PATIENT SAFETY INCIDENT RESPONSE POLICY

June 2025

BARNARDO'S

Changing childhoods.
Changing lives.

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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Barnardo's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues to learn and improve patient safety.

Barnardo's has established policies and frameworks that have been reviewed and amended to support our partnerships and the NHS transition to PSIRF. In the past few years, Barnardo's has transitioned to a learning organisation, and as such, many of our existing policies and guidance currently support the PSIRF movement being initiated by the NHS.

The PSIRF advocates a coordinated and data-driven response to patient safety incidents. It embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy is dedicated to the development and ongoing maintenance of an effective Patient Safety Incident Response Framework (PSIRF) that seamlessly integrates four fundamental aims focused on enhancing patient safety outcomes:

Compassionate Engagement

We prioritise the compassionate engagement and meaningful involvement of all individuals affected by patient safety incidents. At Barnardo's, we believe that children, young people, families, and colleagues deserve access to supportive environments that embody the principles of trauma-informed care. We are committed to fostering safe spaces conducive to healing and relational repair, recognising that these elements are vital for recovery and growth. This commitment is a fundamental aspect of our broader strategic vision, with connections woven into all our policies and procedures.

Our Strategy 2024 – 2027 | Inside Barnardos

System-Based Learning Approaches

Barnardo's is dedicated to implementing a diverse array of system-based methodologies aimed at fostering continuous learning from patient safety incidents. We envision our organisation as a charity where every individual can feel a sense of belonging, encouragement to grow, and the opportunity to thrive. Recognising that each person plays a pivotal role in supporting their colleagues to reach their full potential, we are developing new systems and roles designed to enhance collaboration and learning across the organisation.

Considered Responses to Incidents

Our guiding principle, "Changing Childhoods, Changing Lives," reflects our commitment to working alongside children and young people to ensure they feel safe, happy, healthy, and hopeful. We approach service user safety incidents and safety-related issues with considered and proportionate responses, understanding the importance of managing these situations with care and thoroughness.

Supportive Oversight and Improvement

We believe in providing supportive oversight that focuses on strengthening the functioning of our response systems and fostering continuous improvement. Our approach is rooted in compassion, aiming to learn from incidents as they arise. We have already initiated efforts to gain insights and understanding from various incidents, including serious safeguarding issues, complaints, data breaches, and health and safety concerns. This proactive stance allows us to enhance our strategies and ensure a safer environment for everyone involved. In 2022, Barnardo's launched the quality conversation tool for all services, which has significantly altered the way services track and monitor development and successes.

Barnardo's is establishing a Quality & Clinical Governance Group. This group will have oversight of matters of quality improvement and clinical governance; this includes learning related to safety responses and the monitoring of safety improvement plans. The group will ensure that principles of quality and clinical governance and risk management are integral within all development and delivery of Barnardo's programmes of work. The group's work will seek to minimise preventable harm for children and young people, their families, and staff, including volunteers.

Scope

This policy pertains specifically to the responses to incidents involving service users (patients) conducted with the aim of learning and enhancing practices across Barnardo's NHS-funded and contracted services in England. It is imperative that this policy is effective for Barnardo's staff; therefore, the language utilised within this document will remain consistent with the terminology familiar to our organisation. The term 'service user' will be employed in place of 'patient safety' as this is the primary designation used by our services throughout the four nations.

Responses under this policy follow a systems-based approach. This recognises that service user safety is an emergent property of the healthcare system and those who deliver health services: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

A response conducted for the purpose of learning and improvement does not have the remit to apportion blame or determine liability, preventability, or cause of death. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a service user safety response and are outside the scope of this policy.

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

This policy does not address specific elements or procedures for responding to or reporting incidents and accidents, and those affected by incidents or accidents may wish to consider the following guidance:

Allegations against Adults, including non-recent abuse: **Historical abuse policy**

Claims management: Insurance officer Sarah Fearon.

Complaints: **Complaints Management Framework**

Death of a service user: **Death of a service user**

Financial investigations and audits: **Financial crime**

Professional standards investigations: **Responding to external investigations**

Whistleblowing: **Whistleblowing policy**

Our patient safety culture

Barnardo's basis and values: Our values

Just Culture represents a system of shared responsibility that highlights the significance of both our established processes and the fair treatment of our employees. At Barnardo's, we are dedicated to nurturing a Just Culture guided by the following principles:

Respectful Engagement

We prioritise respectful interactions with everyone involved, fully recognising and valuing their unique perspectives and experiences. Our commitment involves actively listening to individuals to ensure that they feel appreciated, heard, and understood from the very start. We acknowledge that we aren't perfect, and the insights of others are vital for achieving thorough and successful outcomes. By promoting collaboration and open dialogue, we create an environment where respect and understanding lead to meaningful connections and effective solutions. Our staff will apply their trauma-responsive training to support all individuals involved.

Barnardo's is committed to improving communication with service users and their families/carers when a service user is involved in an incident, and where this includes moderate harm, prolonged psychological harm, (non-permanent harm) severe harm (permanent harm) or death. This also relates to those incidents that are retrospectively reported following identification via the claim process. Barnardo's will also ensure that service users, their carers/family, will be kept informed of the investigation and the outcomes.

