensuring policies and procedures are implemented and adhered to • Promoting a just culture and encouraging incident reporting • Supporting learning from patient safety incidents

	• Ensuring risks and learning are escalated appropriately through governance structures
SERVICE MANAGERS / TEAM LEADERS	Service Managers and Team Leaders are responsible for the day-to-day management of patient safety within their services. Responsibilities include: • Ensuring all patient safety incidents and near misses are reported via Ulysses • Reviewing incidents promptly and supporting proportionate learning responses • Implementing and monitoring safety actions • Supporting staff involved in or affected by incidents • Promoting open communication and learning within teams
CLINICAL DIRECTOR	The Clinical Director provides clinical leadership and oversight in relation to patient safety incident response. Responsibilities include: • Supporting clinically appropriate learning responses • Ensuring learning informs safe and effective clinical practice • Providing expert advice where incidents involve clinical risk or complexity
PATIEND SAFETY & EXPERIENCE MANAGER	The Patient Safety & Experience Manager has operational responsibility for patient safety incident response arrangements. Responsibilities include: • Acting as Document Owner for the Patient Safety Incident Response Policy • Coordinating PSIRF learning responses • Providing advice, guidance, and support to services • Leading thematic analysis and organisational learning • Supporting engagement with service users, families, and staff
ALL COLLEAGUES	All colleagues are responsible for contributing to a safe, open, and learning-focused organisation. Colleagues must: • Report all patient safety incidents, near misses, and concerns promptly • Engage openly and honestly in learning responses where required • Act in accordance with Duty of Candour requirements • Uphold Everyturn values of Innovation, Compassion, Accountability, Respect, and Excellence

	• Speak up where they identify safety concerns or risks

GLOSSARY OF KEY TERMS/DEFINITIONS	
PATIENT SAFETY INCIDENT	Any unintended or unexpected incident that could have, or did, lead to harm for one or more patients receiving healthcare. This includes incidents resulting in harm, no harm, or near misses
NEAR MISS	An incident that did not result in harm but had the potential to do so
PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)	The national framework that sets out how organisations respond to patient safety incidents for the purpose of learning and improvement. PSIRF promotes proportionate, system-based, and compassionate responses rather than blame-focused investigations.
PATIENT SAFETY INCIDENT REPONSE PLAN (PSIRP)	The operational plan that sets out how this policy is implemented in practice, including the organisation's patient safety incident profile, response methods, and improvement priorities over a defined planning period.
PATIENT SAFETY INCIDENT INVESTIGATION (PSSII)	A formal, system-based investigation undertaken where national or local criteria are met, such as unexpected deaths potentially due to problems in care, in line with PSIRF guidance
LEARNING RESPONSE	A proportionate response undertaken to understand what happened and why, and to identify opportunities for system improvement. Learning responses may include rapid reviews, after-action reviews, case or peer reviews, thematic reviews, or PSII
SYSTEM BASED APPROACH	An approach that recognises patient safety as an emergent property of complex systems, where outcomes result from the interaction of multiple factors rather than the actions of individuals alone
JUST CULTURE	A culture that supports openness and learning by balancing accountability with a non-punitive approach to error, recognising that most patient safety incidents arise from system factors rather than individual failings
DUTY OF CANDOUR	A statutory requirement to be open and honest with patients, families, or carers when a notifiable safety incident has occurred, including providing an apology and clear information about what is known and the learning identified
THOSE AFFECTED	Patients, service users, families, carers, and staff who are directly or indirectly impacted by a patient safety incident
ULYSSES	Everyturn Mental Health's electronic incident reporting system used to record patient safety incidents, near misses, and safety concerns and to support monitoring, learning, and governance oversight
SAFETY ACTION	An action identified through a learning response that is designed to reduce risk and prevent recurrence. Safety actions should be specific, measurable, achievable, relevant, and time-bound (SMART).

CROSS SYSTEM INCIDENT	A patient safety incident that involves more than one organisation or service and requires coordinated learning and improvement activity across organisational boundaries.

MISCELLANEOUS	
REFERENCES	• NHS England – *Patient Safety Incident Response Framework (PSIRF)* • NHS Patient Safety Strategy (2019) • Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • Care Quality Commission (Registration) Regulations 2009Duty of Candour – Statutory Guidance
RELATED DOCUMENTS	• Patient Safety Incident Response Plan (PSIRP). • GG07 Duty of Candour Policy • GG05 Risk Management Framework Policy • CMI02 Safeguarding Adults Policy • CMI01 Safeguarding Children Policy
KEYWORDS	Patient safety; patient safety incident; PSIRF; learning response; system-based learning; just culture; Duty of Candour; PSII; patient safety incident response plan; governance; quality and safety.

MONITORING OF POLICY COMPLIANCE					
Policy Statement	**KPI**	**Method**	**Who By**	**Committee/Group**	**Frequency**
Patient safety incidents and near misses are reported in line with policy	% incidents reported on Ulysses within required timescales	Incident data review and audit	Patient Safety & Experience Manager	Quality & Safety Forum	Quarterly
Serious patient safety incidents are escalated and managed appropriately	Timely escalation and external reporting compliance	Case review and assurance checks	Head of Quality & Safety	Governance & Risk Committee	Quarterly
Learning from patient safety incidents is identified and implemented	% learning actions completed within agreed timescales	Action plan monitoring	Service Managers / Quality & Safety	Quality & Safety Forum	Quarterly
Statutory Duty of Candour requirements are met	Duty of Candour actions completed and documented	Case file audit	Quality & Safety Team	Governance & Risk Committee	Six-monthly
Staff are appropriately trained in patient safety and incident response	Training compliance rates	Training records review	Learning & Development	Quality & Safety Forum	Annually

VERSION CONTROL				
Version No.	**Documentation Section/Page No.**	**Description of Change and Rationale**	**Author/Reviewer**	**Date Revised**
2.0	Patient Safety Incident Response Policy	Full review and transfer to new policy format, including PSIRF alignment	Emma Millar	31/03/26