Talking Therapies

Patient Safety Incident Response Framework (PSIRF) Policy and Plan (DQ050)

withyou

wearewithyou.org.uk

Statement

The Patient Safety Incident Response Framework (PSIRF) is the new way the NHS looks at learning from patient safety incidents. It has replaced the Serious Incident Framework (SIF, 2015) and represents a significant shift in the way the NHS responds to patient safety incidents. In instances where With You are commissioned under the NHS Standard Contract for Talking Therapies we will adopt the PSIRF. We will not adopt PSIRF in our drug and alcohol services as it's not required.

With You's NHS Taking Therapies Service is required to publish documents to explain how we will meet the requirements of PSIRF (a PSIRF Policy and Plan) These documents describe how WithYou will oversee the process of learning from incidents and making improvements, and which areas of patient safety we will focus on. We will update this document every two years.

PSIRF aims to provide a more flexible, transparent, and compassionate approach to learning responses and investigation. They will have a focus on understanding the different factors that contributed to incidents and ensure that organisations learn from them.

The four aims of PSIRF are:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approaches to influence learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and improvement.

Our PSIRF policy and plan is specific to patient safety event responses conducted solely for the purpose of learning and improvement across WithYou's Talking Therapies services. We will explore patient safety incidents relevant to the context and the population who use these services rather than only those that meet a certain defined criteria or threshold. We have detailed our priorities and how we plan to use the learning from these incidents to improve our service delivery in this document.

Document title	DQ050 Patient Safety Incident Response Framework (PSIRF) Policy & plan (Talking Therapies)
Document Summary:	To set out We Are With You's approach to developing and maintaining effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety
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Contents

Introduction

1. The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF), a replacement for the NHS Serious Incident Framework. Within the Strategy, PSIRF is described as "a foundation for change" and as such, it challenges us to think and respond differently when a patient safety incident occurs.

2. To ensure we uphold a system-based approach (not a 'person focused' approach) we will ensure staff have the relevant training and skill development to support this approach. This will support the development of a 'just culture' and reduce the ethnicity disparity in rates of disciplinary action identified across the wider NHS workforce.

3. The removal of the serious incident process and the use of root cause analysis does not mean "do nothing". Rather, it prompts services to consider the incidents that are occurring, their associated factors, and use these to decide how best to maximise the potential for learning from things that go right and minimising the potential for things to go wrong.

4. One of the underpinning principles of PSIRF is to undertake fewer "investigations" but to place more focus on the systems and processes that have contributed to the incident taking place. This means taking the time to conduct systems-based investigations by individuals that have been trained to do them.

5. PSIRF is a whole system to change how we think and respond when an incident happens to prevent recurrence. Previous NHS frameworks have described when and how to investigate a serious incident, whereas PSIRF focuses on learning and improvement. PSIRF allows for a greater range of learning responses to be utilised when patient safety incidents occur.

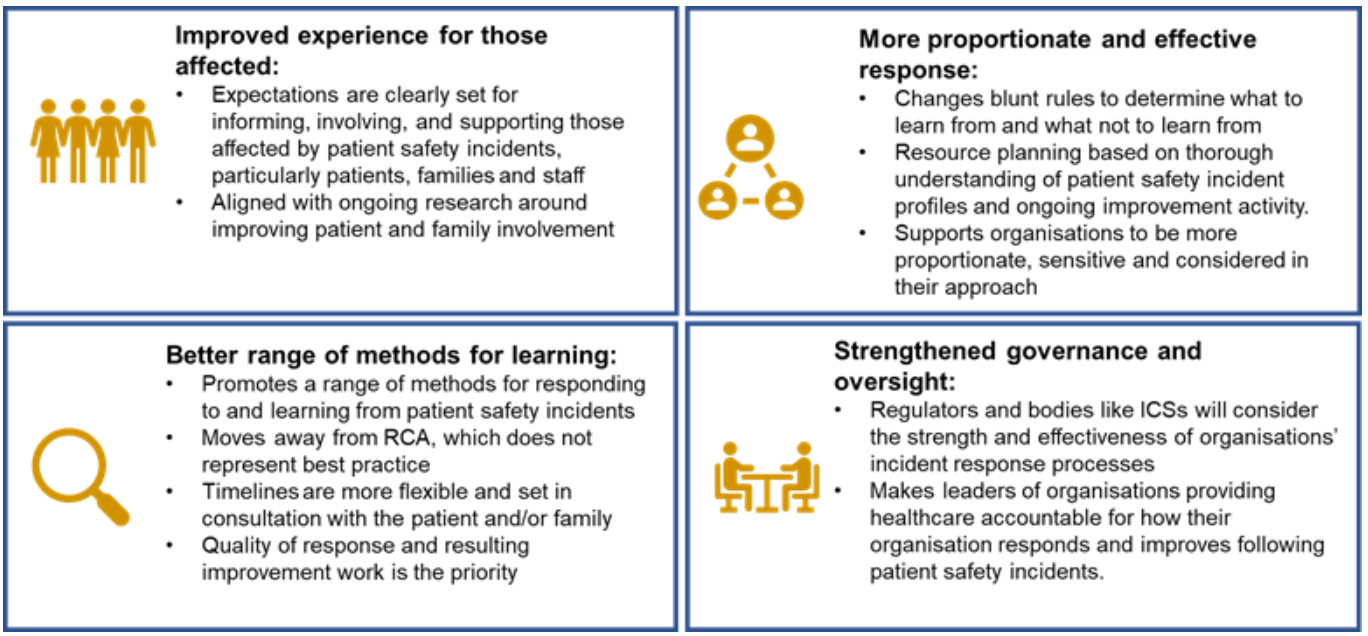
6. This patient safety incident response policy and plan sets out how We Are With You's Talking Therapies service intends to respond over a period of 18 to 24 months. It is not a permanent rule that cannot be changed and we will remain flexible when commissioning learning responses to consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Scope