Transparency in Processes

We aim to create an open and clear environment regarding our evaluation and investigation procedures. This commitment includes providing thorough and detailed explanations of our methods and the specific criteria we consider when making decisions. By ensuring that all stakeholders, including those directly involved, clearly understand how evaluations are performed, and conclusions are drawn, we hope to build trust in our system. We also prioritise open communication throughout the process, using language that is accessible and relatable, avoiding overly technical jargon. By making our processes understandable, we foster collaboration and engagement, helping everyone feel included and informed. Through these efforts, we build a stronger foundation of trust and confidence in our operations.

Accountability for All

We are dedicated to cultivating a culture of accountability that extends beyond personal actions to include our entire organisational framework and our colleagues. This commitment involves a transparent acknowledgement of mistakes and shortcomings, irrespective of an individual's position. We understand that performance often hinges on systemic factors, and we aim to analyse and comprehend these underlying issues. Our approach emphasises a no-blame culture that encourages open dialogue and honest reflection. Instead of placing blame, we work together with individuals to develop constructive solutions that tackle systemic causes of challenges. This proactive mindset aims not only to resolve current issues but also to implement preventive measures that can avert similar problems in the future. Through continuous learning and mutual support, we reinforce our commitment to growth, improvement, and the collective success of our team.

Learning and Improvement

We fully embrace a vibrant culture of continuous learning, seizing every opportunity to grow and evolve. Acknowledging that mistakes are invaluable teachers, we diligently analyse each incident to identify systemic causes. This introspective approach allows us to make thoughtful changes that enhance safety and improve overall performance. By refining our practices based on these lessons learned, we strive to create an environment where growth is continuous, and excellence becomes the norm.

Through these principles, Barnardo's aspires to foster an environment where individuals feel supported and view mistakes as chances for growth and development rather than just grounds for punishment. A just culture considers the broader systemic issues that contribute to errors, enabling professionals and those in the system to learn without the fear of retribution. However, it

also holds individuals accountable when there is clear evidence of gross negligence or deliberate wrongdoing.

Quality Leads across the organisation will receive training in 'Human factors and understanding safety culture'. The ambition is for this to be delivered more widely across our services at the Assistant Director Children's Services (ADCS) and Children's Services Manager (CSM) levels, forming a commitment to our colleagues' learning and development plans. All colleagues working within health contracts in England will be expected to complete 'Essentials of patient safety' for all staff set out in the syllabus developed by Health Education England via eLfh. This introduces everyone working within health and social care to 'human factors and systems thinking'. Furthermore, colleagues identified as Learning Response Leads are required to undertake accredited training, which includes 'Human factors and systems-based approaches, to help foster a just culture'.

To create a Just Culture, everyone needs to commit to our values and show the right attitudes and behaviours. If we all engage with and support these steps, we will improve our Just Culture.

The right culture will be achieved through strong leadership and educating people about a just and safe culture appreciating when it is in action through reflection, benchmarking and commitment of time.

Reporting of incidents

- No-blame reporting of incidents
- Response includes kindness and acknowledgement of the impact on those reporting
- Stress that reporting is about a sense of "in this together" as opposed to accountability and blame

Investigation of incidents

- Conducted in a timely manner
- Apply non-judgemental and proportionate responses.

Learning from incidents

- Apply systematic reviews that encompass all aspects of learning rather than focusing solely on the errors made.
- Continuous review of our learning and development measuring tools

Barnardo's utilises staff surveys via the 'Happiness Index' to address areas such as safety within our culture. The outputs of this survey will be used to identify areas of good culture that can be enhanced and supported to improve where necessary. Services locally reserve the right to conduct surveys with service users to assist with learning and development, including addressing safety issues.

NHS-a-just-culture-guide

Patient safety partners

Barnardo's will set up a Safety Investigation and Learning Board, led by a senior executive director. This board includes heads from various business lines, each responsible for overseeing their specific areas. The primary objective of this group is to meet quarterly to thoroughly review safety data, ensuring that insights gained are shared across all levels of the organisation. Additionally, we will implement systematic changes in the relevant departments to enhance safety measures.

We are committed to working closely with all our commissioners, Integrated Care Boards (ICBs), and external partners on an individual basis, promoting active participation in these review processes. This strategy aims to promote ongoing learning and growth opportunities. Given our extensive network of external partners, our executive director will invite them to join these learning sessions when appropriate, ensuring that information governance is prioritised. The NHS Patient Safety Strategy includes the ambition for all safety-related clinical governance committees (or equivalents) in NHS organisations to include two patient safety partners (PSPs) within their boards.

Barnardo's intends to appoint at least two safety partners from within the organisation this year. The Voice and Inclusion Group are involved in supporting service users to take up this voluntary role. This can include children and young people (over the age of 10 years), their parents or carers. The role will include risk assessment, bespoke training, safety partner identification, remuneration arrangements and support.

