# PATIENT SAFETY INCIDENT RESPONSE PLAN

June 2025

Changing childhoods.
Changing lives.

**Effective date: 01.04.2025**

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|---|---|---|---|
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# Contents

# Introduction

The Patient Safety Incident Response Framework will replace the current **Serious Incident Framework (2015).**

The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS. It is a key part of the **NHS patient safety strategy.** Barnardo's is committed to delivering services against NHS guidelines and as such has developed this action plan to inform our policy and way that services work.

This Patient Safety Incident Response Plan describes Barnardo's strategic methodology for addressing patient safety incidents over the forthcoming 12 to 18 months. Acknowledging the dynamic nature of the healthcare environment, this plan is intentionally designed to be flexible, permitting modifications that correspond to the specific circumstances of each incident, as well as the distinct needs of the individuals affected. Barnardo's has been refining its data collection and information management processes concerning incidents for several years. Our internal procedures have been aligned with our digital initiatives, and in April 2025, we will implement a new digital system across all services to facilitate the recording and monitoring of incidents i.e. Serious Safeguarding and Health and Safety. We have existing systems for capturing the other incidents we consider to be in scope for PSIRF. It is important to note that Barnardo's employs terminology that differs from that used by our health partners; notably, we utilise the term "service user" rather than "patient." Therefore, the subsequent sections of this plan will adopt the language employed by our colleagues.

In developing this plan, Barnardo's has built on its existing safety incident policy to ensure a cohesive and comprehensive approach to service user safety. We are fully committed to implementing this plan in partnership with the various agencies and stakeholders in our health services. This collaboration extends to both direct health service providers and those we work with under commissioned services, fostering a unified effort to enhance service user safety and improve outcomes.

Barnardo's emphasises the importance of proactive engagement, ongoing training, and clear communication throughout the response process. We pledge to remain vigilant, continually assessing and refining our strategies to better serve our service users and communities. Through this concerted effort, we aim to create a safer healthcare environment and build trust with all individuals impacted by service user incidents.

# Our services

## Mapping Overview

Barnardo's delivers an extensive array of health-related services across the country, meticulously tailored to address the specific needs of various commissioning bodies, each possessing a distinct approach to service delivery. A comprehensive mapping exercise has identified significant variations in implementation methods and outcomes among these services. This finding underscores the necessity for a customised response to execute our service user safety action plan effectively.

When drafting our PSIRF plan, Barnardo's delivered 81 services on behalf of or in partnership with NHS England. Notably, 52 of these services possess contracts set to expire within 2025. While certain services may naturally conclude, others might undergo retendering or extension, we may also add to these Services through our ongoing Tendering activity.

Our Business Development team maintains an updated inventory of all contracts and services within Salesforce. Access to this information proved crucial during our mapping exercise.

The primary categories of our services encompass:

- Mental Health & Emotional Wellbeing
- Integrated Child & Family Health
- Early Support
- Disability
- Child Abuse and Exploitation
- Youth Work (including Youth Justice)
- Service Engagement and System Development
- Education
- Mental Health
- Family Support Services
- Advocacy, Children's Rights, and Participation
- Disability

Crucially, none of our services involve invasive procedures, reducing the potential for incidents. Our principal objective is to provide advice, support and guidance, assisting individuals to navigate various networks.

In support of the structured development and effective implementation of the service user Safety Incident Response Framework (PSIRF), Barnardo's will coordinate targeted stakeholder engagement forums. These forums convene key representatives from partner agencies, healthcare providers, and commissioning bodies. The primary aim is to establish a collaborative platform that ensures our strategic approach is comprehensive and adaptable, effectively addressing the diverse needs of the services involved. By cultivating robust relationships among stakeholders, we endeavour to enhance service delivery and improve health outcomes for the communities we serve.

Our initial step entailed identifying which health contracts already employed a recognised reporting and recording system in collaboration with a lead partner. Our research determined that certain services already operated within the PSIRF framework, reporting incidents and accidents through systems such as Datix into Learning from Patient Safety Events (LFPSE). This was prominently observed in our partnerships, where we did not serve as the primary service provider, necessitating close collaboration with the lead organisation to ensure confidence in data gathering for oversight. The learning aspect in these relationships is always maintained by the lead organisation and Barnardo's is committed to working in partnership and addressing all learning outcomes.

During our internal stakeholder meetings, our project manager convened experts from each field, including heads of service and business areas. This process facilitated effective communication with the appropriate departments and ensured that all current information was compiled in a structured manner.