1. There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of systems-based learning and improvement. There is no remit within this approach to apportion blame or determine liability, preventability, or cause of death.

2. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, People matters, legal claims, or inquests following a patient's death. This Plan explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities. Other types of responses exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners' inquiries or criminal investigations. The principal aim of each of these responses differ from the aims of a patient safety response and are outside the scope of this Plan.

7. There are four strategic aims of PSIRF upon which this plan is based.



8. These aims are aligned with our strategic objectives. Implementation of PSIRF will embody both the aims and visions of the WithYou's work by focusing on using learning from PSI data to improve patient safety and the

overall quality of care.

9. Our patient safety incident response policy & plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months. Updated plans will be published on our website, replacing the previous version.

Our Services

We are With You (WithYou) is an independent healthcare provider and a national charity, providing services across England and Scotland to support people with drugs, alcohol and mental health problems.

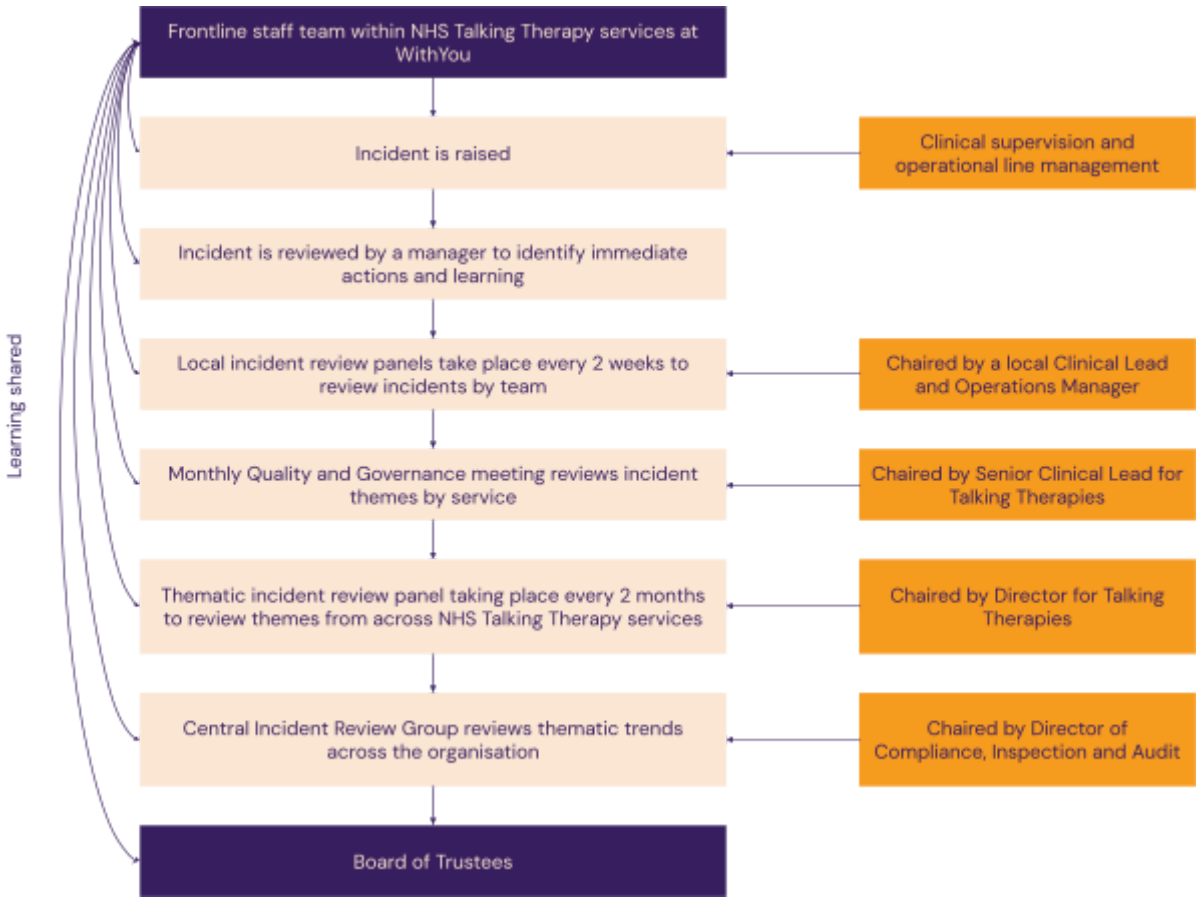
Our NHS Talking Therapy services are delivered in Surrey (where we are commissioned by Surrey and Sussex ICB), and in Kent (where we operate as a subcontracted provider to Vita Health Group). WithYou has been delivering Talking Therapies services since 2008, working in line with the NHS Talking Therapies Manual.