The patient safety partner (PSP) is a role that service users, patients or other lay people can play in supporting and contributing to an organisation's governance. PSPs are recognised for making a valuable contribution to service user safety discussions due to their often unique insight as users of services or those with experiences of harm, which can help inform learning and solutions to improve safety without the organisational bias that some colleagues may unconsciously exert. All feedback received through our PSP board will be considered within our learning and development of both future action plans and policy documents.

Barnardo's maintains a positive relationship with the Care Quality Commission (CQC). We actively welcome independent audits and strongly encourage all services to collaborate with regulatory bodies to enhance outcomes for children and their families. This teamwork highlights our commitment to safety and quality in service delivery.

All Barnardo's staff will operate within the NHS PSIRF requirements. The following guidelines will help staff maintain a consistent approach when dealing with service users affected by incidents.

Engaging and involving patients, families and staff following a patient safety incident

Where the above policy discusses media involvement, Barnardo's policy will supersede.

Addressing health inequalities

Our commitment to anti-racism is clearly demonstrated through our Anti-Racism Commitments, which underscore the importance of addressing discrimination in all its forms. This dedication is essential to embodying the values and behaviours outlined in our People and Culture Strategy, as well as our EDI Action Plan. These commitments reaffirm our determination to confront racism whenever it arises and strengthen our mission to operate as an anti-racist charity.

All incident reports at Barnardo's include information on Protective Characteristics, which guide our responses to specific incidents and help us analyse the data to see if certain groups are overrepresented or underrepresented in those incidents.

When developing safety actions and improvement plans, we will prioritise health inequalities to ensure our services promote equality effectively.

Barnardo's is dedicated to adopting a system-based approach which will encourage all our staff to adopt a person-centred approach. ensuring that our colleagues receive the necessary training and skill development to integrate this approach into our strategy and anti-racist pledge. This commitment will foster a just culture and help bridge the ethnicity gap in disciplinary actions within our services.

EDI Policy

Patient and Carer Race Equality Framework (PCREF)

Following the 2018 independent review of the Mental Health Act, NHS England has taken a significant step forward in addressing racial inequalities within mental health services by developing and launching the PCREF.

The PCREF empowers organisations to improve access and experiences of services and improve outcomes for diverse ethnic, racial, and cultural communities.

This mandatory framework aims to support service providers in their journey to becoming actively anti-racist organisations in three main domains:

- Leadership and governance: Trusts' boards will be leading on establishing and monitoring concrete plans of action to reduce health inequalities
- Data: A new dataset on improvements in reducing health inequalities will need to be published, as well as details on ethnicity in all existing core datasets.
- Feedback mechanisms: visible and effective ways for patients and carers to give feedback will be established, as well as transparent processes to act and report on that feedback.

Barnardo's commitment to the PCREF:

By adopting and implementing the PCREF, Barnardo's is demonstrating our firm commitment to reducing racial inequalities within our mental health services.

Senior leaders have cemented their commitment to tackle race inequalities and inequities by improving governance structures, accountability and leadership across the organisation, to include better representation of racialised people and improve services accordingly.

Barnardo's belief in Equality, Diversity and Inclusion (EDI) runs deep in our DNA. Our language, framing, and the depth of our understanding has changed over time, but the goal remains the same; *Barnardo's must be a charity where everyone can belong, whatever your background or circumstances.* This means offering the right services regardless of disability, religion, gender, sexual orientation, belief, racial origin or language.

Barnardo's is committed to being a diverse charity and of challenging bias and discrimination, putting equality and diversity at the heart of our organisation.

Our commitment to the PCREF | Barnardo's

PCREF_Report and Action plan_2025.pdf

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves 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.

Service users, their family members, and carers may be the only people with insight into what occurred at every stage of a person's journey. Not including those insights could mean an incomplete picture of what happened is created.

Staff also have important contributions to make about their experience of the incident and the working environment at the time and should be supported to share their account. The opportunity to be listened to is part of restoring trust and repairing relationships between organisations and staff, patients, and families.

It is important to recognise the impact that a safety incident has on staff involved. The service user is the person most directly harmed following an incident, but harm can also occur to others. 'Second victim' is a staff member involved in an unanticipated adverse event (HSIB 2021)

To maintain support and psychological safety to support staff to feel enabled to stay in work, they can be supported by their line manager, via clinical supervision or by Occupational Health or Employee Assistance.

Duty of Candour

The Duty of Candour Policy has been reviewed and strengthened and includes all Four Nations and all Services within Barnardo's. This is an over requirement in relation to the policy; however, Barnardo's commitment to this area deemed our wider coverage a necessity.

The Strategic Lead for Quality and Clinical Governance will adopt the lead role for learning response lead and engagement lead during the implementation of this policy. Our Learning and Development Lead will work with our newly appointed Strategic Voice and Influence Lead (Health) to create a PSP board, which will assist in engaging service users in safety matters following an incident. The PSP board will work within the following guidelines:

Engaging and involving patients, families and staff following a patient safety incidents guidance, patient safety incident response standards and the PSIRF preparation guide

Currently, our 'All Lessons Learned' reports include the views of all who are part of the incident, including the patient/service user hurt/harmed, the staff involved, managers and other departments where necessary.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety responses relevant to their context and the populations they serve. The Barnardos Incident Response Form will be triaged and assessed by the senior safety team for the most appropriate response. An After Action Review (AAR) will take place soon after the event where there is good staff recall of what happened. The MDT Reflective Review will look at safety incidents (including incidents where multiple service users 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.