# Service library

Since its founding in 1866, Barnardo's has been dedicated to supporting children and young people. While the specific services we offer and the environments we operate have evolved, our core principles and values remain unchanged. Our mission at Barnardo's is clear: "changing childhoods, changing lives." We do this by providing diverse services nationwide to improve outcomes for children and young people.

## Barnardo's basis and values: Our values

As an organisation, Barnardo's has been continuously adapting to new ways of working by embracing our trauma-responsive approach, investing in colleague development, and implementing our five-year strategy. Throughout our planning and mapping processes, we have successfully transitioned to a more effective way of addressing incidents across the organisation. We understand that we must concentrate on learning and developing a deeper understanding to improve. That's why Barnardo's is committed to implementing a Safety Incident Reduction Framework across all its services.

Please contact the nominated individuals below for further information on our service departments.

**Fostering and Adoption**
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At the time of writing, in addition to the 81 Health Contracts, we have 676 contracts and agreements to provide a range of other Services, including:

- Family Support
- Education, Training and Skills (including two schools)
- Advocacy
- Children's Homes and other Residential Services
- Family Placement
- Exploitation and Trafficking

The current portfolio has evolved significantly over the last 160 years when Thomas Barnardo established our Children's Homes and demonstrates how the organisation has innovated through learning, being responsive and adapting. This has included a longstanding commitment to learning from our incidents, mistakes and errors, in order to ever reduce the likelihood of harm to our Service Users, Staff Members, Volunteers and Foster Carers. This means that PSIRF should be about further improvement and enhancement of what we do, not a wholesale change.

# Defining our Service user safety incident profile

## Most pertinent safety issues within NHS contracts

Within the framework of NHS contracts that Barnardo's operates under, senior leaders have identified several safety areas of focus based on their analysis of safety and quality data; this enabled the identification of the most significant safety issues to be included in our PSIRF plan and covered within our framework PSIRF policy. These issues include:

### Serious safeguarding incident: Serious safeguarding incident form

We have implemented a structured process for documenting and managing serious safeguarding incidents with a dedicated Serious Safeguarding Incident form, to be replaced with an online reporting tool called Safety Online Reporting Tool (SORT) mid 2025. This tool allows for thorough reporting and analysis of very serious incidents involving our service users, enabling us to learn from each case and improve our safeguarding practices.

Our existing reports, including our annual lessons-learned report on serious safeguarding incidents (SSIs), have provided insights regarding these safety issues. From these reports, we have identified that Suicide and self-harm are the single most significant reasons for serious safeguarding incidents. This report emphasises the importance we place on ongoing organisational change and systematic reviews, ensuring we continuously improve our practices and responses to these critical issues.

We have established comprehensive guidelines to address incidents of serious self-harm and intentions of suicide effectively.

**Serious self-harm and suicide intent guidelines**

These guidelines outline best practices for assessing risk, ensuring immediate support for affected individuals, and maintaining ongoing monitoring to prevent escalation where possible.

### Data Protection: Information governance and data protection

We prioritise stringent information governance protocols to safeguard sensitive data. Compliance with the Data Protection Act and adherence to best practices in data management are fundamental in maintaining the confidentiality and integrity of the information related to our service users.

## Health & Safety

Our existing reports and data have provided insights regarding our health and safety issues. From these reports, we have identified that physical aggression towards our colleagues is of concern as is injury and psychological stress during suicide and self-harm episodes for our service users.

**Group health and safety policy statement**
**Incident and Accident Reporting Flowchart**

### Safe People and Culture

Safety is integrated within our People and Culture strategy. We have a clear focus to embed safe behaviours to drive our safety culture. We have a clear training strategy to develop highly skilled dynamic people who recognise that everyone plays their part when keeping people safe. Leaders are visible, accountable and committed. We are committed to reducing work-related ill health and harm towards our people.

### Robust Safety Management System

We are committed to continually review the strong foundations of our current safety management system to simplify and demystify. We quality assure and benchmark our Safety Management system against recognised standards.

### Enabling the delivery of the Barnardo's Organisational Strategy

We hold a first-class safety reputation as enablers. We ensure that the organisation can achieve its strategy to build better outcomes for more children and young people by working together to achieve the collective goal of stronger families, safer childhoods and positive futures. We underpin new ways of working with strong robust risk management frameworks. We recognise that we do risk management, not risk elimination.

### Working Collaboratively

We work collaboratively internally and externally to manage risk and enable delivery of safe work. We are committed to providing safe environments for our people to work in.