Across our Talking Therapy services, we provide evidence based treatment to around 12,500 people per year. Our services are delivered by appropriately trained and accredited practitioners, delivering treatment in line with NICE Guidance to people experiencing mild to moderate, and moderate to severe symptoms of anxiety, depression, and other anxiety disorders such as obsessive compulsive disorder, health anxiety, and PTSD.

WithYou has a culture for learning and encourages the reporting of incidents or near misses to maximise organisational learning and improve patient safety. All staff are required to report all incidents, including complaints and near misses. Our Incident Management Policy ensures that incidents are appropriately reported and managed so that their impact can be minimised, safety is increased and maintained and learning regarding themes and trends can be extracted.

We monitor themes and trends across reported incidents and use local and national comparators to drive quality improvements. Within Talking Therapies, our Incident Panel Group, comprising Senior Clinicians and Operational Managers, meet regularly to review all clinical and non-clinical incidents, ensuring that we reflect on both clinical and operational factors. Learning is shared through our Clinical Governance Structure, ensuring learning is disseminated both locally and nationally, and allowing themes and trends to be identified and monitored.

Our Clinical Governance Framework ensures that lessons learnt are embedded within practice. Learning is collated and shared with our teams.


Frontline staff team within NHS Talking Therapy services at WithYou
Incident is raised
Clinical supervision and operational line management
Incident is reviewed by a manager to identify immediate actions and learning
Local incident review panels take place every 2 weeks to review incidents by team
Chaired by a local Clinical Lead and Operations Manager
Monthly Quality and Governance meeting reviews incident themes by service
Chaired by Senior Clinical Lead for Talking Therapies
Thematic incident review panel taking place every 2 months to review themes from across NHS Talking Therapy services
Chaired by Director for Talking Therapies
Central Incident Review Group reviews thematic trends across the organisation
Chaired by Director of Compliance, Inspection and Audit
Board of Trustees
Learning shared

Learning Response Methods

1. The Patient Safety Incident Response Framework (PSIRF) learning response methodologies focus on compassionate engagement, systems-based analysis, and proportionate investigation rather than just blaming individuals. The learning response approaches, outlined in the NHS England Patient safety learning response toolkit, are designed to improve safety culture, strengthen response systems, and move away from, but not entirely replace, formal investigation reports.

2. One of the underpinning principles of PSIRF is to undertake fewer "investigations" but to place more focus on the systems and processes that have contributed to the incident taking place.

Key PSIRF Learning Response Methodologies

- **SWARM Huddle:** A rapid, short, and focused gathering of staff to discuss a recent incident or safety concern, allowing for quick, early learning and identification of immediate risks.

- **After Action Review (AAR):** A structured, professional discussion that allows teams to reflect on an incident, understanding what happened, why it happened, and how it can be improved, often held shortly after the event. These will be facilitated by AAR trained staff.

- **MDT Review:** A review involving a multidisciplinary team to collectively analyse incidents, particularly for understanding complex clinical pathways or cross-departmental issues.

- **Patient Safety Incident Investigation (PSII):** An in-depth, systems-based review of a single incident or cluster of incidents, aiming to understand the "how" and "why" and generate actionable improvements. Deaths thought more likely than not to have resulted due to problems in care will always be subject to a PSII.