Resources and training to support patient safety incident response

Barnardos is committed to providing at least two colleagues who have fully completed the required training as outlined in the standards, ensuring they are sufficiently qualified to deliver the role of Learning Response Lead. These individuals will also provide the role of engagement lead for the organisation. Completing the required training will become a priority and fulfilled by the time this policy is reviewed.

All learning records are available on our internal learning and development records, where staff are accessing eLfh for the purpose of learning and development. Our dedicated learning and development team has established ways of producing evidence to demonstrate compliance with these learning requirements.

Appendix A shows the required learning for staff involved within PSIRF services.

In accordance with the **safety incident response standards** all colleagues working in a health service are expected to complete level 1 'Essentials of Patient Safety'. It can be found within the **patient safety syllabus** link.

Those staff fulfilling the learning role are required to complete Level 2, 'Access to practice'. Barnardo's senior leadership team, ADCS, CSMs, and Executive leads will all complete Level 1: 'Essentials of Patient Safety for Boards and Senior Leadership Teams'.

PSIRF training is available from the Health Services Safety Investigation Branch (HSSIB) and these will be utilised for staff as required. These include SEIPS in Action, Investigative Interviewing and Level 2 Safety Investigation Training. Additionally, the Strategic Lead for Quality and Clinical Governance has completed the equivalent 30 days of safety training and has prepared a suite of PSIRF training packages for the organisation.

Our patient safety incident response plan

The proposed plan articulates Barnardo's strategy for addressing patient safety incidents over the forthcoming 12 to 18 months. This plan is not intended as a rigid framework; rather, it is designed to be flexible and responsive. We will consider the specific circumstances surrounding each incident, the needs of those affected, and the broader context of the plan.

BSIRF Action Plan

Barnardo's action plan was developed collaboratively with subject matter experts and heads of services. Initially, we engaged with all services under existing NHS contracts to map out our offerings, thereby gaining a comprehensive understanding of the specific details associated with each contract.

Stakeholder engagement commenced through open dialogue with key representatives from our larger NHS contracts, including meetings with PSIRF leads and quality assurance officers. These preliminary discussions underscored the necessity for our organisation to engage with each commissioner individually, as identifying a single lead would not adequately support the diverse range of services we provide.

Reviewing our patient safety incident response policy and plan

Our Patient Safety Incident Response Plan serves as a dynamic and evolving framework, designed to be meticulously amended and updated in direct response to patient safety incidents, feedback from staff, those families involved and our commissioning partners. Recognising the need for continual adaptation, we will conduct a comprehensive review of the plan every 12 to 18 months. This periodic review ensures that our strategies and protocols remain relevant, reflecting the ongoing improvement efforts within our organisation, which may lead to shifts in our patient safety incident profile. It is our intention that an initial review will begin within the first six months, led by our audit and assurance team. This review aims to provide initial support for services, examining the systemic approaches employed by various services. Feedback from this audit will inform the future development of our policy and action plan by identifying what is working well and where systems require further development to be fully embedded.

Furthermore, these regular assessments will provide a crucial opportunity to re-engage with our stakeholders, facilitating meaningful discussions about any modifications made in the previous 12 to 18 months. Through collaborative dialogue, we will reach a consensus on the necessary adjustments to enhance our response capabilities.

Updated versions of the plan will be promptly published on our official website, effectively superseding prior iterations to ensure that all stakeholders have access to the most current information. All information in relation to this policy and supporting documents can be found on: **Home | Inside Barnardos.** Using the policies and guidance tab will direct individuals to the most up-to-date versions.

In addition to these regular reviews, we will embark on an extensive planning exercise every three to four years, to coincide with our strategy review. This rigorous evaluation may occur more frequently, should we deem it necessary in coordination with our Integrated Care Board or commissioners. The aim of this in-depth analysis is to maintain a balanced focus on both learning and improvement. This comprehensive review will encompass several critical components: assessing our response capacity, mapping our services in detail, and conducting a thorough examination of organisational data. This data will include, but is not limited to, reports from patient safety incident investigations (PSIIs), improvement plans, patient complaints, claims data, staff survey results, and analyses of health inequalities. Additionally, the review will involve broader engagement with stakeholders to glean insights and experiences that can inform our strategies moving forward.

Responding to patient safety incidents

Patient safety incident reporting arrangements

All colleagues will continue to follow the required reporting and recording guidance outlined in the **Incident and Accident Reporting Flowchart.** Subject matter experts from across our organisation will provide the appropriate response to matters, ensuring that all internal reporting and external bodies are notified.

In the event of a Patient safety incident investigation (PSII) being required, our patient safety lead will work with our ADCS and coordinate the response along with the head of corporate safety, or Safety executive. These staff will support the decision making regarding appropriate and proportionate response to service user incidents. All alerts to key individuals will be required concurrently to avoid unnecessary delays in escalation.

