



# Patient Safety Incident Response Policy

**Policy Number:** 1

**Responsible Post:** Head of Services

**Date of this version:** April 2026

**Date of next review:** April 2029

## Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the approach Beat will take to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

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

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

## Scope

The PSIRF is an NHS approach and regulatory requirement and as such uses terminology and language familiar within the NHS. References to patient within this policy refer to beneficiaries or service users, terms more generally used within Beat.

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Beat.

Response types that are outside the scope of the patient safety incident response plan are: complaints, human resources investigations, coronial inquests, criminal investigations, claims management, financial investigations and audits, safeguarding concerns, information governance concerns and estates and facilities issues. For the above, the relevant Beat policies, procedures and processes will be referred to.

### 1.0 Patient safety culture

Beat supports open and transparent reporting by having the following mechanisms in place:

- Day-to-day operations: support planning and risk assessments; supervision and support; structured learning and development; incident reporting; complaints; feedback and comment, service user satisfaction feedback opportunities and surveys; line management review, quarterly safeguarding DSO (designated Safeguarding Officer) meetings and six weekly safeguarding leadership meetings
- Management oversight: Operations risk register; policies, procedures and processes (including complaints and whistleblowing); management performance meetings; quality assurance processes and outcomes monitoring.
- Governance: Services subcommittee and HR subcommittee, as sub-committees of the Board of Trustees, are responsible for overseeing delivery and HR aspects of the charity's external and internal audit arrangements, internal control procedures and risk management and also has responsibility for monitoring health and safety and for ensuring that the charity delivers high quality services, operating in compliance with regulatory frameworks, as well as reporting to the wider Board.
- Independent / external assurance: Commissioner / stakeholder reviews; Accreditation; Health and Safety Executive and Charity Commission.

Beat promotes a climate that fosters a just culture through our proactive approach to safeguarding, and internal review process which is implemented following a patient safety incident.

## 2.0 Patient safety partners

The Beat response to the patient safety incident response framework is overseen through the Services Sub-committee and included in Quarterly reports to the Board of Trustees.

The leadership for patient safety includes:

- Team based DSOs
- Head of Service Development (Deputy Head of Safeguarding)
- Director of Services (Head of Safeguarding)
- Head of HR (Designated Safeguarding Officer)
- CEO
- Trustee Lead for Safeguarding

The following patient safety partners:

- Service users
- Families and carers (where appropriate)

The Head of Safeguarding and/or Deputy Head/CEO will be involved where required to enable the views of our identified patient safety partners to be engaged in the incident response process.

Beat has identified the following external partners:

- Local Authority Safeguarding Teams
- NHS Trusts/ICBs
- National governments who fund services

Beat has established relationships with external partners ensure roles, responsibilities and oversight processes are clear and established.

### 3.0 Addressing health inequalities

Beat's mission is to lead the way to a better quality of life for all people impacted by eating disorders. We want to influence the quality of care that people receive at a UK, national and local level and work in partnership with others to deliver support and services needed.

Equity considerations are an integral part of the current Beat patient safety incident response processes and those identified through our work to improve the safety culture will help to identify any disproportionate risk to service users with specific characteristics.

Any disproportionate risks will be included within the Patient Safety Incident Response Plan and learning will be shared to inform future service delivery. Our processes enable us to identify relevant parties and involve service users, and where relevant and appropriate, families and staff following a patient safety incident which will take into consideration their different needs, and ensure investigations are conducted in a positive and compassionate way with appropriate training and support as needed.

### 4.0 Engaging and involving parents, families and staff following a patient safety incident

Beat has a duty of candour, which means we are committed to openness and transparency with people engaging with our services.

Where harm does occur, we have a requirement to tell a service user what has happened and give an apology, and follow up in writing.

The duty and our responsibility means we will ensure that the engagement principles identified in the patient safety incident response standards are followed, including:

1. Apologies are meaningful

2. Approach is individualised
3. Timing is sensitive
4. Those affected are treated with respect and compassion
5. Guidance and clarity are provided
6. Those affected are 'heard'
7. Approach is collaborative and open
8. Subjectivity is accepted
9. Strive for equity

The approach Beat takes to investigations following a patient safety incident already incorporates engaging and involving staff and volunteers who have been affected. Beat recognises the importance of working with those affected to understand questions they have and ensure learning and improvement is achieved.

#### 5.0 Patient safety incident response planning

PSIRF supports Beat to respond to incidents and safety issues in a way that maximises learning and improvement. Beyond nationally set requirements, PSIRF allows Beat to explore patient safety incidents relevant to our context and the service users we support, rather than only those that meet a certain defined threshold.

PSIRF guidance specifies standards that plans should reflect, including:

- A thorough analysis of relevant organisational data
- Collaborative stakeholder engagement
- A clear rationale for the response to each identified patient safety incident type

Plans will also be updated as required in line with emerging intelligence and improvement efforts.

#### 6.0 Resources and training to support patient safety incident response

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. Beat will evaluate capacity and resources to deliver the PSIRF framework, which will form part of the agenda of the quarterly safeguarding operations group and the services trustee sub-committee.

#### 7.0 Responding to patient safety incidents

##### 7.1 Incident reporting arrangements

Patient safety incident reporting remains in line with the key policies such as Safeguarding, Health & Safety and Whistleblowing. Staff must feel supported to report any incident or concern related to patient safety, promoting an open culture.

Operational managers and DSOs ensure incidents that may meet the patient safety threshold are identified and shared through existing channels. Certain incidents will require external reporting (e.g., to funders, ICBs, local authorities, Charity Commission)

## 7.2 Patient safety incident response decision making

Beat will ensure responsiveness to incidents reported by partners that require input, and seek assurance that engagement, information sharing and learning has been achieved.

Reporting continues in line with existing policies, with oversight systems at local and organisational levels. Key arrangements include:

- Identification and escalation of incidents causing significant harm (moderate, severe or death)
- Identification of themes, trends or clusters of incidents
- Identification of incidents related to local risk issues
- Identification of other incidents of concern such as serious near-misses

## 7.3 Responding to cross-system incidents/issues

Where Beat is working in partnership, we ensure responsiveness to incidents with information sharing agreements with key partners to support communication during incident response and improvement work.

## 7.4 Timeframes for learning responses

Learning responses balance timeliness with thorough investigation. Guidelines include:

- Initial incident investigation — as soon as possible and within 5 working days of reporting
- Comprehensive investigation — usually within 30-60 days depending on complexity

## 7.5 Safety action development and monitoring improvement

Actions identified from patient safety incidents are reviewed and signed off by the Safeguarding Leadership. Actions are shared with relevant leadership and

disseminated across the organisation. Plans are monitored for completion and reported to the Services Sub Committee quarterly as part of our safeguarding report & risk register.

### 7.6 Safety improvement plans

Safety improvement plans will be informed by analysis of quality audits, investigations, complaints and other data. The plan determines key safety risk drivers and how improvements will be monitored for completion and effectiveness.

### 8.0 Oversight roles and responsibilities

Responsibility for PSIRF oversight sits with the Board of Trustees. The Board has designated the Services Sub Committee to hold responsibility for effective monitoring and oversight of PSIRF. Beat is committed to close partnership working with relevant local ICBs, to ensure oversight and quality improvements are delivered.

### 9.0 Complaints and appeals

Any complaints relating to this policy or its implementation can be raised via the Complaints process.

### Related Beat documents

- Complaints Policy
- Safeguarding Policy & protocols
- Whistleblowing Policy
- Health & Safety Policy
- Equality Impact Assessment

The content of the policy does not adversely affect any group with protected characteristics as defined by the Equality Act 2010.