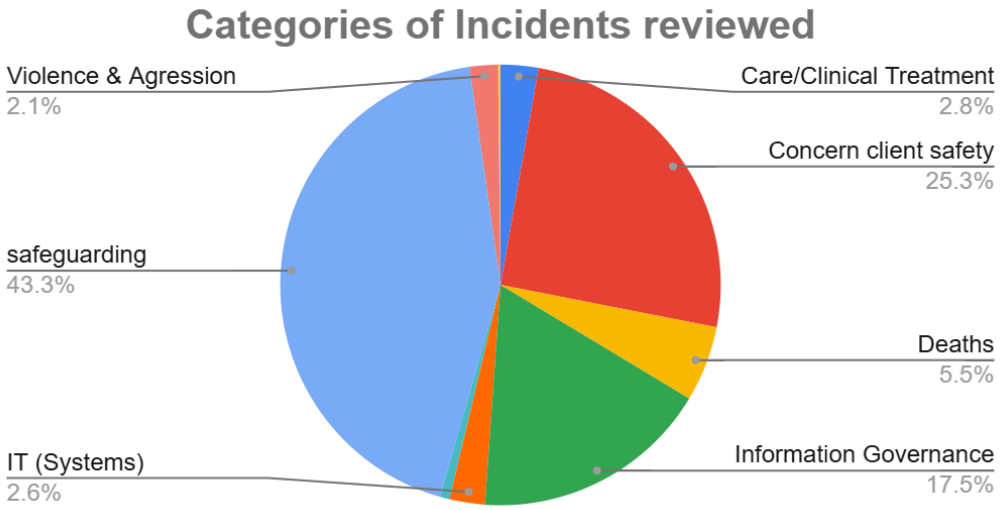
- **Round Table Review:** A meeting used to explore safety themes, pathways, or to identify learning from multiple similar incidents when detailed staff recollections are unavailable. This will be undertaken by the Talking Therapies Thematic Incident Panel which meets every other month

Defining our Patient Safety Incident Profile

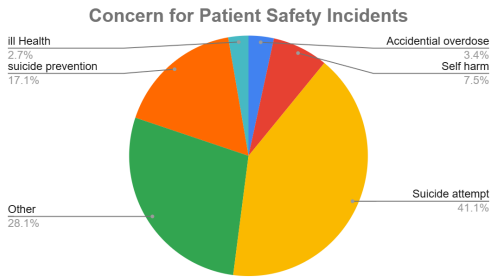
1. A key part of developing our PSIRF Policy and plan (2026) has been understanding the issues that lead to risks for patient safety within With You's Talking Therapies services. To understand the PSI profile, a wide range of information sources about risks to patients were reviewed and evaluated.

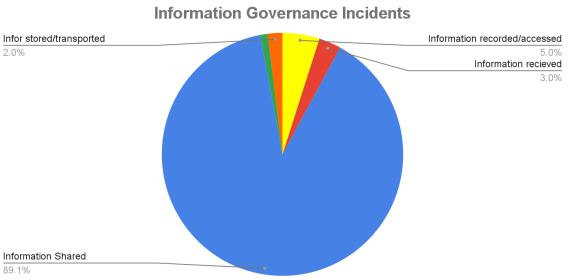
2. From 2026 onwards we will be looking at how we can include Key stakeholders such as patient representatives and external organisations and invite these to attend either an internal or external stakeholder event, How we engage and involve patients, families and staff following a patient safety incident will have consideration of their different needs.

3. We have reviewed 579 incidents and 204 complaints reported on our Incident & Complaints Management System (Ulysses) between 01/01/2024 and 31/12/2026. During this time there were no Regulation 28's received and no concerns raised on our 'working in confidence' platform (whistleblowing/freedom to speak out).



4. The number of incidents recorded in some categories reflect good practice being implemented in our services For example almost half of the incidents reported relate to safeguarding. These are incidents where we have identified concerns and taken steps to safeguard our clients. We have identified the following priorities in our plan for 2026 onwards.





Priority area 1: Ensure that patients do not deteriorate whilst waiting for treatment (fewer suicide attempts /suicide prevention incidents or deaths) by ensuring risk assessments do not fail to identify deterioration during treatment waits.

Priority area 2: Reduce human errors in sharing confidential patient information (reduce Information Governance incidents) We have identified a number of incidents relating to information governance where the sharing of information, mainly attributed to human error, needs improvement. We know that these types of incidents can cause further stress and anxiety for our patients and we will focus our attention to further minimise these errors moving forward automating systems where possible.

Priority area 3: to identify any disproportionate risk to patients with specific characteristics, and how this information informs the development of our patient safety incident response policy and plans. The tools we use will prompt consideration of inequalities, including when developing safety actions.

Further reading

Routes to Involvement Whitepaper - JW Associates