Our service teams are dedicated to upholding the terms of each contract by ensuring we provide all necessary data required for compliance with the Patient Safety Incident Response Framework (PSIRF). We understand the importance of maintaining high standards in patient safety, and as part of our commitment, we actively gather, analyse, and submit the requisite information to not only meet regulatory obligations but also to promote transparency and continuous improvement in our services.

Patient safety incident response decision-making

All incidents will be reviewed in accordance with the agreed 'Patient Safety Incident Response Process' to identify whether further investigation is required. See Appendix B

Some events will require a PSII to be nationally mandated; where this is identified, the response will begin immediately. The guidance for a PSII is outlined in our action plan; relevant staff will ensure they are familiar with this guidance.

There are times when Barnardo's will necessitate a PSII to be completed for learning and improvement across services. This conclusion will be drawn based on patient safety priorities or where similar incidents have occurred within the same service. Where a PSII is not initiated, an alternative learning method should be completed such as an After-Action Review, MDT Reflective Review or Thematic Review; these methods are set out in our action plan. In all incidents, the Learning Response Lead will coordinate the response, and the most appropriate learning response will be implemented.

Service heads and Safety leads will monitor all safety and safeguarding incidents; these initial oversight roles will coordinate any emerging needs.

Barnardo's will prioritise appropriate resources and time to support staff managing and responding to incidents.

Safety Incident Responses that sit outside of PSIRF

Service user safety incident type or issue	Planned response	Anticipated improvement route
Safeguarding – early recognition and escalation of all events meeting the criteria for internal and external reporting eg suicide and self-harm	Follow safeguarding policy and reporting requirements and PSIRF including reporting via LFPSE. Consider a PSII if Barnardo's could be considered "responsible" for the specific incident.	Included in reports to Oversight Board for consideration of policy, practice, learning and development, etc changes. Continued training and development of all staff.
Data Protection – early recognition and escalation of all events meeting the criteria for internal and external reporting	Ensure all service users' privacy policies are maintained. Ensure incidents are reported via LFPSE.	Included in reports to Oversight Board for consideration of policy, practice, learning and development, etc changes. Continued training and development of all staff, including 12 monthly refresher training.
Health and Safety – early recognition and escalation of all events meeting the criteria for internal and external reporting	Follow safety policy and incident reporting requirements and PSIRF including reporting via LFPSE. Consider a PSII if Barnardo's could be considered "responsible" for the specific incident.	Included in reports to Oversight Board for consideration of policy, practice, learning and development, etc changes. Continued training and development of all staff.
Complaints – early recognition and escalation of all events meeting the criteria for internal and external reporting	Follow complaints policy and reporting requirements and PSIRF including reporting via LFPSE. Consider a PSII if Barnardo's could be considered "responsible" for the specific incident.	Included in reports to Oversight Board for consideration of policy, practice, learning and development, etc changes. Continued training and development of all staff.
Whistleblowing – early recognition and escalation of all events meeting the criteria for internal and external reporting	Follow whistleblowing policy and reporting requirements and PSIRF including reporting via LFPSE. Consider a PSII.	Included in reports to Oversight Board for consideration of policy, practice, learning and development, etc changes. Continued training and development of all staff.
RIDDOR	Where the incident is a fatality, escalate via management chain immediately. Where the incident is classified as RIDDOR (not fatality) (see RIDDOR guidance) inform the senior management team and Safety Adviser within 24 hours of occurrence, this applies to all incidents (employee/contractor/temp/visitor).	The Safety Business Partner will work alongside management to determine whether the incident is recordable. The Regional Health and Safety Manager or most senior manager on the applicable site will report the incident to the local Government using the online RIDDOR procedure.

Responding to cross-system incidents/issues

We shall report all incidents within our knowledge to the LFPSE, including instances where the incident is managed by an external partner or agency and is unrelated to our services. Staff at Barnardo's will actively engage with and support partner agencies in all aspects of learning. Should Barnardo's identify that another organisation is involved in an incident, we will directly contact that agency to inform them and seek their collaboration in a systematic approach to learning and investigation.

This collaborative approach will be promoted through the establishment of strong working relationships with all agencies participating in service delivery, founded on early recognition of issues and prompt communication.

Timeframes for learning responses

The learning lead will establish timeframes for responding to learning at the beginning of any investigation. These timeframes will align with PSIRF standards, typically ranging from one to three months. The learning lead will communicate these timeframes to everyone involved, including the patient, family, carer, and staff, primarily through digital communication to facilitate prompt responses, followed by written confirmation. The timeframe will be determined by factors such as the type and severity of the incident, the number of individuals affected, and those necessary for the investigative process. Barnardo's is committed to allocating appropriate resources to all learning responses and implementing systematic changes where identified.

