Oxford University Hospitals
NHS Foundation Trust

# Cover Sheet

**Trust Board Meeting in Public: Wednesday 11 March 2026**

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| **Title:** | **Annual Patient Safety Incident Response Framework (PSIRF) Report** |

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| **Confidential:** | **No** |
| **Strategic Pillar:** | **Patients, People, Partnerships, Performance.** |

## Executive Summary

1. This report provides an organisational overview of the second year of implementation of the Patient Safety Incident Response Framework (PSIRF). It includes how its implementation has evolved over the last year and what has been achieved.
2. The report reviews progress with how the organisation meets the four key aims of PSIRF:
    a. Compassionate engagement and involvement of those affected by patient safety incidents - OUH has strengthened compassionate engagement by embedding a consistent approach to involving patients, families and staff in investigations, supported by an expanded group of Patient Safety Partners and improved staff-support mechanisms.
    b. Application of a range of system-based approaches to learning from patient safety incidents - OUH has advanced its use of system-based learning through widespread adoption of After Action Reviews (AARs), Learning Multidisciplinary Team Reviews (LMDTRs) and Patient Safety Incident Investigations (PSIIs), enhanced training, and new tools such as the refreshed PSII template and systems-analyst course.
    c. Considered and proportionate responses to patient safety incidents - have improved through clearer decision-making, streamlined PSII processes.
    d. Supportive oversight focused on strengthening response system functioning and improvement - new quality-assurance mechanisms and the introduction of PSIRF metrics, collectively strengthening the Trust's ability to learn, improve and deliver safer care.
3. In addition, recommendations for future improvement work are presented and will be considered by the PSIRF Implementation Group and PSIRF Improvement Group to inform this year's workplan.

## Recommendations

4. The Trust Board is asked to receive this report and acknowledge the PSIRF work achieved in the last year noting the recommendations made which will inform this year's PSIRF workplan.

## Contents

# Annual Patient Safety Incident Response Framework (PSIRF) Report

## 1. Purpose

1.1. This paper informs the Committee of the progress with PSIRF over its second year of implementation and reviews our current practice against the key aims of PSIRF:

1.1.1. Compassionate engagement and involvement of those affected by patient safety incidents

1.1.2. Application of a range of system-based approaches to learning from patient safety incidents

1.1.3. Considered and proportionate responses to patient safety incidents

1.1.4. Supportive oversight focused on strengthening response, system functioning and improvement.

## 2. Background

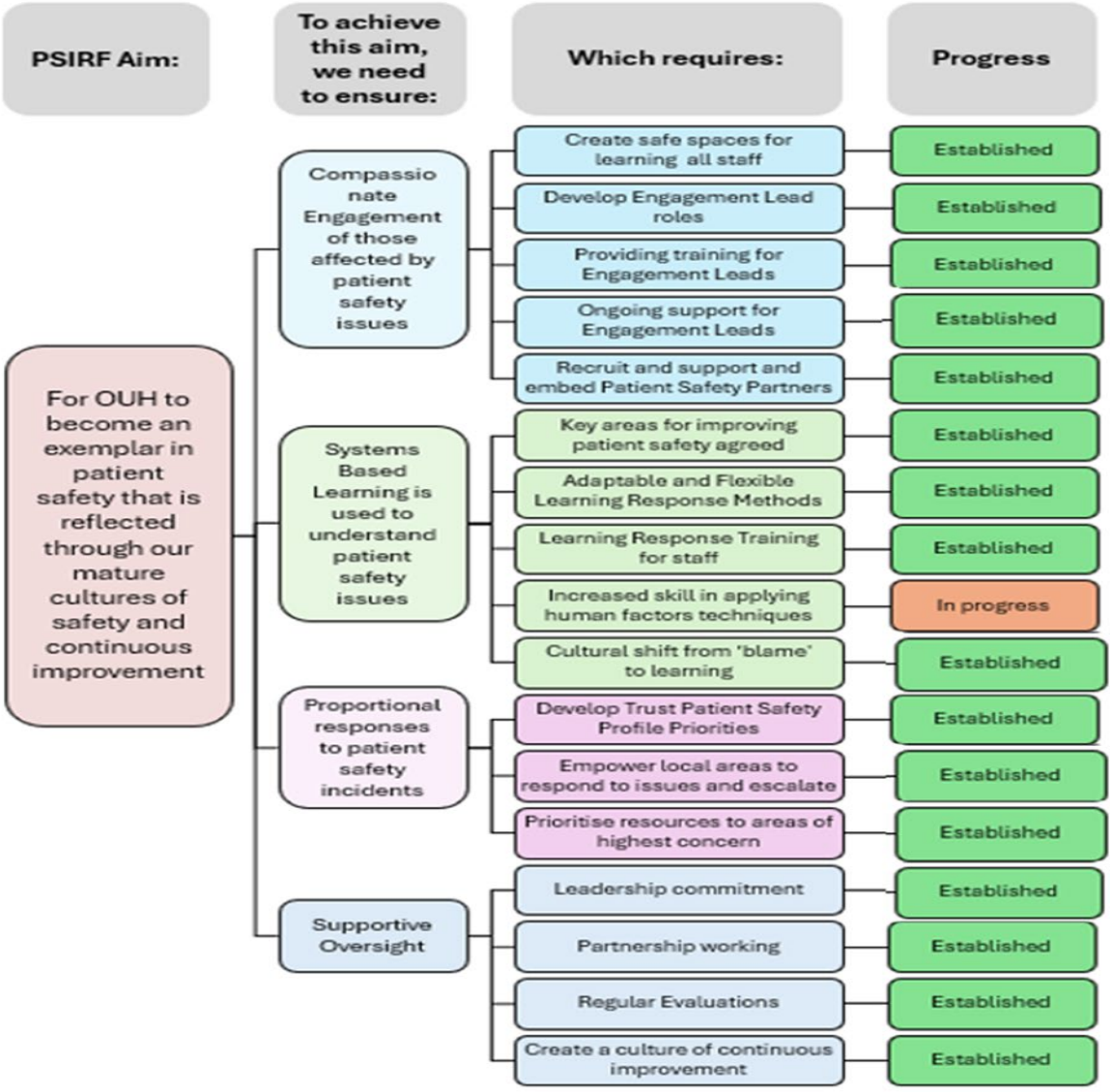
2.1. PSIRF, the national replacement for the Serious Incident Framework (SIF), was launched in the OUH on 2 October 2023. The OUH approach to managing incidents under PSIRF may be seen in our PSIRF Plan and PSIRF Policy.