### Future proofing

All Health and Safety matters will also be subject to SORT reporting from mid 2025, being escalated to the correct department for oversight and learning response. In addition, all services are subject to yearly Health and Safety Quality Assurance (HSQA) inspections.

Barnardo's is committed to closely monitoring and addressing all safety issues within its organisation. Our approach encompasses a culture that prioritises learning and development, focusing significantly on safety and safeguarding and protecting the rights of all individuals involved. We actively support our service managers and staff in all types of reporting, promoting an environment of openness and transparency.

All incidents and accidents are routinely monitored and meticulously recorded. Each report is submitted to our safety team for comprehensive oversight and review. Our process emphasises the need to understand the circumstances leading up to each event and analysing the outcomes thereafter.

## Other incidents we regularly monitor

The following are reported centrally and will be in scope for our PSIRF approach when they impact or involve service users:

- Allegations against Adults, including non-recent abuse: **Historical abuse policy**
- Complaints: **Complaints Management Framework**
- Death of a service user: **Death of a service user**
- Professional standards investigations: **Responding to external investigations**
- Whistleblowing: **Whistleblowing policy**

## Collaboration of stakeholders

At the outset, Barnardo proactively initiated in-depth discussions with several internal and external stakeholders involved in the Patient Safety Incident Response Framework (PSIRF) within the context of our larger NHS contracts. These discussions emerged from ongoing dialogues rooted in our key performance indicator (KPI) reviews. During these meaningful exchanges, it became clear that a more comprehensive engagement with all our commissioners would be vital for success.

Identifying a single commissioning body to partner with, in developing our detailed framework presented a significant challenge. This complexity stemmed from our vast array of services and geographical spread across England, each with unique needs and circumstances.

Our dedicated learning and development team concentrated on fostering collaborative relationships with e-Learning for Health (eLfH) to ensure that access to the agreed-upon training was consistent and fully aligned with the stringent standards set by the PSIRF. We take pride in our ability to monitor the requisite learning outcomes effectively, and our learning response leads are well-equipped to provide concrete evidence of completing mandatory training across our NHS contracts.

# Data Sources

Barnardo's has developed strong data sources that systematically capture and document incidents that we consider to be in scope for PSIRF. These systems are specifically designed to promote the early recognition of issues and enable services to log incidents effectively for learning and reporting purposes. The organisation is accountable to the Charity Commission and various regulatory bodies, ensuring that we can report, record, and respond in a timely and effective manner.

To gain insight into the organisation's safety profile and identify key priorities for improvement, the established PSIRF Implementation Working Group will conduct a comprehensive review of safety data from previous years. This analysis focuses on identifying opportunities for enhancement, particularly in areas where there are gaps in care and treatment, or where certain types of incidents continue to raise concerns due to their impact on service users, families, carers, or colleagues.

# Reporting into LFPSE

Currently, none of our established reporting systems outlined above have the functionality to report directly to the LFPSE. Our NHS services will continue to use the reporting systems and functions as detailed above and will be required to record patient safety incidents directly into the LFPSE via the following link:

**Learn from patient safety events**

Where there are no existing arrangements to use partner systems, all services will be supported to establish a secure login so that incidents and events can be recorded directly into LFPSE data base.

# Defining our Service User Safety Improvement Profile

## Process of review

After gathering information and understanding how our systems align with PSIRF's requirements, we have identified several growth and development opportunities that we will incorporate into our service design and policy reviews.

In recent years Barnardo's has been on journeys of transformation, this has naturally allowed us to consider new roles to support our development of services in the current climate. In the very near future, we will have several new posts that will oversee the development of existing practices to ensure that all data is being captured and reviewed for quality and assurance.

## National improvement Plans

### New roles

- Strategic Lead for Clinical and Quality Governance, began role in April 2025
- Strategic Voice and Influence lead (Health) Begins May 2025

### Learning and Development

- Learning Response Leads trained in SEIPS
- Strategic Voice and Influence lead (new role May 2025) to establish Patient Safety partner (PSP) board to support review and development of the action plan and policy.

### New coordination

- Implementation of an oversight board with a specific health focus. This will be a central point in considering the patterns of safety incidents to identify learning and areas for improvement.
- To ensure ongoing improvement, we will establish learning objectives and outcomes, which will be subject to regular reviews via a Safety Investigation and Learning Board, led by a senior executive director. This approach guarantees that those involved receive the necessary support and that our services incorporate any insights gained to minimise the likelihood of similar incidents occurring in the future.