The timeframe for completing safety investigations will be agreed upon with those impacted by the incident as part of defining the terms of reference for the investigation, provided they are willing and able to participate in that discussion. All safety investigations and related local responses are expected to conclude within six months. If the process takes longer than six months, a review will be conducted to explore ways to enhance timeliness. In exceptional cases, such as when a partner organisation requests a pause in the investigation, a longer timeframe may be needed. In these situations, any extension should be mutually agreed upon with those involved, including the patient, family, carer, and staff.

If external bodies or those impacted by the patient safety incidents are unable to provide the necessary information to complete the investigation within the six-month period or agreed timeframe, local response leads will utilise the available information to finalise the response to the best of their ability. This may be revisited later if new information comes to light that necessitates further investigation. Under normal circumstances, access to safety information will be maintained for six years. After this period, any requests for access will need to be directed to the information governance officer for consideration.

Safety action development and monitoring improvement

After identifying lessons learned from an incident response, the learning response lead or team Will pinpoint and agree upon the elements of the work system that could be modified to lower risk and minimise further potential harm. This includes identifying areas for improvement and addressing systemic issues that contributed to the incident. For each identified area of improvement, actions will be developed to reduce risk. Following this, strategies for monitoring safety and reviewing the implemented measures will be outlined and closely tracked. Safety actions will be recorded in our local management systems and linked to any service user safety incidents for effective oversight and monitoring.

If safety actions require additional time for implementation, Barnardo's will ensure that all other achievable actions are prioritised, providing necessary adjustments to service delivery to support future learning and development initiatives. A comprehensive report will be prepared, detailing the necessary steps and establishing realistic timelines for the organisation and services to respond in full.

Barnardo's is dedicated to showcasing our core strategy for quality improvement and learning within its health services, aiming to enhance our approach to ensuring service user safety.

Safety improvement plans

By thoroughly analysing all safety-related data, Barnardo's will develop comprehensive safety improvement plans tailored to effectively address the identified learning outcomes. These plans may encompass a range of strategies, including an organisational approach aimed at reshaping internal processes, systemic changes to enhance operational efficiency, targeted learning requirements to strengthen staff competencies, or specific service-focused improvement plans designed to elevate client outcomes.

Each improvement plan will articulate the necessity for key safety enhancements, drawing from meticulous assessments and a well-reasoned rationale for the proposed actions. This information will be disseminated among teams, partner agencies, and relevant regulatory bodies as appropriate, ensuring transparency and collaborative engagement. Additionally, our quality and assurance team will conduct periodic reviews of the developed learning and improvement plans in conjunction with service delivery assessments. Any recommendations resulting from these audits will be systematically addressed and evaluated in alignment with our audit and assurance approach, fostering a culture of continuous improvement and safety excellence throughout the organisation. Improvement plans will be monitored for efficacy at the aforementioned Quality and Clinical Governance Group.

Oversight roles and responsibilities

Barnardo's Strategic Lead for Quality & Clinical Governance will work in conjunction with our senior executive director and business heads of services to form our oversight board. Their primary function will be to oversee all PSIIs providing sign-off and agreement to learning improvement plans.

The Strategic Lead for Quality & Clinical Governance will be supported by our Patient safety specialists in the strategic oversight of service user safety. Their role will ensure that all data trends and improvement plans are shared and follow up all necessary actions, including reviewing, updating or developing safety improvement plans within services.

Colleagues within Barnardos who will undertake an oversight role, fulfilling learning requirements as set out in the PSIRF standards, identifying as patient safety specialists will be:

- Strategic Lead for Quality & Clinical Governance
- Chief Operating Officer
- Audit and Assurance team
- Assistant Director of Children's Services
- Children's Service's Manager
- Strategic Voice and Influence lead (Health) to support Patient Safety Partners

Additional colleagues within Barnardo's, such as Heads of business or departments, will be encouraged to complete 'Oversight of learning from patient safety incidents' training to demonstrate their commitment to the methodologies used and learning processes set out in this policy.

All colleagues will be encouraged to share learning opportunities at Corporate Leadership Team (CLT) and Senior Management Team (SMT) events.

Barnardo's has implemented robust systems for the oversight of all services. The core functions of these, encompass incidents, accidents, safeguarding, complaints, and compliance with the General Data Protection Regulation (GDPR). All services are mandated to report into our Quality Conversation, which generates real-time data for service managers and directors, enabling the integration of qualitative insights with quantitative data. These responses are

meticulously supervised by our Health, Quality and Inclusion team in preparation for review by senior management. This team will analyse trends, patterns, and anomalies that directly inform future systemic and organisational changes.