2.2. PSIRF recognises that healthcare is a highly complex socio-technical system and that safety incidents require responses which are patient-focused, proportionate, based on systems thinking and are supported by those with relevant expertise, who can use a range of different tools to produce effective responses and improve safety.

2.3. Under PSIRF, the OUH aims to be an exemplar in patient safety, reflected through our culture of safety and continuous improvement. We aim to improve safety by increasing the capacity of staff trained and supported to use system-based approaches to learning from safety events, creating a culture of safety and openness, bringing the patient perspective and voice into the centre of patient safety and ensuring that safety is considered a core activity by all.

2.4. A comprehensive driver diagram demonstrating how each of the four areas of PSIRF are assessed was developed in October 2023. A high-level summary of the key drivers and progress to date is in Figure 1.

*Figure 1: High level driver diagram showing progress of establishing PSIRF within OUH*




## 3. PSIRF two-year anniversary summit

3.1. The summit was held at the Nuffield Orthopaedic Centre lecture theatre on 7 November 2025. The event was live-streamed and recorded (with thanks to the Oxford Simulation, Teaching and Research Team (OxSTaR).

3.1. The event was opened by the Chief Medical Officer and hosted by the Deputy Chief Medical Officer (Director of patient safety), (DCMO).

3.2. The human factors podcasts and handbook were launched, available in the OxSTaR section on MyLearningHub.

3.3. The updated PSIRF Plan was launched on OUH website, which contains the new thematic PSIIs.

3.4. The new OUH patient safety incident investigation (PSII) template and sign-off process was launched.

3.5. PSIRF metrics were introduced.

3.6. A panel discussion involved four patient safety partners (PSPs) who talked about their work in partnership with OUH and their reflections. Additionally, three prospective (undergoing onboarding process at the time) PSPs introduced themselves and talked about their backgrounds and what they hoped to contribute to the role.

3.7. The 2025/26 thematic PSIIs were outlined by the leads (see revised PSIRF Plan for details).

3.8. A clinical governance and risk practitioner (CGRP) from each division presented their highlights from the past year and their reflections on how PSIRF had been effective in their divisions.

3.9. A presentation on measuring the quality of our PSIIs, using the Healthcare Services Safety Investigations Body (HSSIB) learning response review and improvement tool was delivered by a resident doctor.

3.10. A poster competition ran alongside the event, in memory of Liam Oliver (who was instrumental in our setting up of PSIRF in 2022-24) was awarded to Riji Varghese, infection prevention and control nurse and team for their poster *"Enhancing Cleaning Standards to reduce Clostridioides difficile cases: A Multi-Ward Intervention"*.