### New Digital systems

- Digital and device redesign, the ability for staff to access systems across multiple platforms and devices without minimising effectiveness. With the arrival of SORT our ability to reflect on incidents and improve our response will develop further.

### New Guidance

- Review all policies and procedures to ensure relevant criteria and PSIRF are represented at every level and that all our processes support early identification, recording, and learning response.

# Service User (Patient) safety incident investigations (PSIIs)

Service user safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. PSIIs focus on improving healthcare systems; they do not look to blame individuals. Other organisations and investigation types consider issues such as criminality, culpability or cause of death including responsibility or trying to determine whether an incident was preventable can lead to a culture of fear, resulting in missed opportunities for improvement.

The key aim of a PSII is to clearly explain how an organisation's systems and processes contributed to a service user safety incident. Recognising that mistakes are human, PSIIs examine 'system factors' such as the tools, technologies, environments, tasks, and work processes involved. Findings from a PSII are then used to identify actions that will lead to improvements in the safety of the care service users receive.

PSIIs begin as soon as possible after the incident and are normally completed within three months. However, with the agreement of those affected, including service users, patients, families, carers, and staff, this timeframe may be extended.

If a PSII finds significant risks that require immediate action to improve service user safety, this action will be taken as soon as possible. However, according to a safety improvement plan based on the findings from several investigations or other learning responses, some safety actions for system improvement may not follow until later.

PSIIs will be led by colleagues who have completed the required training to fulfil the role of Learning Response Lead. The organisation's Service user Safety Specialist will retain a directory of trained Learning Response Leads for the purposes of assurance of training, allocation/involvement in PSIIs and undertaking of continuing professional development.

# Our Service User Safety Incident Response Plan: National Requirements

There are instances when events occur that require a Service user Safety Incident Investigation (PSII) to be conducted as part of national regulations. This investigation aims to identify opportunities for learning and improvement. Providers of HNS services are obligated to carry out a PSII in specific circumstances, as outlined in the supporting documents of the Patient Safety Incident Response Framework (PSIRF).

**guide-to-responding-proportionately-to-patient-safety-incidents**

## National requirement for PSII

A list of events which necessitate a nationally mandated learning response be undertaken can be found in our table below.

| Service user safety incident type | Required response | Anticipated improvement route |
|---|---|---|
| Child deaths | • Refer for Child Death Overview Panel (CDOP)<br>• Locally-led PSII (or other response) may be required alongside the panel review if the death occurred in our care – we will liaise with the CDOP | Cooperate with any external review and respond to recommendations from external agencies/organisations as required and feed into our quality improvement strategy. |
| Deaths of persons with learning disabilities | • Refer for Learning Disability Mortality Review (LeDeR)<br>• Locally-led PSII (or other response) may be required if the death occurred in our care alongside the LeDeR – organisations should liaise with the LeDer Programme | Cooperate with any external review and respond to recommendations from external agencies/organisations as required and feed into the quality improvement strategy. |
| Mental health-related homicides | • Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII<br>• Locally-led PSII may be required if the death occurred in our care but liaise with RIIT | Cooperate with any external review and respond to recommendations from external agencies/organisations as required and feed into the quality improvement strategy |

| Service user safety incident type | Required response | Anticipated improvement route |
|---|---|---|
| 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 | Our services do not currently detain individuals. Add to the plan if this changes. |
| 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<br>• Healthcare organisations must fully support these investigations where required to do so | None of our services currently fall within this criteria.<br><br>Add to plan if this should this change. |
| Domestic homicide | • A domestic homicide 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<br>• Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel<br>• 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 | Cooperate with any external review and respond to recommendations from external agencies/organisations as required and feed into the quality improvement strategy |