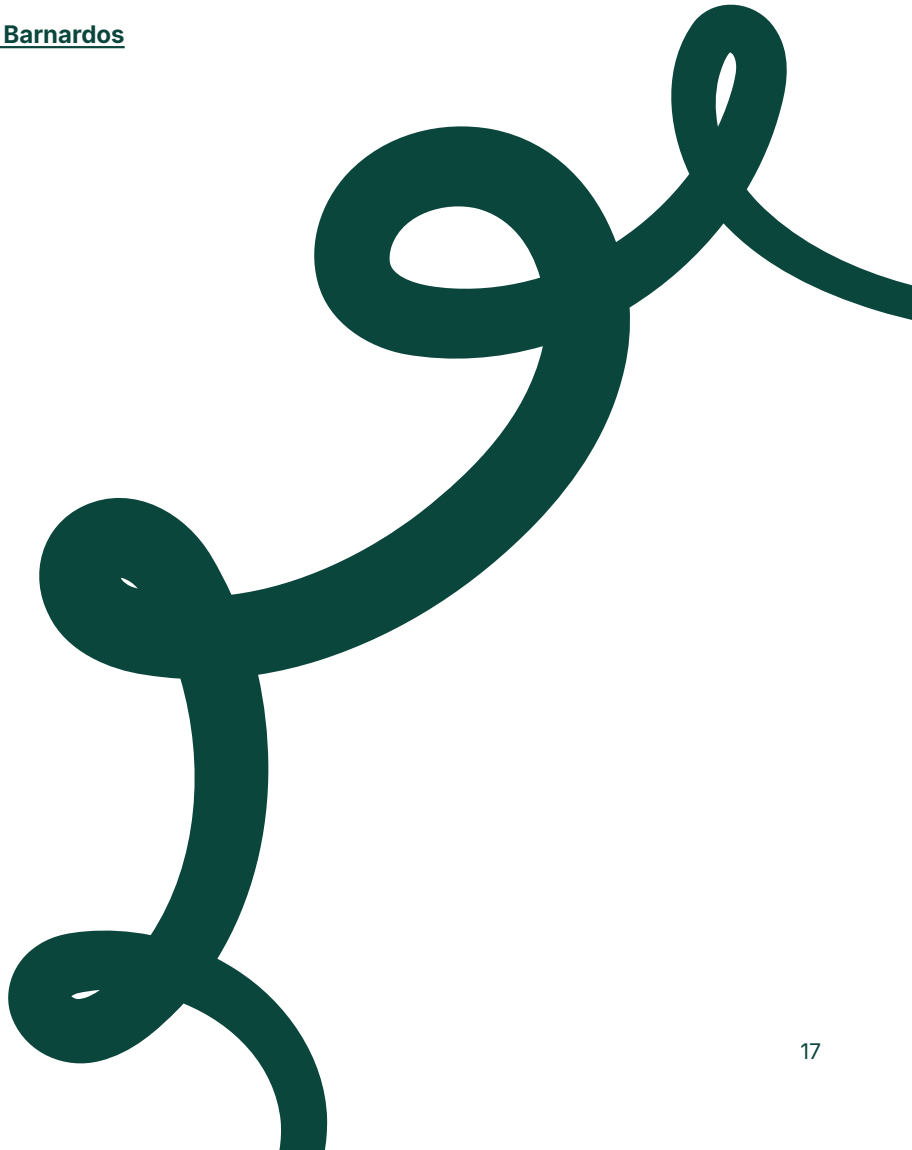
In all our health contracts, service heads will collaborate with the individual commissioners, ICB leads, and CQC or other regulatory bodies utilising open dialogue in relation to our framework, action plan and review of service user data. All services will commit at a local level to ensure that we provide clear concise data for all incidents and work with ICB's and quality teams. Barnardo's will inform the relevant ICB of any patient safety incidents that meet national or local priorities.

Complaints and appeals

All complaints regarding our safety policy should be submitted through our established complaints procedure. For convenience, the full policy is accessible on our main webpage, where you will find comprehensive guidance to navigate the complaint process effectively. This document outlines the necessary steps to ensure your concerns are addressed promptly and thoroughly. We encourage all individuals to familiarise themselves with the policy, as it provides important information on the types of complaints that can be submitted, the timelines for responses, and the resources available to assist you throughout the process. Your safety and satisfaction are our top priorities, and we are committed to addressing any issues that arise in a transparent and efficient manner.

Complaints at stage 2 will be overseen by an independent complaints manager.