3.11. Evaluation of the PSIRF Summit was positive and attendees included colleagues from BOB ICB, NHSE Region, other Trusts within BOB.

## 4. Compassionate engagement of those affected by patient safety incidents

4.1. OUH has significantly advanced compassionate engagement by:

**Patients and Families**

4.2. OUH now has a consistent, structured approach to patient/family involvement in Patient Safety Incident Investigations (PSIIs), supported by a co-designed Patient Engagement SOP.

4.3. Every PSII (11/11) since implementation has had an assigned engagement lead.

4.4. Engagement leads ensure early contact, regular communication, answering patient questions, and follow-up feedback at the end of the investigation.

4.5. Training for engagement leads has expanded, supported by peer learning via the PSIRF peer support group.

**Patient Safety Partners (PSPs)**

4.6. The PSP programme has grown to eight fully onboarded partners, bringing diverse lived-experience and technical expertise.

4.7. PSPs now have a regular, meaningful role: weekly Safety Learning & Improvement Conversation (SLIC) attendance, PSII review panels, advising on patient-friendly report writing and contributing to improvement work.

4.8. PSPs have influenced practice (e.g., use of real names/pseudonyms, clearer narrative focus in PSIIs).

4.9. OUH is improving onboarding processes, introducing buddying/mentoring, exploring remuneration, and planning targeted PSP recruitment.

**Staff Engagement and Psychological Safety**

4.10. OUH has strengthened support for staff affected by incidents through senior-leader outreach, hot debriefs, and a blame-free learning culture promoted through SLIC, After Action Reviews (AARs) and Learning Multidisciplinary Team Reviews (LMDTRs).

4.11. Staff receive ongoing advice and support from the PSIRF Learning Manager and Patient Safety Team during investigations.

4.12. A Staff Engagement SOP is in development to formalise how staff are supported throughout PSIIs.

4.13. Safety-culture evaluation will be enhanced using validated tools in 2026.

## 5. Application of a range of system-based approaches to learning from patient safety incidents

5.1. OUH has significantly expanded and strengthened its use of system-based approaches to understand and learn from patient safety incidents. Key progress includes:

**Growth in system-based learning activity**

5.2. High volumes of learning responses: 164 AARs, 30 LMDTRs, and 27 PSIIs completed in the reporting period.

5.3. AARs and LMDTRs are being used more flexibly, including for no-harm and low-harm incidents, supporting earlier learning.

**Improvements in AARs and LMDTRs**

5.4. AAR training refreshed to be shorter, more clinically relevant, and include SEIPS-based (Systems Engineering Initiative for Patient Safety) systems thinking.

5.5. LMDTR approval process streamlined: reports uploaded to SharePoint for review prior to SLIC discussion, reducing delay.

**Strengthening PSII process and quality**

5.6. PSIIs now consistently incorporate subject matter expertise, systems analysis, and dedicated engagement leads.

5.7. A new PSII template launched, making reports more patient-centred, better structured, and clearer in their systems analysis.

5.8. Introduction of PSII review panels (since Sept 2025) has improved report quality and reduced reviewer burden.

**Wider adoption of systems-analysis tools**

5.9. Increased use of SEIPS, bow-tie, hierarchical task analysis, interaction mapping and thematic review.

5.10. OUH staff increasingly use artificial intelligence tools (Copilot) to support thematic analysis, improving identification of patterns and trends.

5.11. Thematic reviews have led to tangible improvements, e.g., reduced dispensing incidents and better communication workflows.

**Building system-analysis capacity**

5.12. Training gaps identified; OUH commissioned a bespoke OxSTaR two-day systems analyst course, training 24 staff from Feb 2026.

5.13. Aim is to build a sustainable pool of trained systems analysts able to support PSIIs and LMDTRs across all divisions.

**“Closing the loop” improvements**

5.14. We identify actions from all levels of incident investigations, which meet the criteria for ‘closing the loop’:

1. The action was clearly defined
2. The action was measurable
3. The action was measured and showed an improvement
4. There is evidence to suggest that the improvement has benefited patient safety
5. The improvement is sustainable (or has been sustained over a sufficient period)

5.15. In 2025, we reported 12 ‘closing the loop’ actions resulting in measurable improvement, demonstrating real-world impact from incident-driven actions (e.g., reduced falls, improved medicines safety, safer equipment processes; further details are available in the accompanying report to Clinical Governance Committee).

## 6. Considered and proportionate responses to patient safety incidents

6.1. OUH has strengthened its ability to respond to patient safety incidents in a way that is proportionate, risk-based, and aligned with PSIRF principles, ensuring that the most intensive investigation methods are reserved for the issues of highest priority.