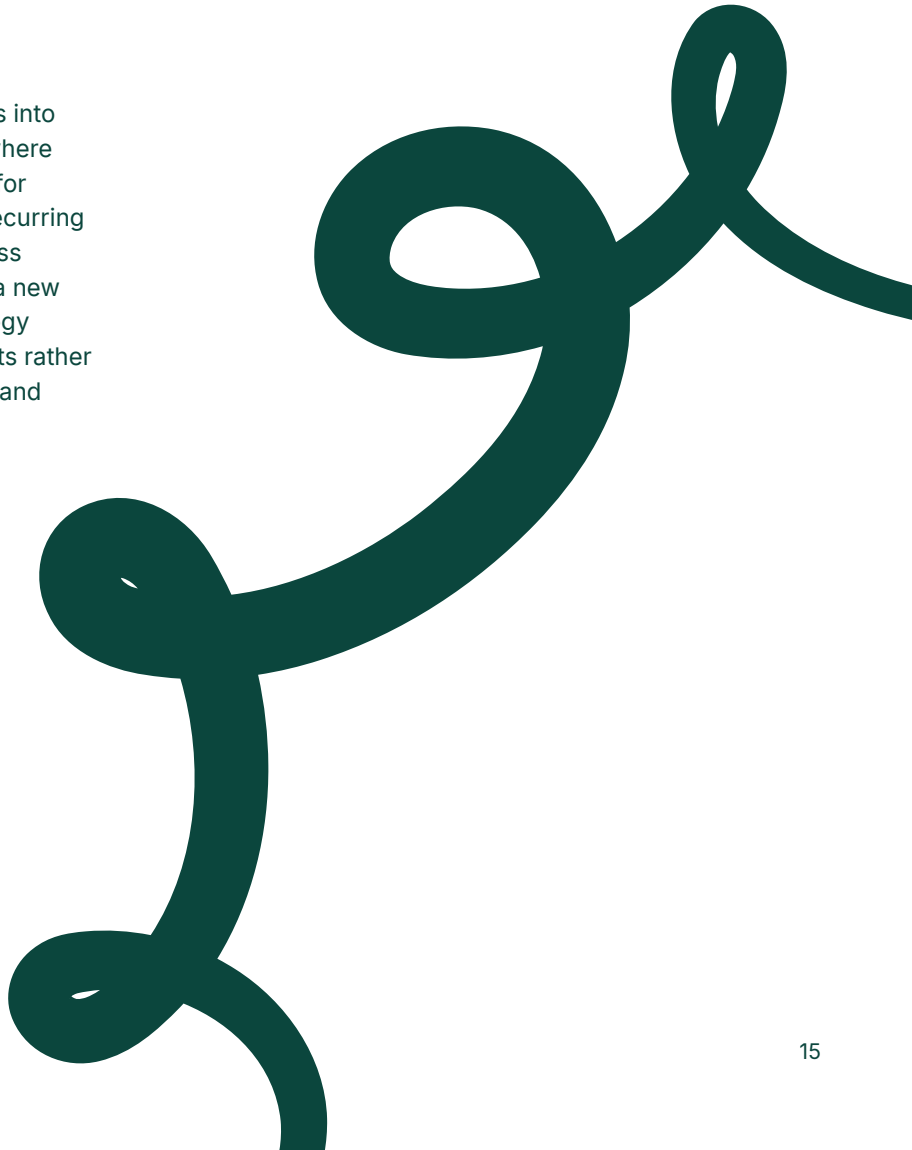
| Service user safety incident type | Required response | Anticipated improvement route |
|---|---|---|
| Incidents in NHS screening programmes | • Work with our partners to ensure referral to UK health security agency and/or refer to local screening quality assurance service for consideration of locally-led learning response<br>• **managing-safety-incidents-in-nhs-screening-programmes** | Currently our services do not offer screening programmes. Add to plan if this changes. |
| Safeguarding incidents in which:<br>• babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence<br>• adults (over 18 years old) are in receipt of care and support needs from their local authority<br>• the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence | • Refer to local authority safeguarding lead<br>• Healthcare organisations 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 | Cooperate with any external review and respond to recommendations from external agencies/organisations as required and feed into the quality improvement strategy |
| Maternity and neonatal incidents meeting Healthcare Services Safety Investigation Branch (HSSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place | • Refer to HSSIB or SpHA for independent PSII<br>• See also Appendix B within: **Guide-to-responding-proportionately-to-patient-safety-incidents** | Cooperate with any external review and respond to recommendations from external agencies/organisations as required and feed into the quality improvement strategy |
| Deaths thought more likely than not due to problems in care (incidents meeting **guidance-on-learning-from-deaths** for PSII) | • Locally-led PSII | Unless the death falls under another more specific category in Table A1, in which case that response must be followed. |

# Our Service User Safety Incident Response Plan: Local Focus

Barnardo's has the flexibility under the Patient Safety Incident Response Framework (PSIRF) to pinpoint local service user safety priorities that may require a Service user Safety Incident Investigation (PSII) for the sake of learning and improving our services. We have compiled a list of agreed priorities that align with our safety incident profile outlined above.