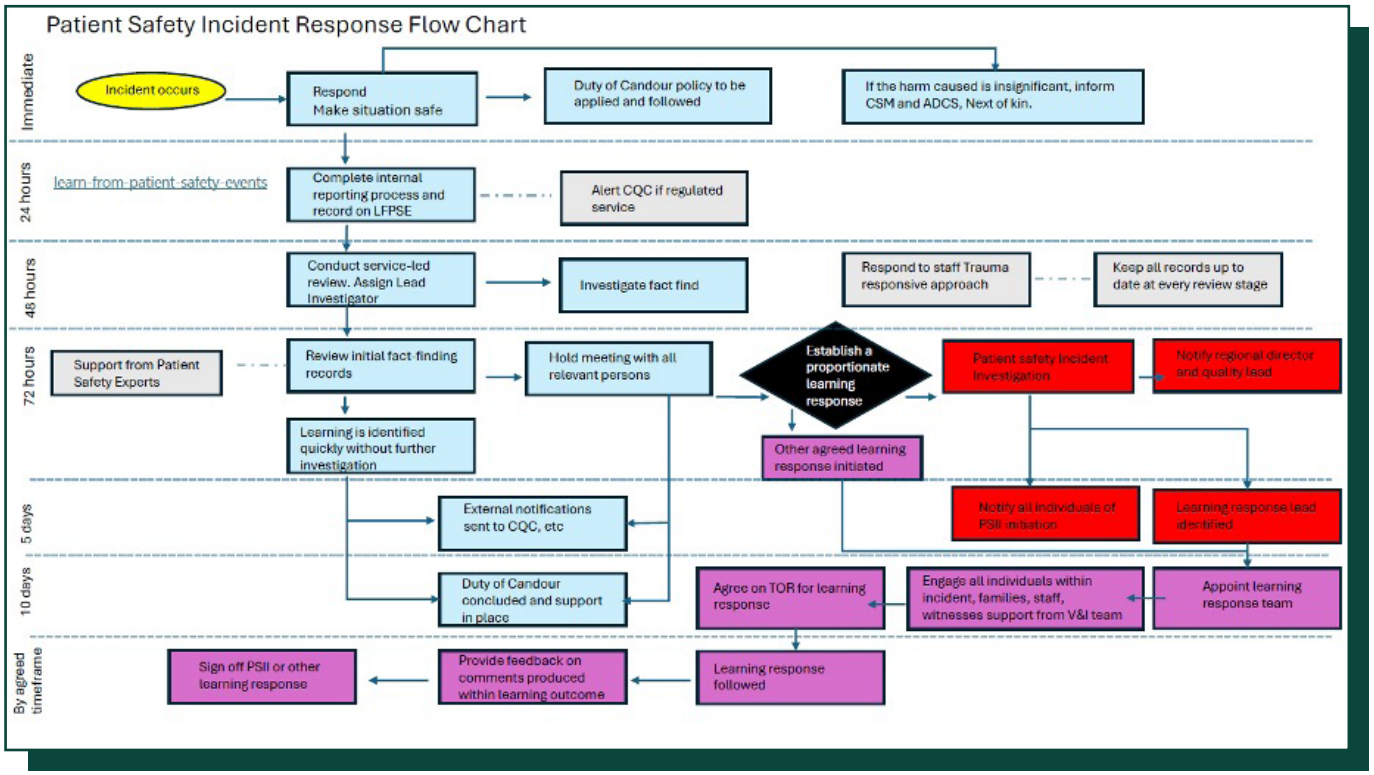
Complaints Management Framework | Inside Barnardos



Appendix A

	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
Systems approach to learning from patient safety Incidents	2 days/ 12 hours	Introduction to complex systems, systems thinking and human factors. Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews. Safety action development, measurement, and monitoring.	Yes		
Oversight of learning from patient safety incidents	1 day/ 6 hours	NHS PSIRF and associated documents. Effective oversight and supporting processes. Maintaining an open, transparent and improvement focused culture. PSII commissioning and planning.			Yes
Involving those affected by patient safety incidents in the learning process	1 day/ 6 hours	Duty of Candour. Just culture. Being open and apologising. Effective communication. Effective involvement. Sharing findings. Signposting and support.		Yes	
Patient safety syllabus level 1: Essentials for patient safety (for all staff)	eLearning	Listening to patients and raising concerns. The systems approach to safety: improving the way we work, rather than the performance of individual members of staff. Avoiding inappropriate blame when things don't go well. Creating a just culture that prioritises safety and is open to learning about risk and safety.	Yes	Yes	Yes
Patient safety syllabus level 1: Essentials for patient safety (for boards and leadership teams)	eLearning	The human, organisational and financial costs of patient safety. The benefits of a framework for governance in patient safety. Understanding the need for proactive safety management and a focus on risk in addition to past harm. Key factors in leadership for patient safety The harmful effects of safety incidents on staff at all levels.			Yes
Patient safety syllabus level 2: Access to practice	eLearning	Introduction to systems thinking and risk expertise. Human factors. Safety culture.	Yes	Yes	Yes
Continuing professional development (CPD)	At least annually	To stay up to date with best practice (eg through conferences, webinars, etc). Contribute to a minimum of two learning responses.	Yes	Yes	Yes

Appendix B


Patient Safety Incident Response Flow Chart
Immediate
24 hours
48 hours
72 hours
5 days
10 days
By agreed timeframe
Incident occurs
Respond
Make situation safe
Duty of Candour policy to be applied and followed
If the harm caused is insignificant, inform CSM and ADCS, Next of kin.
learn from patient safety events
Complete internal reporting process and record on LFPSE
Alert CQC if regulated service
Conduct service-led review. Assign Lead Investigator
Investigate fact find
Respond to staff Trauma responsive approach
Keep all records up to date at every review stage
Support from Patient Safety Experts
Review initial fact-finding records
Hold meeting with all relevant persons
Establish a proportionate learning response
Patient safety incident investigation
Notify regional director and quality lead
Learning is identified quickly without further investigation
Other agreed learning response initiated
Notify all individuals of PSII initiation
Learning response lead identified
External notifications sent to CQC, etc
Duty of Candour concluded and support in place
Agree on TOR for learning response
Engage all individuals within incident, families, staff, witnesses support from V&I team
Appoint learning response team
Sign off PSII or other learning response
Provide feedback on comments produced within learning outcome
Learning response followed

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