**Better use of proportionate investigation methods**

6.2. A significant proportion of learning responses—16% of AARs and 20% of LMDTRs —were triggered by no-harm or low-harm incidents, demonstrating that divisions are increasingly responding based on learning potential, not severity.

**More appropriate commissioning of PSIIs**

6.3. A review by Clinical Governance of 28 PSIIs found in discussions with Divisional governance staff that 79% were correctly commissioned and only 11% would have been more suitable as an LMDTR, indicating strong decision-making about when the most resource-intensive response is needed.

6.4. This also highlighted why OUH now has fewer PSIIs than historic serious incidents requiring investigation (SIRIs): improved use of LMDTRs now provides an effective, formal alternative for many cases.

**Clearer criteria and learning-led decisions**

6.5. Divisions follow updated PSIRF plan criteria to determine whether an incident warrants a PSII, considering themes, novelty, recurrence, and potential system risks—not automatic triggers.

6.6. Some PSIIs were found to have been commissioned because of legacy practices (e.g., historical approach to Never Events), and learning from these reviews is now informing future decisions.

**Linking LMDTRs and PSIIs for deeper analysis**

6.7. In several cases, LMDTR findings informed subsequent PSIIs, enabling more efficient, targeted investigations.

6.8. This two-stage approach strengthens systems analysis and ensures deeper understanding where needed.

**Impact and forward view**

6.9. The review estimates OUH will require around 25 PSIIs per year, creating a predictable workload for planning.

6.10. Stronger use of proportionate responses ensures better allocation of staff time, improved timeliness, and more focused system-level learning.

## 7. Supportive oversight focused on strengthening response, system functioning and improvement

7.1. OUH has strengthened the governance, assurance and oversight mechanisms that support PSIRF, ensuring safer, more reliable and more transparent patient-safety processes.

**Strong leadership commitment**

7.2. The Chief Medical Officer and Chief Nursing Officer maintain direct oversight, including review of all PSIIs and visible support at key events such as the PSIRF two-year anniversary summit.

7.3. Regular reporting cycles ensure PSIRF activity is reviewed by Clinical Governance Committee, Integrated Assurance Committee, and Patient Safety & Effectiveness Committee, reinforcing organisational accountability.

**Updated PSIRF Plan**

7.4. The PSIRF plan was refreshed in November 2025, incorporating new thematic PSIIs and updated priorities.

7.5. A full refresh is scheduled for 2026/27, ensuring PSIRF remains a live, continually improving framework.

**Strengthened system-level partnerships**

7.6. OUH maintains active collaboration with BOB ICB, with quarterly meetings providing supportive challenge and shared learning.

7.7. OUH's Patient Safety Specialists contribute to the BOB Patient Safety & Improvement Forum, including development of cross-organisational templates and shared investigations.

**Quality assurance of investigations**

7.8. The Health Services Safety Investigation Body (HSSIB) Learning Response Review and Improvement Tool is now routinely used to assess PSII quality.

7.9. Comparative evaluation shows improvement in PSII quality over historical SIRI reports.

7.10. OUH plans to extend the tool to evaluate LMDTRs and examine the impact of the new PSII template.

**Introduction of PSII review panels**

7.11. Review panels, launched in September 2025, provide structured feedback to investigators before final sign-off.

7.12. Early feedback shows panels improve clarity, reduce review time and enhance report quality.

## 8. Thematic PSIIs

8.1. OUH has continued to use thematic Patient Safety Incident Investigations (PSIIs) to explore complex, cross-cutting safety issues. Since PSIRF launch, seven thematic PSIIs have been commissioned, with three active during 2025/26. Strong multi-disciplinary engagement, PSP involvement, and effective cross-divisional collaboration underpin this work.

8.2. Thematic PSIIs have enabled OUH to identify deeper systemic issues, co-design solutions across specialties, and implement improvements that would not emerge from single-incident investigations. Progress to date demonstrates strong engagement, practical safety improvements, and clearer pathways for future monitoring and impact evaluation.