All PSII must be documented following our incident management policy and complemented by our patient safety incident framework, both of which are available on our website for colleagues and service users. When an event occurs and is recognised early as related to patient safety priorities, a PSII will be carried out by a qualified lead. We will monitor and track all systematic reviews, committing to perform a minimum of three index case reviews for each type of incident or issue proposed. This approach allows us to adopt a systems perspective for learning from events.

Furthermore, we will consider integrating recommendations from our learning responses into existing quality or safety improvement plans where appropriate, thereby enhancing opportunities for improvement. If no such plan is in place and recurring thematic recommendations are identified across multiple services, the organisation will create a new quality or safety improvement plan. This strategy ensures that we focus on making improvements rather than repeatedly investigating the same issues and issuing similar recommendations.



# Our Service User Safety Incident Response Plan: Local Focus

There are instances in which the most appropriate response may not require a comprehensive Patient Safety Incident Investigation (PSII). In such cases, it is imperative to meet all contractual, statutory, and policy obligations; however, an alternative learning approach will be utilised if deemed more suitable.

All responses will be coordinated by a designated learning lead, utilising Systems Engineering In Patient Safety (SEIPS), with emphasis on broader systematic opportunities for development and transformation. It is anticipated that all learning responses will contribute to overall improvement. Local learning leads will be responsible for monitoring trends and reporting any necessary improvement plans. Our executive leadership will provide recommendations for organisational improvement, informed by various informational and data sources.

| Service user incident type | Required response | Anticipated improvement route |
|---|---|---|
| Service user incident resulting in moderate or severe harm or where there is opportunity form learning. | Duty of candour where required.<br><br>Complete proportionate learning response such as an After-Action Review (AAR) | Included in reports to Oversight Board to enhance thematic analysis and support existing improvement plans to improve organisational efforts. |
| Service user incident resulting in no harm or low harm including near miss, or where following initial review there is no recourse to learn. | Validation of initial findings.<br><br>Consolidation of incidents to ensure thematic review. | Included in reports to Oversight Board to enhance thematic analysis and support existing improvement plans to improve organisational efforts. |

## Alternative learning methods

It should be noted that the Organisation has a range of other mechanisms around Safety that identify issues for addressing and ensure appropriate action is taken, these include:

- Serious safeguarding Incident reviews, involving all professionals.
- Case study walk through's – Opportunities to read all elements and review events within the areas they took place. Add context to events and real-life opportunities to learn and develop.
- Barnardo's considers that the After-Action Review (AAR) will be the approach of choice as this will provide the most effective learning using SEIPS.
- A multi-disciplinary team (MDT) will look at patient safety incidents (including incidents where multiple patients were affected) or where there has been some time passed since the incident occurred.
- A thematic review will be used where there are similar types of incidents.

## Governance and approval

To maintain oversight of the implementation of this plan, it is intended that our new cross-organisational Quality and Clinical Governance Group will hold responsibility for giving a view on the proportionality of responses and identify any emerging themes in case a wider approach is appropriate. This group shall be accountable to the organisation's Chief Operating Officer and will be reviewed within 6 months of this plan being published to integrate into our already established governance structure.

As set out in our Service user safety incident response policy, the organisation's Strategic Lead for Clinical Governance shall hold delegated responsibility for the oversight of service user safety which includes the review and approval of service user safety incident investigations (PSIIs) in line with the PSIRF. As well as being a core member of the 'PSIRF Oversight Group', the

Strategic Lead for Clinical Governance, along with the organisation's service user Safety Specialists will receive PSIIs in final draft form. Local review and agreement within the service department should involve the ADCS and Safety Lead.

The 'PSIRF Oversight Group' will evaluate the effectiveness of the organisation's approach to PSIRF in conjunction with other stakeholders and sources of information (such as safety data, colleague, and service-user feedback) once this plan has had time to embed. This will inform future iterations of the organisation's plan.

## Other internal processes that will evoke learning and development within services

Barnardo's is committed to fostering learning and development at an organisational level, which is rooted in a systematic review and oversight of services across all tiers. The procedures outlined below will contribute to ongoing development and improvement of services, eliminating the necessity for incidents to prompt change.

- Data Protection Combined Assessment – annual audit assessment of Services adherence with GDPR and the Data Protection Act including annual compliance around annual Data Protection training
- Health and Safety Quality Assurance – annual audit of all Services adherence with the organisational Health and Safety Framework
- Quality Conversation – quarterly report by all Services against a range of quality measures that includes the ability to raise issues affecting performance and compliance
- Safeguarding Standards – currently in development a set of minimum Standards that all Services should adhere to and be able to evidence.

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