**Handover, Communication and Documentation (2425-T1)**

8.3. Updated and simplified transfer and escort policy nearing approval.

8.4. Digital handover tools now widely used, improving clarity and efficiency; Horton Hospital shows full adoption.

8.5. Ongoing work with portering services to optimise patient transfers.

**Reporting and Endorsement of Results (2425-T2)**

8.6. Automatic redirection of test results for staff leavers.

8.7. Training video produced to prevent missed results.

8.8. Planned auto-endorsement of normal results to reduce workload and risk.

8.9. Safety-netting pilot for suspected cancer results.

**Cancer Referral and MDT Processes (2425-T3)**

8.10. SOP for MDT-to-MDT referrals implemented.

8.11. Coordinators trained and practice standardised across MDTs.

8.12. EPR (electronic patient record)-based referral pathway audited and completed.

**Vulnerable People (Learning Disability) (2425-T4)**

8.13. Trustwide Learning Disability Steering Group established.

8.14. Power BI dashboard enables identification of patients with learning disability for safer planning.

8.15. High compliance with Oliver McGowan Training.

8.16. Passport template updated, audits now ongoing.

**Safe and Timely Discharge – Dosette Boxes (2526-T1)**

8.17. Thematic review identified failures in dispensing, communication and planning for patients using dosette boxes.

8.18. Next steps include refining the discharge process and defining baseline metrics.

**Escalation of Deteriorating Patients (2526-T2)**

8.19. RAID (Recognising Acutely Ill & Deteriorating patients) huddles refined through PDSA (plan, do, study, act) cycles and expanded.

8.20. Review underway of communication tools (e.g., SBAR [Situation, Background, Assessment, Recommendation]) and SEND (System for Electronic Notes & Documentation) system opportunities.

**Positive Patient Identification (PPID) (2526-T3)**

8.21. Focus on wrong-blood-in-tube (WBIT) incidents and safer systems in ED.

8.22. Strengthened wristband and PPID audits.

8.23. Workstreams also planned for wrong-procedure incidents and medication-to-wrong-patient errors.

## 9. Summary of improvements made in 2025

9.1. Over the past year, OUH has strengthened compassionate engagement by embedding a co-designed patient-engagement process, assigning engagement leads to every PSII, expanding the contribution of Patient Safety Partners and improving staff support through hot debriefs, senior-leader outreach and learning-focused forums.

9.2. The organisation has significantly advanced its use of systems-based approaches, completing high volumes of AARs, LMDTRs and PSIIs, increasing use of SEIPS, bow-tie and thematic review, and launching a new PSII template and systems-analyst training programme.

9.3. Responses to incidents have become more considered and proportionate, with improved decision-making on when to commission PSIIs, expanded use of LMDTRs, and the introduction of PSII review panels and a streamlined timetable to enhance quality and timeliness.

9.4. Oversight has been strengthened through regular reporting to Trust committees, the introduction of PSIRF metrics, routine use of the HSSIB quality review tool and improved regional collaboration, all contributing to a more resilient and learning-focused patient safety system.

9.5. Our peers from neighbouring trusts and BOB ICB colleagues have provided positive feedback on our learning responses and implementation of PSIRF at OUH.

## 10. Conclusion

10.1. The second year of PSIRF has seen evidence of the key principles and what were once novel approaches (after action review, patient engagement in the investigation process, human factors-based systems analysis, proportionate responses to incidents) becoming ‘business as usual’ and we are starting to see measurable impacts, through our SLIC presentations (‘closing the loop’ examples) and qualitative reviews of PSIIs.

10.2. The challenges we face in the coming year include sustaining these improvements and improving training and support for staff in applying the wide range of systems-based tools, which can lead to improved safety.

10.3. An expanded team of PSPs and expected increase in the number of systems trained staff should provide more opportunities for OUH to develop exemplary patient safety practice and engagement of patients, families and staff in our learning responses and improvement work.

10.4. The review of the last year brings together a series of workstreams to strengthen PSIRF delivery, including:

10.4.1. Improving insight into SLIC participation to ensure inclusive learning.

10.4.2. Introducing validated safety-culture measurement tools into the 2026 metrics.

10.4.3. Finalising and implementing a consistent Staff Engagement SOP for PSIIs.

10.4.4. Broadening the use of systems-based investigation tools such as SEIPS and Bow-tie.

10.4.5. Expanding and sustaining the pool of trained systems analysts through initiatives like OxSTaR training.

10.4.6. Refining PSII commissioning criteria to ensure proportionate and non-duplicative investigations.

10.4.7. Assuring the quality of LMDTRs by applying the HSSIB Learning Response Review and Improvement Tool.

10.4.8. Further refining the PSII template based on feedback and patient-centred principles and evaluating the impact of the new template to confirm improvements in clarity, quality and systems thinking.

10.5. These workstreams will be considered by the PSIRF Implementation Team and a roadmap produced for the PSIRF Improvement Group to review.

## 11. Recommendations

11.1. The Trust Board is asked to receive this report and acknowledge the PSIRF work achieved in the last year noting the conclusions made which will inform this year's PSIRF workplan.